Discovery Health and Discovery Health Medical Scheme response to Health Market Inquiry request for input on the need for and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition

Overview

Discovery Health Pty (Ltd) (“DH”) and the Discovery Health Medical Scheme (“DHMS”) note the discussion document published by the Health Market Inquiry (“HMI”) on 1 December 2017 regarding the regulatory gaps within the healthcare financing sector.

We share the vision of the HMI that the goal of the healthcare system must be to enhance access to affordable, quality and cost effective healthcare. We acknowledge that there are challenges and limitations of the current regulatory framework impacting on risk pooling and leading to the complexity of benefit options, notably Prescribed Minimum Benefit (“PMB”) regulations and the lack of risk equalization and mandatory membership which are key elements of a social solidarity regulatory framework.

A summary of the principles included in this document are:

- We agree that there is a need for benefit options to be more understandable and simplification in this regard could be helpful. For example, a standardized table of benefits for presenting benefits could be made available to the market. It is important to note that this is not a standardization of the benefit package, but rather a standardized format for presentation of benefits to assist consumers in understanding various benefit options. Schemes could be required to adhere to this format as a minimum, but may also present additional formats. We believe that taking this step will largely mitigate the information asymmetry between schemes and members by allowing members to effectively compare options and thereby promote competition, without restraining innovation and value-based offerings to members by schemes. We strongly disagree with the concept of reducing the number of benefit options within schemes as a response to the problem of asymmetry of information. This will have negative impacts on competition and consumer welfare. We set out our reasons for this view in more detail below.

- We support the concerns that the current Prescribed Minimum Benefits (PMBs) are too broadly defined and hospice-centric to be used for common pricing of benefits across all benefit options. Using the current definition would simply increase the cost of cover for lower cost options and hence cause a large number of low income families to withdraw from cover. The implication of stipulating a minimum list of benefits that each medical scheme is required to cover is that medical schemes are not able to offer low-cost medical plans based on a subset of the PMBs (possibly including other primary care benefits as well), which would enable more low-income households to enter the private healthcare market. As such, consideration should be
given to modifying the current PMB package, to create a better balance between primary care benefits, which are GP focused, and specialist care benefits, which are primarily hospital care based. This should have the effect of reducing the costs of the current PMB package, a barrier to scheme and industry growth.

- A different set of basic benefits (more akin to a NHI-aligned benefit package of primary care and emergency care) could be a better basis for pooling and this would need to be carefully defined and properly modelled to ensure that it has the effect of expanding access to affordable care instead of the unintended consequences of reducing it. There is little doubt that as soon as chronic cover and elective hospitalization is included, the subsidies will work in the wrong direction from an income perspective.

- Standardising or limiting the number of benefit options available will materially reduce competition and consumer choice, as schemes will not be able to compete effectively on diverse and innovative offerings. The net effect will be reduced consumer choice, reduced competition between open schemes, and net consumer welfare loss. Also, a reduction in the number of benefit options on existing schemes will necessitate anti-selective membership movements and could have adverse short- and long-term consequences. For all of these reasons, limiting the number of benefit options within schemes is an inappropriate and very risky solution to the problem of lack of transparency and information asymmetry.

- Risk equalization is a valuable mechanism for pooling risk across fragmented risk pools. Risk equalization needs to be associated with some form of mandate to be helpful in expanding access and promoting competition. It should also be noted that the Risk Equalisation Fund (REF) as defined during the shadow period (2006-2011), did not provide schemes with stochastic risk (catastrophic claim) protection. The REF has an important role to play in ensuring that medical schemes are competing on the basis of risk management rather than risk selection, but medical schemes are still exposed to risk in respect of non-equalised claims (non-PMBs as per the previous iteration of the REF) and large claims. This will also aid the transition to an NHI framework (which entails compulsory cover).

- Catastrophic risk pooling (in various forms) is another form of risk equalization that could also assist with promoting competition but there is a challenge in ensuring that risk management incentives are in place.

- These suggestions are consistent with a transition to NHI on a hybrid multi-payer basis as proposed by the High-Level Panel on the Assessment of Legislation and the Acceleration of Fundamental Change (HLP)\(^1\).

\(^1\) https://www.parliament.gov.za/high-level-panel
- DHMS has always competed on the basis of providing value for money and innovation, but has had some regulatory challenges in this regard. The ability to enter into innovative contracting with providers and moving away from fee for service remuneration is affected by the structure of PMBs and by archaic HPCSA rules and regulations. The DH input to the HMI has recommended that these obstacles to innovation and cost effective care delivery are urgently addressed.

- DHMS has developed an innovative benefit design incorporating a medical savings account which balances the provision of promotive care with managing moral hazard.

- Medical schemes compete to provide value-for-money to members in respect of contributions, the design of benefit options, the richness of benefits, sufficient access to quality provider networks and the ability to effectively manage member claims. A key objective of any intervention must be to sustain this and promote this type of competition, and not to undermine or hinder it in any way.

- In this document we refer to the original Discovery Health submission to the HMI (November 2014). We note also that Discovery Health and Discovery Health Medical Scheme have made detailed submissions on the proposed NHI framework to the Department of Health, and would welcome an opportunity to discuss these with the HMI.
Detailed discussion

The comments below are set out per paragraph according to the numbering in the HMI document of 1 December 2017 calling for submissions on regulatory gaps. The bold wording indicates the headings and questions posed in the HMI document.

Introduction

1. We support the contention that the social solidarity principles of mandatory membership and risk equalization would mitigate against anti-selection. Significant progress was made in the collection and analysis of data during the REF shadow period from 2006 to 2011. The rationale for stalling this process remains unclear. It is important that a proper impact assessment of any risk equalization mechanism is conducted using adequate data and with adequate stakeholder consultation.

2. The incomplete implementation of social solidarity principles has contributed to inflation in medical scheme claim costs. This is because the absence of a mandate has led to large scale anti-selection against open medical schemes – those who will benefit from cross subsidies have an incentive to enroll while those who are more likely to be subsidizing will be less likely to enroll.

3. The HMI document suggests that members are encouraged to self-select based on their perceived risks. We contend that this is a function of the incomplete social solidarity framework. DHMS experience indicates that affordability and risk aversion are also significant factors in option selection. Risk management mechanisms can be structured to balance risks, allowing for members to be able to make benefit purchasing decisions while at the same time ensuring appropriate cross subsidies to operate. This document includes a number of suggestions in this regard. The consolidation trend in the medical schemes industry has meant that the number of benefit options has reduced from 405 in 2005 to 272 in 2014. The HMI document also notes that the current environment of open enrolment and community rating without the complementary effects of mandatory membership and risk equalization hinders competition in the funder market. We do not agree that the main effect of the incomplete implementation of a social solidarity framework is hindering competition, but rather that it has driven up the costs of cover by facilitating anti-selection.

