ACTUARIAL SOCIETY OF SOUTH AFRICA

Actuarial Society of South Africa's comments on the Health Market Inquiry provisional findings and recommendations report

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1. Introduction

The Actuarial Society of South Africa ('the Actuarial Society') welcomes the opportunity to comment on the Provisional Health Market Inquiry Provisional Findings and Recommendations Report (HMI Report) released on 5 July 2018. The response is outlined below.

This response does not seek to address or comment on all aspects of the report, but rather to focus on issues of actuarial concern, primarily relating to the sustainability of the financing of healthcare. We also comment on issues of a technical or statistical nature.

2. Commentary on the analysis of funder data

Members of the healthcare committee of the Actuarial Society have been involved in a number of engagements with the HMI on the analysis of the medical scheme data that was conducted. There are a number of actuarial issues that need to be raised in this respect. In our submission of May 2018 we noted the following:

- Limited insights can be derived from analyzing only medical scheme demographics and claims data. We note that the provisional report includes analysis of some other data sources but scheme financial statements and pre-authorisation data does not appear to have been considered;
- Casualty visits are included in hospital admissions, and this has a distorting impact on the analysis of hospital claims; and
- The distortion of claim trends at an administrator level due to the exclusion of large capitation arrangements or scheme amalgamations.

These concerns have not been addressed in the provisional report although the separation of hospital visits with an overnight stay at least isolates the effect of casualty visits being included. This has not been noted in the analysis however.

3. PMBs as a cost driver

As noted in our May submission, the PMB analysis relies on ICD10 codes to identify PMB claims. The shortcoming of this approach is that it overstates some claims where clinical criteria would not be met to justify the claim as a PMB, despite the indication of the ICD10 code. Further, relying on ICD10 codes alone, ignores pathology and pharmacy claims (which do not usually include specific codes), and does not consider emergency cases. We therefore suggest caution in the manner in which results are analysed and interpreted.

4. Incomplete implementation of legislation

The policy principles that underlie the Medical Schemes Act are social solidarity. The Actuarial Society supports these principles, however we have expressed that the lack of risk equalization and any mandatory membership requirements have led to an unsustainable risk pool. This incomplete implementation of social solidarity principles has facilitated anti-selection which has been a key contributor to the "unexplained" escalations identified in the provisional HMI report. We are concerned that the inflationary role of anti-selection has been understated in the report despite the evidence that has been presented by a number of our members. This is particularly the case for open medical schemes where guaranteed acceptance and community rating are combined with limitations on underwriting criteria (in terms of waiting periods) that can be applied to members with pre-existing conditions entering medical schemes or switching between schemes.

The use of annual exposure distorts analyses by duration in membership in the Funder report. This is acknowledged by the HMI in paragraph 40 of the Funder report but the analyses using beneficiary counts rather than exposure weightings are still included in the report: "Since even restricted schemes show a considerable gap between actual and predicted claims for new joiners it is likely that partial exposure i.e. beneficiaries joining mid-way through the year is playing a role in this differential".

In September 1998, the Actuarial Society presentation to the Portfolio Committee on Health noted that the implementation of community rating and guaranteed acceptance without risk equalization and mandatory membership would lead to cost escalations and reductions in covered lives due to anti-selective withdrawals. It should be noted that such actions on the part of members are rational when the regulatory framework permits members to defer entry until justified by health status (or buy up to more comprehensive cover if ill).

We encourage the HMI to increase the emphasis given to anti-selection as a cost driver in the report to support the recommendations regarding a risk adjustment mechanism. We suggest the HMI consider recommending mandatory membership as a policy solution to anti-selection.

5. Reference to non-indemnity cover as "actuarial health insurance"

We are concerned that the provisional report refers to health insurance policies written by short-term and long-term insurers as "actuarial health insurance." Paragraph 26 of the Executive Summary refers to

health insurance plans as “actuarial solutions” (in quotations with no citations) and in chapter 3 health insurance policies are referred as “actuarial health insurance”. We are concerned that this ignores the important actuarial contribution to risk management in medical schemes. We therefore request that the references are amended to be consistent with the legislative definitions under which these products are written.

6. Benefit design

The HMI suggests that medical schemes have introduced a wide range of benefit options as a way to induce clients to self-select, based on their own perceived risk, which is often termed innovation. The HMI has expressed the concern that the range of options and lack of transparency to members means that competition between schemes is on demographics (attracting the young healthy) rather than lower contributions and richer benefits (value for money). The growth of savings options, and declining comprehensive options is cited as evidence of this.

