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ANTI-SELECTION AND REGULATORY GAPS IN THE PRIVATE HEALTH SYSTEM

Presentation for…

Health Market Inquiry
Competition Commission

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This talk

- Locating anti-selection within the requirements for a well-functioning private health system

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Is the problem of anti-selection contributing to systemic cost increases in the private health system

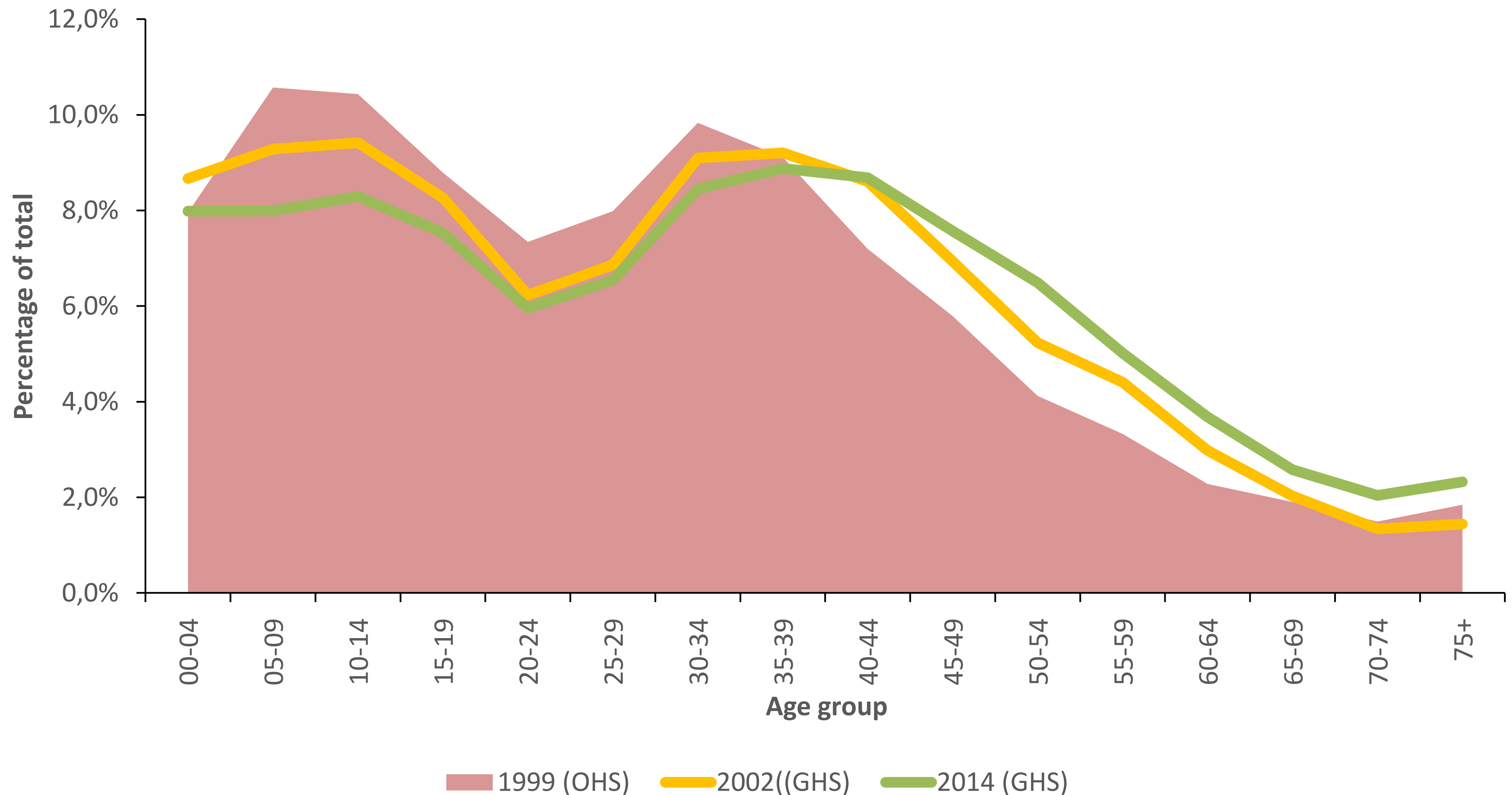
- No evidence of any significant difference between the regulatory regimes that existed between 1994 to 1999 and 2000 onward
- The aging in the system is below the aging expected for the population in the medical schemes system
- The cost of aging cannot account for the cost increases seen in the industry

- The industry is able to mitigate the risk of anti-selection in the following ways:
  - The waiting periods
  - The late joiner penalty (which is also applied unfairly to members who are not anti-selecting)
  - Medical savings accounts and below threshold benefits – which effectively *experience-rate* beneficiaries for the majority of out-of-hospital expenditure and a substantial portion of PMBs

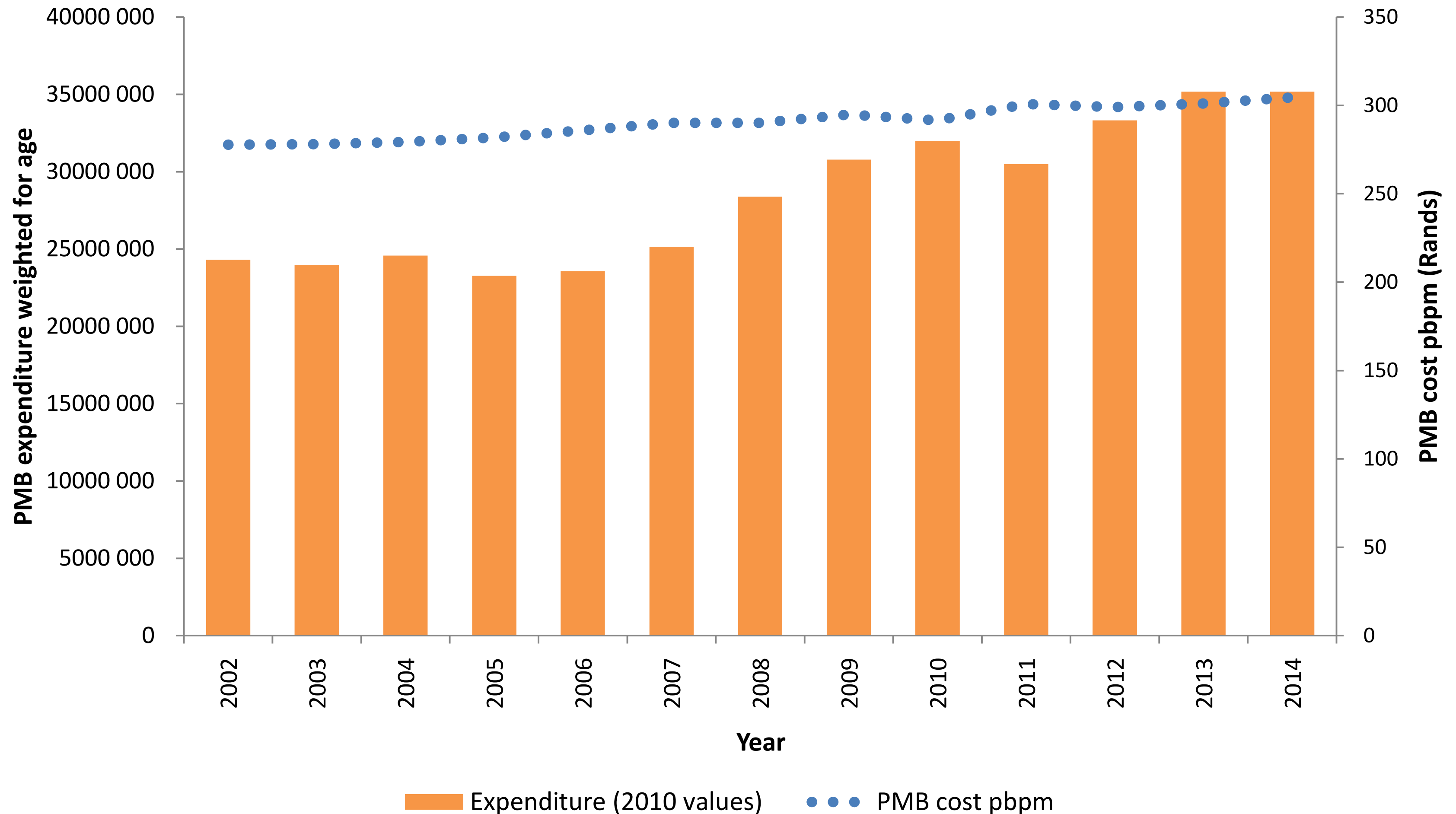
- The differentiation of benefit options by level of coverage – which allows for *risk-rating* through self-selection
  - Note that lower-income older members would have to buy down for affordability reasons
  - Higher-income members buy-up when older
  - Upper-middle-income members buy comprehensive cover regardless – although they don't realise that a lot of what they are contributing goes to medical savings accounts and is not a genuine risk benefit
  - The average ages by benefit option, accounting for variations in coverage, plainly demonstrate these effects

- Open schemes also mitigate against extreme risk-rating by cross-subsidising low-income and comprehensive options using surpluses from the “middle-income” options (this is a positive outcome of competition – but is probably not stable going into the future

Change in the age structure of medical scheme beneficiaries 1999 (pre-reform), 2002 and 2014



Calculated cost changes per beneficiary per month (pbpm) due exclusively to the aging of medical scheme beneficiaries from 2002 to 2014 and the implied total expenditure on PMBs (2008 prices)



- Using the REF weights (count and cost tables of 2010) the estimated effect of aging demonstrated in the scheme population accounts for 9.7% of the per capita cost change over the entire period – or an increase of 0.8% per year
- Real costs pbpa for private hospitals and medical specialists, however, increased at an annual rate of 3.3% and 4.7% respectively
- This leaves an unexplained residual for private hospitals and medical specialists of 2.4% and 3.4% respectively for this 12-year period

Average age of medical scheme beneficiaries by scheme type from 2005 to 2014

Scheme type	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Open	31.5	31.4	31.8	32.6	32.9	33.1	33.3	33.8	33.5	33.6
Restricted	32.2	31.8	30.4	29.8	29.7	29.4	29.5	29.9	30.0	30.2
Industry	31.7	31.6	31.4	31.5	31.6	31.5	31.6	32.1	31.9	32.1

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Addressing regulatory gaps

- Regulatory gaps affect
  - Barriers to entry of new and more creative funders (incorporating a wider variety of funding and provider arrangements)
  - Allow for more choice for consumers without confusing them or making them reliant on conflicted advice
  - The current framework is driving industry consolidation at all levels, rendering the market uncompetitive and detrimental to the societal interests of South Africa
  - Certain of the proposals emanating from the DOH seek to further this consolidation and weaken the ability of consumers to hold funders, providers and government to account

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- Solutions
  - Risk equalisation and social reinsurance to address anti-selection risks both based on a mandatory package
  - Mandatory benefits that ensure coverage of all conditions with *catastrophic financial implications* *(rather than the proposal from Discovery that PMBs be reduced to emergency and primary care – which will allow them to risk-rate the residual catastrophic health conditions resulting in a severe decline in financial risk protection)*

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- All benefit packages to be standardised in presentation to members, with variation in coverage permitted on non-mandatory benefits
- Limited risk-rating permitted on non-mandatory benefits
- Mandatory benefits to be offered as a distinct package in all schemes
- For low-income inclusion:
  - Income cross-subsidy from government
  - Failing which an exemption from mandatory benefits provided incomes can be verified and access to the public sector is free for residual benefits

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- Late joiner penalties
    - Removed if mandatory cover introduced
    - Retained if cover remains voluntary – but revised to ensure that it is applied only to instances of anti-selection
    - Should not be as extreme as the Australian system as their conditions are substantially different (there is no evidence that the SA structure has undermined scheme sustainability) (Australai

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- Flexibility for providers and funders to enter the market as funders offering region-specific coverage
- Required data production and reporting of health service performance – available after processing to service users and medical scheme members

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DISCUSSION