4. We note the statements regarding the effect of the range of options available, but believe that the data indicates that members have been able to make rational benefit selection choices. This is evidenced from the current member distribution across options (in terms of risk factors and claims experience). The key problem is thus the incomplete social solidarity framework, and not the number of benefit options. We are of the view that simply restricting the number of benefit options will have major negative impacts including undermining competition and innovation,

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2 Alex Van Den Heever: Industry Overview (Submission to the HMI 2016)
reducing consumer choice, and forcing consumers to accept higher premiums or lower cover than they are currently able to choose.

We further note the statements with respect to the factors on which medical schemes compete (“...that attract young and healthy members...”). It is important that medical schemes take a pro-active approach to encouraging members to manage their health better, rather than simply relying on medical interventions (particularly in the case of lifestyle-related ailments). Hence there is currently the opportunity to offer extra value to members who are prepared to take steps to manage their health risks. For the sake of scheme sustainability as well as the lifestyle disease burden of the population, it is important that such incentives are accommodated.

5. We welcome the opportunity to make a contribution on the impact of partially implemented social solidarity principles. An overview of key points is as follows:

- **What interventions, if any, are required to address anti-selection, if it occurs, so as to increase meaningful competition;**
  - Mandatory membership is a key element of the social solidarity framework that has not been implemented. While implementing mandatory membership may meet with public resistance initially, we can show that overall costs will fall (as evidenced below) and thereby increase public acceptance. It may also ease public transition to and acceptance of mandatory NHI membership.
  - Risk equalization can operate on a variety of bases and can be effective in promoting competition on the basis of medical management rather than risk selection.
  - Underwriting tools can be effective in encouraging early entry into the system, but our analysis shows that current underwriting framework as provided for in the Medical Schemes Act has limited effectiveness. Increasing schemes’ ability to underwrite on initial entry, and also on changes between options, would increase this effect.
  - The extent of PMB coverage (which is hospi-centric) and requirements to cover claims at cost make it difficult for medical schemes to apply risk management mechanisms.
  - The uneven playing field between medical schemes and other healthcare insurance products (caused by differences in regulations) worsens the problem of adverse selection. Demarcation regulations have addressed some of these concerns but need to be monitored as there remain concerns that insurance products are impeding medical scheme risk management mechanisms (such as co-payments or deductibles to discourage inappropriate use of medical interventions).
• **How to improve risk pooling in the market so as to improve competition?**
  o Risk equalization is a tool that can be used to equalize both demographic and catastrophic risk.
  o The key challenge is an ageing covered population and increasing disease burden. Membership mandates would broaden the risk pool and reduce the cost of cover overall.
  o The structure of the PMBs also promotes over-treatment and over diagnosis, and medical schemes are constrained by the regulatory gaps in managing these sources of waste and inefficiency.

• **How could changes to medical scheme benefit options improve competition in the market?**
  o We are of the view that the implementation of a more complete social solidarity framework would address many of the concerns around the fragmentation of risk pools in benefit options.
  o A revised PMB framework incorporating a basic package of benefits would also be an effective mechanism for pooling risk across benefit options.

6. We note the following points on which input is sought:
   - Anti-selection in relation to medical schemes:
   - Risk pooling across medical schemes:
   - Risk pooling within medical schemes:
   - The range of medical scheme benefit options:
   - The inability of members to make meaningful choices based on value:

**Anti-selection in relation to medical scheme membership**

7. DH has submitted to the HMI that incomplete implementation of social solidarity principles, notably open enrolment and community rating without mandatory membership and risk equalization, has led to anti-selection since members are able to join medical schemes with limited restrictions. DHMS experience is similar to that reflected in Figure 1 of the HMI document. The graph below shows the proportion of beneficiaries for each age band for 2008 vs. 2016.
8. The growth that has been experienced by DHMS over the period 2008 to 2016 has been greater on the Keycare options. Approximately 73% of these members had some prior medical scheme cover. There has been greater ageing in the more comprehensive benefit options. We are of the view that those who join later will only do so if they expect to claim more than any penalty imposed.

Table 1: DHMS membership growth per option 2008 to 2016

<table>
<thead>
<tr>
<th>Option (grouped)</th>
<th>Change in membership</th>
<th>Change in average age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Years</td>
</tr>
<tr>
<td>Executive</td>
<td>16.9%</td>
<td>5.8</td>
</tr>
<tr>
<td>Classic</td>
<td>31.5%</td>
<td>2.2</td>
</tr>
<tr>
<td>Essential</td>
<td>15.4%</td>
<td>0.8</td>
</tr>
<tr>
<td>Keycare</td>
<td>135.3%</td>
<td>1.0</td>
</tr>
<tr>
<td>DHMS</td>
<td>40.7%</td>
<td>1.3</td>
</tr>
</tbody>
</table>

9. The “twin-peaks” phenomenon membership arises from an apparent lower propensity to cover older children as well as children who no longer qualify to be dependents on their parents’ medical scheme not taking up membership of their own. This is likely to be due to affordability and the fact that they can enter up to the age of 35 without penalty.
10. The graph presented in the HMI document indicates that affordability constraints appear to have exacerbated the anti-selection effect. A comparison of the experience of members who are part of employer groups\(^3\), as compared to individual members provides clear evidence of the anti-selection that is associated with the limited ability of medical schemes to manage selection. The analysis shows that:

- Individual members have an older age profile (figure 2) and higher chronic prevalence (figure 3) as compared to group members.
- Even for individual members with no chronic conditions, the age profile is more averse (figure 4).
- The claims experience when analysed by benefit option (figure 5) and risk adjusted for age, gender and chronic status show that individual members have claims experience that is 36.6% higher than group members after adjusting for age, gender and chronic status (R1,319 vs R965 pbpm for 2016).

Figure 2: DHMS age distribution of beneficiaries who belong to employer groups vs. those who are individual members (for 2016)

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\(^3\) For a member to be classified as being part of a group, they needed to both belong to an employer and that employer was underwritten as a group.
Figure 3: DHMS chronic prevalence of beneficiaries who belong to employer groups vs. those who are individual members

![Proportion Chronic](image)

Figure 4: DHMS age distribution of beneficiaries who are non-chronic and belong to employer groups vs. those who are individual members

![Age Distribution for Non-Chronics](image)
11. McLeod and Grobler (2009) demonstrated evidence of anti-selection in the voluntary environment by women in the child-bearing years. “The minimum benefit package includes almost all maternity care, and thus, it has become a common phenomenon for women to join a medical scheme to have their children and to leave if the children are healthy.” — from the same paper. This is illustrated in Figure 6.

Figure 6: Female coverage comparing mandatory and voluntary groups

12. It is important to note that when GEMS was registered in 2007, it enrolled only active members (and not pensioners who were accommodated on other schemes – the Medihelp pensioners were only transferred to GEMS in 2012). This meant that the cross-subsidy of pensioner members by active members was borne by the active members of other medical schemes, particularly open schemes.