Our members are of the view that it is the incomplete implementation of a social solidarity framework that is the driving factor of the described behaviour. The concerns noted above can be adequately addressed through risk equalisation and the revision of the PMBs away from a hospi-centric, curative approach. It is the complex, and poorly-defined construct of the PMBs that has led to a complexity in benefit design.

The Actuarial Society shares the concern that members are confused by multiple benefit options and lack of comparability. Standardisation of benefits is not necessarily in the interests of consumers however a standardised framework presenting benefit options and an option classification system as proposed by the Council for Medical Schemes (CMS) will assist in addressing these concerns.

We note the view that medical savings accounts increase this complexity as consumers do not always know whether the administrator paid their claims from their savings or the risk pool. This highlights the need for member education and the important role that brokers play in this regard. It also suggests that savings options require members to have a certain level of financial sophistication in order to plan their benefit expenditure. Savings options do not tend to be targeted at lower income consumers. The migration of membership towards savings suggests that medical scheme members value having some discretion in how their benefits are allocated.

The Actuarial Society supports the proposed standardised mandatory base benefit package incorporating PMBs and with risk equalisation and a supplementary offering based on CMS rules and standards which may be risk rated. The members of the member of the Actuarial Society Healthcare Committee are prepared to support the analytical work required to assess the feasibility of this recommendation and the implications for existing medical scheme members.

7. Out of pocket expenditure

The World Health Organisation World Health Report indicates that South Africa has relatively low levels of OOP as compared to other middle-income countries. The World Bank analysis of global health expenditure has specifically looked at catastrophic health expenditure, defined as the percentage of the

population spending more than 10% of their household budget on out-of-pocket health expenses. For South Africa this was found to be just 1.41% (across the whole population). This puts South Africans' risk of catastrophic health expenditure on a similar level to people living in the UK (1.64%) or Panama (1.4%).

The analysis presented on the medical scheme data suggests that the difference between claims made and benefits paid is member out-of-pocket liability. This is not the case as there may be contractual arrangements or the service provider may not collect the difference. This needs further investigation before conclusions can be drawn.

Further, The references made to out-of-pocket expenditure (OOP) in the provisional report do not differentiate between situations where OOP is planned or expected, i.e. where the beneficiary is purposefully making a choice that is not cost effective or is outside of benefits (voluntary use of a non-DSP, choice of an out-of-formulary drug, new technologies), as opposed to cases where the beneficiary is not fully informed or unable to make an active choice. Whilst the latter is undesirable and we support mechanisms to reduce OOP, we recognize that there is a role for the former. Cost sharing is also an important risk management mechanism in encouraging members to access care in a clinically appropriate way. The report makes reference to the lack of systematic collection of OOP data. We refer the HMI to the work done to inform the OOP estimates contained in the National Health Accounts prepared by the National Department of Health. The National Health Accounts provide a useful framework for considering and tracking different types of OOP. It should also be noted that OOP in South Africa is low relative to most other countries in the world.

8. Anti-selection

The HMI finds that there has been a lack of attention to the regulatory framework in the private healthcare sector and that partially regulated environment creates incentives for risk selection. As noted above, the incomplete implementation of the social solidarity framework is a key problem that has adversely affected medical scheme risk pools. The HMI also notes the phenomenon of members buying down to cheaper options in order to address affordability constraints and that this has an adverse effect on schemes.

The high levels of cost escalation in medical schemes is concerning as it is making medical scheme cover less affordable. The HMI notes that there is evidence of anti-selection but that this is not a key driver of annual increases (although there is a progressive effect which is leading to a decrease in depth and range of covered services). The Actuarial Society is of the view that this effect has been understated by the HMI. The voluntary nature of a risk pool based on open enrolment and community rating makes it highly conducive to anti-selection and the waiting periods permitted provide very limited protection to medical schemes.

The exposure used in the GLM analysis does not allow for adequate adjustment for months of membership per year. This is particularly significant for new members and leads to the incorrect observation of new joiners claiming less than members with higher durations. This has the effect of obscuring the impact of anti-selection in the market and is contrary to our experience in the market where new members claim significantly higher than members with longer duration due to anti-selection against medical schemes. There are many factors that complicate results for new entrants (e.g. newborns).

Additional analysis should be performed to completely appreciate these nuances before drawing conclusions on anti-selective effects.

A number of detailed submissions have been made to the HMI on the topic of anti-selection including presentations by the CMS, the Actuarial Society and various stakeholders at the seminar of 1 February 2018. