
# HMI: Financing Regulatory Framework

1 February 2018

## Medscheme submission

- Anti-selection in relation to medical scheme membership
- Risk pooling
- Incomparability of benefit options

# Anti-selection

## Anti-selection

### Medscheme position statement

The current suboptimal regulatory framework is contributing to increased anti-selection, leading to medical scheme contributions that are higher than they otherwise would be, cet. par. Open enrolment, without

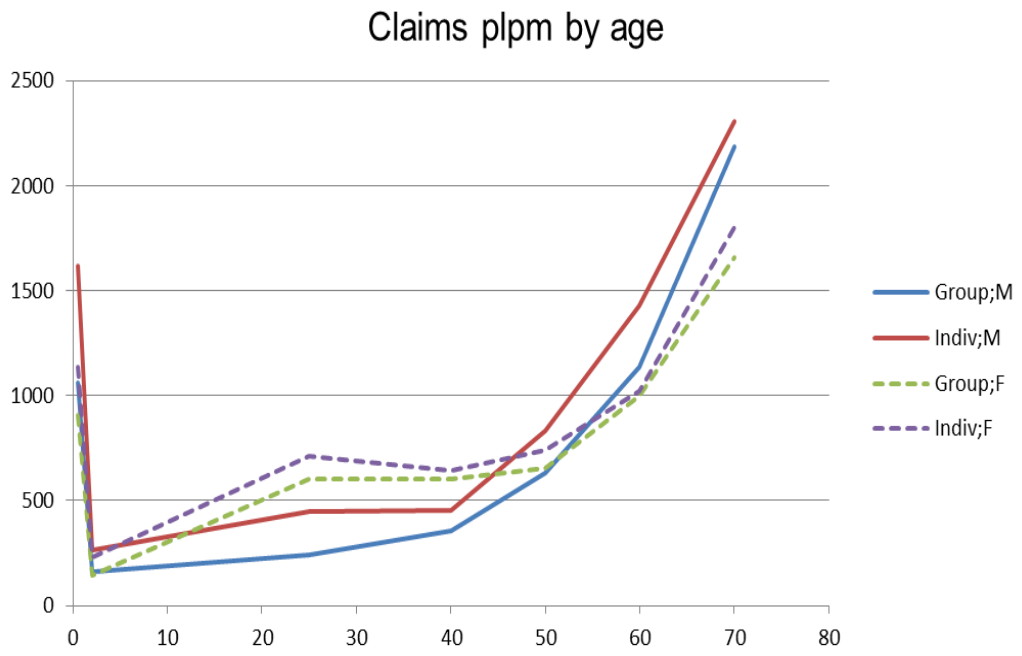
- Sufficient underwriting
- Risk rating
- Mandatory membership

⇒ ***Individual deferral possible, based on***

  - Need
  - Affordability - spiral

## Is there evidence of anti-selection?

- Double hump age profile – studies estimate contributions would decline 10-15%
- Groups vs individuals in open schemes – simulated compulsory vs voluntary cover




**Individual 25% higher than Group => anti-selection costs significant**

## Does the current level of underwriting discourage late joiners?

- **Late joiners:** current LJPs < present value of higher claims for older lives
- **Joining on specific need:**
  - case of a high-cost (R200 000 – R400 000) surgical procedure covered by few schemes
  - 47% of lives having the procedure had it within 2 years of joining
  - 18% terminated membership within a year of surgery
  - 6% terminated within a month of surgery

  ⇒ 12 month condition specific waiting period, with LJPs, would **not provide sufficient compensation** for the procedure

  ⇒ Current waiting periods and LJPs do **not provide sufficient incentives to enter the system before need arises** – but will more stringent underwriting do so?

## What mechanisms can limit anti-selection?

- **Voluntary system:** full underwriting and risk rating
  - ⇒ Exposes sicker/older and lower income lives to potentially unaffordable contributions
- **Compulsory system** – preferred approach
  - Compulsory cover OR
  - Compulsory contributions
  - ⇒ **Requires income cross subsidy and (potentially) direct employer/state subsidies** to ensure affordability to lower income lives
  - ⇒ Average contributions likely to reduce by 10-15%
  - ⇒ Higher income earners may experience contribution increases

# Risk pooling

## Within-scheme risk pooling

- In practice, pooling occurs at a scheme level, despite MSA
- Typically the higher benefit and lower income plans are in deficit

  ⇒ Cover remains affordable for most vulnerable – sick/elderly and low income
- “Correcting” deficits would mean unaffordable contribution increases

  ⇒ Buy downs

  ⇒ Uncovered low income lives
- True low income product, exempt from PMBs, needed

## Industry risk pooling

- Currently no risk pooling at industry level
- Claims costs, and hence contributions, determined primarily by profile of lives covered by each scheme
  - ⇒ Schemes compete for the youngest/healthiest lives to remain competitive
  - ⇒ Sick/elderly lives make schemes less competitive
  - ⇒ Marketing and product design focused on attracting younger/healthier lives
- New entrants and healthy “movers” gravitate towards better profile, and hence cheaper, schemes, further entrenching the profile disparities
  - ⇒ Organic growth difficult for schemes at a profile disadvantage
  - ⇒ Can lead to death spiral of increasing claims costs and declining membership
  - ⇒ Lack of willing amalgamation partners, hindering consolidation

## Industry risk pooling

### Medscheme position

We support the introduction of a risk equalisation mechanism

- Nature of the mechanism
  - Significant work by RETAP
  - Prospective vs retrospective (calculation and payment)
- Time to implementation
  - Much conceptualisation already done
  - Phased implementation desirable, in particular a shadow period
  - Income cross subsidy critical

## How would risk equalisation affect competition?

- Guiding principles set out by RETAP
  - *"…eliminate incentives to select preferred risks…"* – remove risk selection as a focus of competition
  - *"…equalise payments based on the most reasonably achievable efficient cost…Schemes will then compete on the actual cost of delivery…"* – allow schemes to focus on competing on the efficiency of care delivery
- Prospective model based on expected costs fosters efficiency in funding
- Retrospective model based on redistribution of actual claims experience would not (but would still remove the incentive to select risks)

## Who will benefit or be harmed by risk equalisation?

- Schemes with poorer than average risk profiles will be net recipients of funds, allowing a reduction in contributions
- Schemes with better than average risk profiles will be net contributors of funds, leading to an increase in contributions
- Lower income schemes likely to be amongst net contributors (income cross subsidy)
- Schemes that can develop mechanisms to fund care more efficiently will benefit as they will have a competitive advantage – larger schemes and administrators

## Impact of risk equalisation on the path to NHI?

- Schemes can focus attention on efficiency, quality and price of healthcare delivery
- Schemes can actively promote solutions to manage higher cost lives – impact of attracting such lives more limited
- Schemes compensated for poorer risk lives => less reluctance to amalgamate => may promote consolidation
- Running a risk equalisation fund will promote competencies required in an NHI environment
  - Managing a large fund
  - Distributing funds according to health risk

# Incomparability of benefit options

## Incomparability of benefits

- Health insurance is by nature complex – multiple contingencies, multiple parties, potentially wide variation in cost of treatment
- But, **competition on value can be improved**
- **Simple, standardised classification system** based on objectively measured benefit richness

| Benefit Option Classification | Benefit Richness and Description |
|---|---|
| Hospital Plans | No day-to-day benefits other than PMBs and preventative tests |
| Low Benefit Plans | Benefit richness below 70%. |
| Medium Benefit Plans | Benefit richness 70% to 79%. |
| High Benefit Plans | Benefit richness 80% to 89%. |
| Comprehensive Benefit Plans | 90% and above benefit richness. |

  - Industry agreement on definitions
  - Common comprehensive claims dataset required
  - Possible ownership by the CMS

## Incomparability of benefits – simplification of benefit options

- Common benefits with supplementary top-up benefits, and risk equalisation
  - Likely to increase cost of cover for lower income lives
  - Income cross subsidisation required for risk equalisation
- Common benefits with supplementary top-up benefits
  - Without risk equalisation, schemes with a poor risk profile, nomatter how efficient, would be exposed as obviously expensive, hastening their death spiral
- One standardised option, limited number of other options
  - Without risk equalisation, the standard package would appear obviously cheap or expensive – loss making or reliant on risk selection

## Incomparability of benefits – simplification of benefit options

- Limited number of options
  - Similar to current practice, although perhaps more consistent
  - Closing current options can result in risks to schemes (buy downs)
  - Could limit innovation and choice
- No restrictions, but options must be classified
  - Preferred approach

## Incomparability of benefits – other suggestions

- Current benefit design could be argued to be driven by current methods of provider reimbursement
- For example, FFS => using benefit limits to control utilisation
- Payment reform could lead to less complex benefits with more predictable outcomes for members
  - Bundled payment for IH events could eliminate uncertainty with respect to provider reimbursement and prostheses
  - Capitation could eliminate complexity in day-to-day benefits

## Conclusions

- Inefficiencies caused by anti-selection and inadequate risk pooling can be addressed through the **completion of the social solidarity framework**
  - Mandatory membership
  - Risk equalisation
  - Both of the above require income cross subsidisation to mitigate the impact on lower income lives
- Incomparability of benefit options, and hence competition on value, can be improved through
  - A simple framework of standardised classification using benefit richness
  - Enabling payment reform

A Member of AfroCentric Group

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