13. The trend in the age profile and chronic profile of DHMS is shown graphically below. This shows the increasing chronic prevalence **per age band** i.e. chronic prevalence is increasing by more than what is explained by ageing.

Figure 7a: Change in DHMS age profile

![DHMS Age distribution](image)

Figure 7b: Change in DHMS chronic profile

![DHMS Chronic distribution by age](image)
14. The tools available to medical schemes to manage anti-selection are:
   
   - Late joiner penalties that can be applied from the age of 35.
   - Pre-existing condition exclusions (12 months) that can be applied in respect of conditions for which the applicant received treatment or advice in the 12 months prior to application. In many cases, treatment can be deferred until after the 12-month period, thus limiting, or eliminating entirely, the risk protection of the underwriting provision for the scheme.
   - General waiting periods of 3 months that can be applied to members who have no prior coverage (the waiting period also applies to prescribed minimum benefits) or who change schemes voluntarily (but in this case the waiting period does not apply to prescribed minimum benefits which must be covered in full).

   DHMS is the largest open medical scheme and applies the above restrictions to new applicants where applicable. The proportion of members where such restrictions have been applied is as follows (as at 31 December 2017):

<table>
<thead>
<tr>
<th>Restriction</th>
<th>Proportion of new entrants in 2017</th>
<th>Proportion of all beneficiaries at 31 December 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 month general waiting period</td>
<td>13.6%</td>
<td>0.4%</td>
</tr>
<tr>
<td>12 month pre-existing condition exclusion</td>
<td>7.6%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Later joiner penalty</td>
<td>4.7%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

It is difficult to determine the effectiveness of the available underwriting measures as one does not know which members would have joined and when they would have joined in the absence of these measures or if different measures could be applied. However, there is some anecdotal evidence to suggest that these measures are not effective, and that members that really require the cover still join.

**Late joiner penalties (LJP)**

Figure 8 shows that while the South African LJP system increases in broad steps, the quantum of the LJP’s are on average very similar to the Australian system except for the very old ages where the South African LJP is much lower.

The US Medicare system also applies premium penalties for those who choose to delay joining Medicare. In this case a penalty of 10% is applied for every year from

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5 Medicare is the federal government program that gives you health care coverage (health insurance) if you are 65 or older or under 65 and have a disability, no matter your income.
age 65 that a person was not a member of Medicare (MedicareInteractive.org). This penalty remains the same for as long as someone belongs to Medicare. The penalty is significantly higher than in South Africa and Australia to allow for the steeper increase in costs amongst older people.

Figure 8: Comparison of South African and Australian Late Joiner Penalties

The later in life members join a medical scheme, the higher the claims costs and contributions will be. A LJP should theoretically be set at least at a level so that the higher claims costs are recovered by the scheme through the higher contribution. When doing this calculation, allowance should be made for expected mortality rates, future claims inflation and investment returns. DHMS has used analysis of claim costs by age to construct a theoretical LJP structure. Figure 9 shows that the LJPs as prescribed by the Act are more or less in line with the theoretical requirements, except at the old ages (greater than 65) where the LJPs are significantly too low.
The above assumes that there is no anti-selection of members who only join later in life and are subject to an LJJP. One would expect there to be some form of anti-selection from members who are given an LJJP when joining a scheme as only members who really need the medical care would be willing to pay the LJJP. An analysis of this was done using DHMS claims. The risk adjusted claims of joiners that received an LJJP was compared to the risk adjusted claims of those that did not receive an LJJP. It was found that the members who did receive an LJJP claimed between 16% and 23% more than similar aged members that did not receive an LJJP. This difference also increases as the LJJP increases. In order to compensate schemes for taking on this anti-selection risk, the theoretical LJJP calculated above should thus be increased in the order of 16% - 23%.

Table 1: The difference in risk adjusted claiming patterns between joiners with and without LJPs

<table>
<thead>
<tr>
<th>LJJP %</th>
<th>% difference in PLPM claims</th>
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<tbody>
<tr>
<td>5%</td>
<td>17%</td>
</tr>
<tr>
<td>25%</td>
<td>16%</td>
</tr>
<tr>
<td>50%</td>
<td>22%</td>
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<tr>
<td>75%</td>
<td>23%</td>
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</table>

Pre-existing condition exclusions

The original DH submission to the HMI notes that many serious and high cost conditions require treatment over many years, or even the lifetime of the member. These thus have significant long term financial consequences for schemes, and the current 12 month condition specific waiting period (CWP) is not sufficient to counter the effect of anti-selection for many high cost long term conditions. Some examples include Rheumatoid Arthritis (RA), Ulcerative Colitis (UC), Haemophilia, Crohn’s
disease and Multiple Sclerosis (MS). Current treatment with biologics for RA typically cost DHMS approximately R71,000 per claimant per year, and treatment with biologics for MS costs R106,000 per claimant per year, and Haemophilia up to R220,000 per claimant per year.

In this context, a 12 month waiting period is thus not sufficient protection for the scheme and its members, as a person diagnosed with one of these conditions will wait out the period and then claim substantially more than they pay in premiums for the rest of their life. However, if CWPs were extended, the young and healthy would think much more carefully about joining schemes much earlier in life.

Figure 10 illustrates adverse selection by members who join DHMS to receive treatment that would not be affordable to the general public, when they are diagnosed with a serious chronic condition such as multiple sclerosis, rheumatoid arthritis or breast cancer. Figure 10 shows that 17% of members who claimed biologics for multiple sclerosis had been on the Scheme for less than 1 year. In the case of musculoskeletal conditions or rheumatoid arthritis (middle graph) this percentage is 14%, and for breast cancer (right graph) it is 9%. A prevailing and concerning trend that can be observed in all the graphs, is that the percentage of first year members who claim, is significantly higher than for members who have been on the scheme for longer. This confirms a high incidence of adverse selection. These 3 conditions which are listed as PMBs, cost between R110,000 and R500,000 per patient per annum, and in 2012, approximately R155m was claimed by 1,359 patients with one of these conditions. On this basis alone, the benefits for a non-member to join a scheme when diagnosed with a chronic disease significantly outweigh the premiums that they would have to pay, despite the 3 months waiting period and potentially LJP imposed on the premiums.

These concerning adverse selection trends are also prevalent in other conditions such as pregnancy, and renal dialysis (which costs between R240 000 and R360 000 per annum).
15. The HMI document presents an analysis of membership by age and race group. It is important to note that race group is not actively collected and recorded by medical schemes and so the analysis presented is based on the General Household Survey (GHS)\(^6\). This is a sample-based survey at household level. The GHS over-estimates medical scheme membership (9.6m lives for 2014 compared to 8.8m lives in the CMS report) and this overstatement may be more pronounced at younger ages (due to the assumption that all household members are covered).

16. When comparing 2006 to 2014 from the GHS data, while only a relatively short period of time, one does not see this start of any normalization (refer to figure 11). In fact, the children become a smaller proportion and the hump between ages 20 and 45 becomes more pronounced. This data thus does not necessarily support the statement that “…the bigger dip for the black population will gradually level out as the income patterns normalize…” and suggests that this dip has marginally deepened over the period. This suggests the requirement to better understand the needs of this population and develop innovative products to address these needs in an affordable and sustainable way.

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\(^6\) As per Statistics South Africa, the GHS is based on a sample of approximately 33 000 households (dwelling units) in 3324 primary sampling units. Equal weighting is given to all members of the household. This may affect the estimates of coverage across age groups since data on medical scheme coverage is not collected at the level of the individual.
Figure 11: GHS Black covered population 2006 to 2014 (based on household data)

17. We acknowledge the affordability challenge of increasing medical scheme coverage. This is exacerbated by the hospi-centric focus of the current PMB package which results in a high minimum cost of cover. DHMS is one of the few schemes that has been able to increase its membership over the period. The bulk of this growth was on the lower cost options (Keycare), although this growth did not necessarily come from members without prior coverage. In terms of income level, DHMS only collects income information for Keycare members. The experience of these members has been assessed with reference to the income band of the contribution tables and risk adjusting for demographic factors. The in-hospital and chronic claims experience (2016) is then compared in aggregate (figure 12) and for members who are part of a group (figure 13) or who are individuals (figure 14). The results show that:

- The claim costs of members in the lowest income band is highest (all other things being equal). For these members, there is a greater propensity for anti-selection since affordability is a more significant constraint.
- The difference in claim costs by income band of group members does not exhibit the large difference by income band and is lower across all income bands. This suggests that it is the anti-selection by lower income earners who are individual members (and thus exercising individual choice) that are driving the claim differences by income band as well as higher claim costs overall.
Figure 12: Risk adjusted in hospital and chronic claims for Keycare beneficiaries (pbpm 2016)

Figure 13: Risk adjusted in hospital and chronic claims for Keycare individual beneficiaries (pbpm 2016)
18. It is also important to note the experience of GEMS also included the adverse effects of anti-selection due to members being able to change medical scheme options during the year, as well as members lapsing and re-entering or enrolling dependants only when healthcare costs were to be incurred\(^7\). This suggests that GEMS members were engaging in anti-selective behaviour.

19. We concur that affordability (and perceived value) are key contributors to the delay in young adults joining medical schemes.

20. **Impact of anti-selection**: Our responses are set out below:

   - **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?**
     - DH has provided further evidence above regarding anti-selection by individual members in particular (as opposed to groups where there may be some form of mandate).
   - **How is this evidence related to developments in income, employment and demographics?**
     - The HMI document suggests that observed patterns may be associated with coverage of previously uncovered population groups. However, DHMS experience with respect to conditions such as Maternity indicates that the current risk management measures are not adequate to protect schemes from members deferring entry until they expect to claim more than any penalty imposed.

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\(^7\) Refer to Q2 GEMS Member Newsletter (September 2016) referring to underwriting changes implemented on 1 October 2016.
• Is the current level of underwriting effective at discouraging late joiners?
  o It was found that the members who did receive an LJP claimed between 16% and 23% more than similar aged members that did not receive an LJP. This difference also increases as the LJP increases. In order to compensate schemes for taking on this anti-selection risk, the theoretical LJP calculated above should be increased by the 16% - 23%.
  o Further, the 12 month waiting period is not effective in protecting schemes from extensive lifetime costs associated with high cost conditions. The cost of this selection is borne by the other members of the scheme.
  o Consideration could be given to allowing for longer waiting periods in respect of certain high cost conditions, both on joining schemes and on moving between benefit options.

• 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)?
  o This document has included a number of suggestions related to managing anti-selection such as revising the PMB structure, the introduction of REF, mandatory membership and further regulating health insurance.
  o It has been estimated that if everyone in South Africa earning above the Tax Threshold were to join medical schemes, the REF industry community rate (this is the average cost per beneficiary for the PMB package) would reduce by 9.5%. This would reduce even further by up to 16.3% if all formal wage earners were to become members of medical schemes (McLeod & Grobler, 2009). While LJP's have helped to reduce the effect of anti-selection, these figures show that there is still a large impact due to anti-selection which would increase should LJP's be removed or reduced.
  o We would therefore recommend increasing the LJP's by 16% - 23% in accordance with the table and information shown above, to further mitigate anti-selection. We also recommend the introduction of mandatory membership for the population earning above the Tax Threshold.
  o This would further have the long term benefit of easing or supporting the implementation of the NHI as a wider population would have adjusted to budgeting for ongoing healthcare cover.
  o We also recommend that schemes be allowed to impose longer waiting periods for certain high cost conditions, both at entry to the scheme, and on movement of a member to a higher option.

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Table 4: Differences in the REF industry community rate for different population groups

<table>
<thead>
<tr>
<th></th>
<th>Current Voluntary Medical Schemes</th>
<th>Mandatory from Tax Threshold</th>
<th>Mandatory Formal Wage Earners</th>
<th>Mandatory Formal and Informal Workers</th>
<th>Total Population Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Rate for Minimum Benefits</td>
<td>257.02</td>
<td>232.55</td>
<td>217.73</td>
<td>210.58</td>
<td>221.42</td>
</tr>
<tr>
<td>Revised rate as percent of initial rate</td>
<td>90.5%</td>
<td>84.7%</td>
<td>81.9%</td>
<td>86.1%</td>
<td></td>
</tr>
</tbody>
</table>

* 2005 data for incomes and coverage

- **How would these proposed mechanisms affect the number of beneficiaries and the level of contributions?**
  - Table 4 illustrates impacts for various scenarios of increased coverage. It is estimated that mandatory membership above the tax threshold would increase the medical scheme population by 5m lives with costs in the order of 9% to 14% lower than current. If low cost benefit options are able to offer basic cover only, we estimate that this could be extended by a further 2m lives.

- **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)?**
  - Membership mandates need to take account of the high levels of inequality in South Africa and the implications for affordability and employment. Unfortunately comprehensive private cover is not affordable to all employed South Africans. However, there is an opportunity to define more affordable benefit packages based on prioritization of benefits within the context of provider networks, particularly primary and promotive care.
  - The level of the required minimum benefits affects the cost of cover. The Low Income Medical Scheme (LIMS) report prepared in 2006\(^9\) developed a mechanism for variations in the minimum benefits to promote access and affordability. This was developed further during 2015 with the Low Cost Benefit Options (LCBOs) policy developed by the CMS\(^10\).

**Risk pooling across medical schemes**

21. We concur that the incomplete implementation of the social solidarity regulatory framework has had an adverse impact on the affordability of medical scheme cover. Paragraph 21 of the HMI document states that the HMI is interested in the effect on risk pooling and competition under a single fund NHI. Clearly this structure results in a single risk pool and no competition (since the White Paper of 30 June 2017 stipulates that only the NHI Fund can provide such cover). However, the level of cover will be materially compromised as a result of fiscal affordability constraints. The High-Level Panel on the Assessment of Legislation and the Acceleration of Fundamental Change included the recommendation that alternative models for NHI should be considered and this includes a multi-fund approach (referred to as the Hybrid Model) with virtual risk pooling.\(^11\)

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\(^10\) Refer CMS Circular 54 of 2015 (but withdrawn in Circular 62 of 2015)

\(^11\) Available at [https://www.parliament.gov.za/high-level-panel](https://www.parliament.gov.za/high-level-panel)
22. We suggest that the focus of the Department of Health should be on improving access to healthcare services for the poor and vulnerable. It is unfortunate that the focus of NHI developments appears to be on consolidating medical schemes and restricting private coverage, rather than on how affordable access to healthcare cover can be significantly expanded. The alternative (hybrid) model noted in the previous paragraph is based on the implementation of improvements in the quality and accessibility of care in the public sector and improvements in efficiency of care in the private sector, along with measures to facilitate the expansion of cover to those who are able to afford funding of their own care. These are not mutually exclusive initiatives and can be carried out in parallel.

23. The REF was originally proposed to equalize risks based on the PMBs. The REF was proposed to be a prospective risk assessment mechanism based on age and chronic conditions and maternity experience. Risk was equalized on the basis of the expected claims experience of a scheme (and not the actual claims experience). Paragraph 23 refers to smaller risk pools having “less predictable claims” and “lack the ability to withstand sudden, large, unpredictable claims.” This should rather be stated as smaller risk pools having greater variability in experience. It is important to note that the REF mechanism mitigates the risk of expected larger claims associated with beneficiaries with higher demographic risk (measured in terms of age and chronic status) but it does not provide protection against individual large claims i.e. the volatility risk. Such protection, which is arguably even more critical for schemes at present, could be provided by high risk pool arrangement, such as the Australian High Cost Claims Scheme (HCCS) which covers 50% of claims over $300 000 for medical insurers\(^\text{12}\). There are thus a range of risk mitigation measures that can be considered for promoting efficiency and competition.

24. We concur that the current regulatory framework results in there being a propensity for higher risk members to move to benefit options with more comprehensive cover. It should be noted that affordability and risk aversion\(^\text{13}\) are also factors to consider. We do not agree 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.” As noted previously medical schemes (particularly open medical schemes) have limited ability to prevent the migration of higher risk members and so to manage cost increases, there is a significant incentive to implement managed care programmes that aim to manage treatment costs and promote lifestyle improvements for higher risk members. The DH submission to the HMI has included a number of such innovative measures (refer to section 5 of the DH submission to the HMI of November 2014). This experience has also been documented in published journal articles.


\(^{13}\) Risk aversion refers to people choosing to buy the highest level of cover they can afford due to their fear of unpredictable health events.
25. We concur with the observation that medical schemes tend to cross-subsidise the higher and lower cost benefit options from the middle cost benefit options. However it is important to note that the nature of the cross subsidies differs. The cross subsidy of the higher cost options is essentially a risk cross subsidy, as increasing the differential cost between benefit options would cause higher risk members to “buy-down” having an adverse effect on the overall cost of cover. The cross subsidy of the lower cost options is more of an income-based subsidy in order to preserve the affordability of cover for low income earners. This is illustrated in a letter sent to the Registrar of Medical Schemes by the Health Funders Association included as Annexure 1 to this document.

26. We concur that the overall sustainability of a medical scheme could be adversely affected if all options were required to be financially self-supporting. This requirement would also have an adverse effect on the number of medical scheme members as lower income members may drop out of cover if the contribution levels are increased. It is also important to note that the current tax subsidy framework is an important consideration here as, for many low income members, the tax subsidy is a significant component of contributions. For DHMS Keycare members the tax credit is worth up to 55% of contributions, and so members would not be able to continue to afford cover if this was removed.

Table 5: KeyCare contributions (2017) for member family of 4 beneficiaries compared to tax credit

<table>
<thead>
<tr>
<th>Monthly income</th>
<th>KeyCare Core</th>
<th>KeyCare Plus</th>
<th>Priority</th>
<th>Executive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan (family of 4)</td>
<td>Contribution</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>R8 000</td>
<td>1,842</td>
<td>2,272</td>
<td>7,679</td>
<td>13,198</td>
</tr>
<tr>
<td>R10 000</td>
<td>23.0%</td>
<td>22.7%</td>
<td>15.4%</td>
<td>16.5%</td>
</tr>
<tr>
<td>R50 000</td>
<td>15.4%</td>
<td>2.0%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>R80 000</td>
<td>16.5%</td>
<td>1.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tax credit as % of income</td>
<td>55%</td>
<td>45%</td>
<td>13%</td>
<td>8%</td>
</tr>
</tbody>
</table>

27. As set out in the HFA letter (Annexure 1), the income cross subsidy for low cost options currently creates additional access to medical scheme membership for families who may not otherwise be able to afford it.

28. Adequacy of risk pooling
- How does the current degree of risk pooling impact competition between medical schemes?
  - The extent and structure of the existing PMB framework has a negative impact on medical schemes’ ability to compete, as there is an effective standardization of benefits and limited risk management opportunities.
  - Further, the existing framework means that risk pooling operates at a benefit option level. Open medical schemes have limited opportunity (no underwriting is allowed) to manage to the migration of higher risk members to more comprehensive cover. This exacerbates the cost differences
between benefit options that are related to differences in utilization in addition to differences in benefits.

- It is also important to note that differences in provider remuneration levels also vary by benefit option, which adds to the complexity. This arises from the variation in charging practices across providers, particularly by specialists.

- **Why are benefit options that are in financial deficit for consecutive years, allowed to exist?**
  - The HFA letter (Appendix 1) illustrates how the losses on high-end and low-end options benefit the scheme overall. The risk cross-subsidy of the high-end option provides some protection from buy-downs.
  - If high risk members are accommodated in a more expensive and comprehensive benefit option, the scheme is still better off even if it is loss making. This is because the cancellation of such an option would mean that these members migrate to the next highest option and are likely to experience a greater reduction in their contributions than in their cover (particularly with respect to PMBs) thus the financial loss to the scheme for these members would actually increase.
  - For low cost options, there are social solidarity considerations for allowing losses to continue, since these options allow lower income members to benefit from a cross subsidy from higher income members, and from investment income.

- **What impact does the lack of a medical scheme wide mechanism to equalise for risk have on medical schemes and the cost of cover?**
  - The incomplete implementation of the social solidarity framework, combined with the impact of a hospice-centric PMB package, have affected the affordability of comprehensive cover due to the fragmentation of risk pools.
  - The impact of such a mechanism will be very dependent on its structure, particularly with reference to the ability to apply innovative tools to disease management and to continue to promote competition.

- **If there is a need for a risk equalisation mechanism:**
  - **What are the various mechanisms that can be introduced;**
    - Risk equalization can operate on a prospective or retrospective basis. The REF was proposed to operate primarily on a prospective basis referring to age and chronic disease risk but with maternity based on experience (retrospective). There is a risk that restrospective mechanisms can be unduly influenced by higher utilization due to poor risk management.
    - Risk equalization can also take place on a catastrophic claim basis and examples of such mechanisms are found in Australia and Israel. Under such mechanisms it is important to ensure that there is an ongoing incentive to manage treatment and ensure that clinical efficiency is in place.
    - In order to prevent arbitrage opportunities, there is a need for detailed and rigorous modelling to underpin any risk equalization mechanism and for monitoring and evaluation to be in place.
How long will it take for them to be fully implemented; and
- A rigorous feasibility study would need to be done to ensure that the required information can be collected and that there is adequate integrity for financial transfers. It is likely to take a minimum of 2 to 3 years to implement.
- The REF shadow period operated from 2006 to 2011 and data continues to be collected. The key learnings from this process should be incorporated in further developments.

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?
- The impact on pricing will depend on the structure of the mechanism as well as the ability for schemes to apply a combined package of risk management measures. It is possible to construct an equalization mechanism in such a way that competition is not harmed.

Who will benefit and who will be harmed by introducing these mechanisms to adjust for risk across medical schemes?
- The impact on members (and prospective members) will depend on the structure of the risk equalization mechanism. Risk pooling is based on the principle of lower risk lives cross subsidizing higher lives and the challenge is to ensure that the former still derive value from participating in the pool.

What costs will be involved to introduce these mechanisms?
- Costs will depend on the structure of the mechanism.

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?
- While risk equalization and risk adjustment are linked concepts, they are not the same thing. Risk equalization suggests a pooling of risk across separate pools whereas risk adjustment is an analytical methodology of accounting for variations in risk factors. There is an opportunity for risk equalization to be used as a virtual pooling measure in the transition to a NHI framework. This is likely to reduce the transitional risk.

Incomparability of benefit options

29. The structure of medical scheme benefits is complex in certain circumstances. This is a feature of health insurance products globally and arises from the inherent complexity of healthcare delivery, which requires that tens of thousands of products and services are covered in a number of different ways. Health insurance systems globally therefore confront a continuous challenge to ensure that members have access to adequate information to make informed choices.

However, it is also important to recognise that the issue of choice overload and complex decision-making is not unique to healthcare insurance, and is typically a feature of all other types of insurance and financial services. Research suggests that consumers have mechanisms to deal with such complexity, but there are also mechanisms in the industry which assist with that decision-making.
• Behavioural research has found that as a decision becomes more complex, consumers are more likely to use heuristics, while at the same time using less information\textsuperscript{14}. The HMI survey is consistent with this, finding that consumers use affordability and health status filters as a means to reduce the options that need to be evaluated, simplifying the decision to some extent.

• For a large number of consumers covered under group cover arrangements or closed schemes, that choice has been simplified by the employer process of identifying (usually with expert assistance) preferred schemes thus restricting the selection of options to a single medical scheme, or two schemes rather than the entire market.

• In addition, intermediaries play an important role in assisting members make benefit selections. This is the case across a wide range of financial services products where members may have limited expertise to make appropriate choices. Regulation of intermediaries (such as through the FAIS Act) has limited the ability of intermediaries to act in ways that are not in the best interests of members. While, this process is not without its flaws, independent advice can be a valuable tool for making option selections.

• Members are also able to obtain advice from medical schemes directly. Medical schemes continue to use various communication mechanisms to make members aware of their benefits in line with the principles of Treating Customers Fairly as set out by the Financial Services Board\textsuperscript{15}.

It is worth stressing that from an economist’s point of view, the solution to choice overload is almost never a reduction or simplification of the option set\textsuperscript{16}. There are more effective options available. In fact, most economists would agree that the optimal situation is one in which options are wide and varied, but where consumers are able to discern easily which option is best for them. The reduction in options is particularly problematic in the healthcare insurance context for a few reasons:

• A reduction in the number of options will in fact result in many consumers that belonged to options that are now eliminated being forced to choose an option that is less suitable to their particular medical and/or financial needs. Specifically, consumers will be forced to pay more to maintain their medical cover, or to accept lower cover than they need, albeit at a lower premium. These forced moves will reduce consumer welfare relative to having a more suitable option available and assisting them to select the correct one.

• Medical schemes also compete on benefit option design and pricing, and this is an important element to innovation and competition in healthcare insurance. Breadth of options within open schemes is a key element of competition, particularly in the employer market, where employer groups seek out schemes that offer a wide set of benefit options ensuring that all the


\textsuperscript{15} https://www.fsb.co.za/feedback/pages/tcHome.aspx

medical and financial needs of a diverse workforce can be met. Reducing the number of benefit options will thus reduce the ability of open schemes to compete on the basis of breadth of benefit options.

- Benefit option design innovations also directly impact on the value and price of medical insurance, and hence filter through to price competition. For instance, recent benefit option design has focused on network models where members are restricted in their choice of providers, allowing schemes to offer material premium discounts. The level of discounts that options registering network-based variations were able to offer illustrates this point. In many cases, members place unrealistic value on the freedom of choice, particularly where networks are based on active evaluation of quality of care. That is best dealt with through education rather than removing the network-based options.

In order to assist consumers to select complex products amongst various options, the literature on choice overload offers a set of toolkits which have been shown to assist consumers in making complex decisions\(^\text{17}\). For our purposes, the most relevant are:

- Concretisation: making decisions vivid, and information easy to digest (European Commission, 2014). This follows the approach used by EU regulators in promoting disclosure requirements for Packaged Retail and Insurance-Based Investment Products (PRIIPs).
- Categorisation: humans can handle more categories than options. This is one of the options proposed in the HMI document (i.e. categorizing benefit options by coverage).
- Condition for complexity: breaking down decisions into phases, beginning with the easiest components first. Providing a decision-making framework that involves phases, or gradually builds up to the more complex parts of the decision. These techniques are often used by intermediaries to assist in the decision-making.

Effective implementation of some or all of the above measures will be far more effective and less harmful than the blunt policy instrument of restricting the number of benefit choices.

Access to information and disclosure requirements can assist in addressing these challenges to some extent, but simplification of the benefits themselves would reduce the complementary agent role (countervailing power) that medical schemes can play in ensuring treatment is appropriate and affordable. It is also critical to understand that variations in provider charging practices, particularly for specialist care and PMBs, is perhaps the major source of complexity within medical schemes, rather than simply the number of benefit options. In response to these wide variations in provider billing practices, schemes have no option but to design options to cater for these variations. This adds materially to the complexity of benefit options. See for example, Moneyweb article of 8 January 2018\(^\text{18}\). It is clear from this


article that the confusion arises mostly in respect of the tariff that a specialist may charge for a particular admission. Patients are further confused by the legal requirements relating to PMBs, where tariffs are covered in full for some medical conditions, but not others, and all the regulatory complexity around designated service providers. Because specialist tariff complexities arise mostly in-hospital, and because medical schemes have fairly universal benefit structures for in-hospital cover, it is clear that member confusion arises primarily from complex legal rules around tariffs, rather than from the benefit structures of schemes per se.

30. Unfortunately it is not realistic to assume that all medical scheme members have a good understanding of their healthcare needs and the needs of their dependants, and they face particular difficulty in predicting unexpected future needs. This makes informed choice very difficult. Medical schemes continue to use various communication mechanisms to make members aware of their benefits in line with the principles of Treating Customers Fairly as set out by the Financial Services Board and provide training to intermediaries on their products so that they may better advise clients on the scheme and benefit option across the market best suited to their needs.

31. The cost of PMB coverage has expanded over time. The latest CMS report notes that PMBs constitute 54% of total risk benefit paid. This means that benefit differentiation between options is limited to the balance of benefits. Considering the range of average cost per average beneficiary per month across benefit options, the difference in utilization levels becomes apparent. For the highest cost benefit options, the risk claims are more than 2.7 times higher than claim costs on the lower cost options, despite them having PMBs in common. This means that if there was common pricing of PMBs across all these options, there would be a substantial increase in the cost of lower cost options, which would in turn cause a selective reduction in the number of covered members, which would further drive up costs (leading to the actuarial spiral referred to in the HMI document). We must also note that there is a risk that product standardization can lead to a loss of cover overall. One of the key drivers of confusion and complexity has been the lack of clear definitions associated with PMBs and the blanket requirement for coverage at cost.

Table 6: Open medical scheme options in 2015

<table>
<thead>
<tr>
<th>Risk contribution grouping</th>
<th>Number of options</th>
<th>Number of beneficiaries</th>
<th>Average risk contribution pbpm</th>
<th>Average risk claims pbpm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>&lt; R950</td>
<td>38</td>
<td>1 146 303</td>
<td>R 801</td>
</tr>
<tr>
<td>Medium</td>
<td>R951-R1600</td>
<td>49</td>
<td>2 590 938</td>
<td>R 1 178</td>
</tr>
<tr>
<td>High</td>
<td>&gt;R1600</td>
<td>49</td>
<td>1 184 036</td>
<td>R 2 085</td>
</tr>
<tr>
<td>Total schemes</td>
<td>All</td>
<td>136</td>
<td>4 921 277</td>
<td>R 1 308</td>
</tr>
</tbody>
</table>

19 https://www.fsb.co.za/feedback/pages/tcfhome.aspx
32. As noted above, we believe strongly that reduction in the number of benefit options and standardization of benefit options, will reduce innovation and competition, and will cause significantly more harm to consumers than the potential benefit derived in terms of consumer information. One of the key issues affecting option selection is the willingness of members to be restricted in their choice of providers. The level of discounts that options registering network-based variations (referred to as “efficiency-discount” options) were able to offer, illustrates this point. In many cases, members place unrealistic value on the freedom of choice, particularly where networks are based on active evaluation of quality of care.

33. Intermediaries play an important role in assisting members make benefit selections. This is the case across a wide range of financial services products where members may have limited expertise to make appropriate choices. Regulation of intermediaries (such as through the FAIS Act) has limited the ability of intermediaries to act in ways that are not in the best interests of members. While, this process is not without its flaws, independent advice can be a valuable tool for making option selections. Members are also able to obtain advice from medical schemes directly.

34. We are concerned about the comments relating to medical savings accounts (MSAs). For members selecting to join these options, there is significant value in a mechanism to provide for day to day cover during the year rather than funding these from the household budget as they arise. The DHMS experience is that many members are able to carry forward savings balances and hence make provision for future expenses. Based on DHMS data, 48% of policies with an MSA had not fully depleted their savings by 31 December 2016. This varied between 27% on the Executive plan and 54% on Classic Saver and between 57% for a single member and 41% for families with at least one adult dependant (with or without child dependants). DH has not followed the practice of housing medical savings accounts outside of the medical scheme, as has been done elsewhere in the market. This means that there is greater transparency regarding savings utilization in DH data. DHMS also offers extensive cover for preventative care in the risk portion of the benefits through the screening benefit as well as extended cover for essential care should savings be exhausted through the Day-to-day Extender Benefit. This approach means that the incentive to manage discretionary care (influenced by social variations in health seeking behaviour) is balanced with provision for promotive and essential care.

35. As noted above, we are of the view that the additional delineation is a symptom of the incomplete implementation of social solidarity principles as medical schemes are limited in their ability to manage anti-selection. Addressing this core cause would be a more effective way of addressing the problem of fragmented risk pools.
36. The International Review Panel of REF\(^20\) provided commentary on Supplementary Benefits packages. The panel noted that in addition to the Basic Benefit Package (BBP), the medical schemes should be allowed to offer supplementary benefits packages (SBP). The panel noted that standardization will reduce product competition based on the design of numerous benefits packages (which does not benefit the consumer) and increase price competition among the medical schemes. This type of regulation of benefits packages exists elsewhere; for example, in the USA, insurers are only allowed to sell a restricted number of standardized benefits packages as a supplement to Medicare (the so called Medigap-insurance). The panel recommended that in order to reduce risk selection, SBP should be sold in combination with contribution rate-bands.

37. The High-Level Panel on the Assessment of Legislation and the Acceleration of Fundamental Change (HLP) has recommended that an alternative Hybrid Model for NHI be considered\(^21\). Under this model the NHI benefits would be offered as a basic benefit package across a number of schemes. This could result in a lower risk transition to universal coverage and promote affordability of cover across a broader sector of the population. Addressing medical scheme regulations that limit the ability to expand cover will make such a transition feasible. This includes factors such as the structure of PMBs, the ability of hospitals to employ doctors and solvency regulations. These recommendations were included in the original DH submission to the HMI.

38. We concur with the statement made in paragraph 38 of the HMI document. A key factor here is the ability to contract innovatively with providers. The current PMB structure (hospital-centric) and requirements (for cover at cost) as well as HPCSA regulations prevent innovative contracting to the detriment of members.

39. **Comparability of benefit options**

- **Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?**
  - Complexity is a feature of health insurance products globally and there is a continuous challenge to ensure that members have access to adequate information to make informed choices.
  - This complexity is driven by a number of factors.
    - First, medical schemes have to cater for a wide spectrum of healthcare needs, affordability constraints, and risk tolerances, and so are required to offer diverse benefit options. As such, open medical schemes tend to provide products that span the entire spectrum of


\(^21\) [https://www.parliament.gov.za/high-level-panel](https://www.parliament.gov.za/high-level-panel)
affordability and vary by specific factors including comprehensiveness of cover and freedom of choice (i.e., network options).

- Second, complexity is also a function of the various regulations imposed on funders, with specific reference to Prescribed Minimum Benefits (PMBs)

- Third, providers bill in multiple, complex ways and schemes are required to respond to this through benefit option design. This element contributes substantially to the complexity of scheme benefit design and consumer confusion.

- Fourth, there are also multiple layers of healthcare provision with health events often requiring the intervention of more than one type of healthcare provider, all of which funders may be required to pay.

- Lastly, medical schemes encounter significant market failures, which they endeavour to address in order to stem healthcare cost increases through price signals to consumers and other means, as discussed above.

  - Yet, despite this inherent degree of complexity, it would be incorrect to suggest that medical schemes do not compete on value, or have no incentive to lower healthcare costs. Medical schemes compete to provide value-for-money to members in respect of contributions, the design of benefit options, the richness of benefits, sufficient access to quality provider networks and the ability to effectively manage member claims. Achieving the lowest possible premium increases each year is a critical strategic priority for the DHMS Board of Trustees, and is also a high priority amongst DH strategic objectives. We can demonstrate this to the HMI by providing confidential access to DH and DHMS’s strategy documents over the past several years, which will confirm the critical importance of achieving lower healthcare costs and therefore lower premiums. DH’s stated strategic priority is to continuously widen the premium gap between DHMS and its open scheme competitors, in order to assist DHMS to grow.

  - Differentiated packages have been key in driving innovation and assisting DHMS in overcoming market inefficiencies and bringing down healthcare costs for its beneficiaries (examples of this include DHMS’ Delta and Keycare plans). In addition, differentiated packages are a crucial aspect of competition between medical schemes. As such, a market in which benefit packages are standardised may well dampen this competition and innovation, ultimately resulting in less efficient market outcomes.

  - The fragmentation of risk pools means that medical scheme options are priced based on their existing membership and this affects their ability to compete.

  - The lack of clarity in PMB definitions and the variations in charging practices, particularly by specialists has added considerable complexity to medical scheme benefit options.
• **What changes would allow members to compare the real value of medical scheme benefit options?**
  o The challenge of understanding complex insurance products is a universal one and alternative communication mechanisms and accessible advice can be of assistance, as noted above. The more complete implementation of social solidarity principles should also be of assistance in addressing the number of benefits options.
  o Collective bargaining around specialist tariffs for PMBs and clarity on PMBs could contribute to addressing these issues.
  o The presentation of benefits in a standardized format would assist.

• **What is the contribution (if any) of medical savings accounts to the member and to the medical scheme?**
  o Medical savings accounts are a useful mechanism for providing for health care services where incidence does not meet the requirements of insurability. There is value in providing a mechanism for members to fund day to day expenses and to manage the way in which they allocate their healthcare spending. Traditional benefit options tend to be subject to specific benefit limits and may promote a “use it or lose it” approach to utilization of discretionary benefits (particularly in the case of elements such as acute medication, dentistry and auxiliary services) which can be inflationary.
  o DHMS has innovative benefit design structures that balance the moral hazard associated with discretionary care with provision for promotive and essential care.
  o When DHMS introduced MSAs (which was a major innovation in the scheme industry), other schemes followed soon thereafter. As such, schemes compete in respect of the introduction of other innovative solutions which improve member value. Furthermore, the reduction in moral hazard as a result of the introduction of MSA has reduced medical expenses and healthcare costs, thus benefitting all members.

• **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?**
  o Moral hazard applies to both members and providers. Where providers have access to information on savings account balances, they may recommend treatment accordingly. Providers should not have access to such information. Further, members need to be educated on preserving their savings to prevent out-of-pocket expenditure when health needs arise. DH experience is that savings options are more appropriate for financially sophisticated members who are able to monitor and manage expenditure.

• **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?
It is our submission that simplification of benefit options will reduce competition but a standardized method of reporting benefit options may increase competition.

DHMS has always competed on the basis of providing value for money and innovation, but has had some regulatory challenges in this regard.

The ability to enter into innovative contracting with providers and moving away from fee for service remuneration is affected by the structure of PMBs and HPCSA rules. The DH input to the HMI has recommended that these points are urgently addressed.

The challenge of competing on value (price AND quality) is compounded by the industry wide challenges around the collection of reliable health information - as described in our submission on the HMI Quality/OMRO document. We suggest that enforcing collection and reporting of quality is a good way to promote competition which is directly related to consumer value.

Benefits that are not adequately defined can have an adverse effect on affordability – this was the experience with respect to the Chronic Disease List which necessitated the definition of entry criteria to ensure that the benefits were applied in a clinically appropriate way.

As noted above, International review panel of REF made recommendations with respect to the structure of equalized benefits and supplementary benefits packages.

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.
  - The response input provided by the Actuarial Society of South Africa in 2006 is appended as Annexure 2. This input notes the risk of “reverse” subsidies inherent in the structure proposed in Circular 8 of 2006 due to differences in access and utilisation.
  - We would support the notion of a common set of benefits at the core of scheme benefits, but this provision must allow schemes to offer additional benefits above and beyond the core benefits. We do not agree that common pricing is desirable, as this would severely undermine competition and harm consumer welfare.

- 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.
  - We do not support the limitation of the number of benefit options, for the many reasons noted above. Limiting schemes to offering top
up benefits only will harm consumers, undermine competition, and carries several other risks.

- 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.
  - As noted above, we do support the concept of a common set of core benefits. We do not support limiting the benefit options above the core set of common benefits, for reasons stated above. This approach would do more harm to consumers and competition than any benefits that might be derived.

- Limit the number of benefit options each scheme can offer, and ensure that each meet the requirements of the MSA.
  - This approach makes no sense as it does not consider the membership size of the Scheme, nor the relative costs and benefits to consumers. As noted above, the costs and harm to competition and consumer welfare of this approach will far outweigh consumer benefit from fewer options. There are more effective solutions to narrowing the information gap and to better informing consumers and assisting them in making appropriate decisions.

- 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.
  - We support this as an alternative to the above proposals.

- What prevented the implementation of the revised benefit design structure proposed in Circular 8 of 2006?
  - They key constraint was the impact on low income members. From the Actuarial Society submission (Annexure 2): “We believe that the implementation of Circular 8 together with the Risk Equalisation Fund in 2007, might imply such significant contribution increases to members of low cost options that it would be impractical to impose this on the industry within a short time frame.”

- What are the disadvantages of simplifying the benefit options?
  - We have argued above that reducing and or forcing simplification of options will cause several potential harms to competition, and to consumer welfare and that these harms will strongly outweigh potential consumer benefits.

- What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?
  - Additional measures will depend on the simplifications proposed but it is likely that industry-agreed standards would be required with a clear process for monitoring, evaluation and updating of such.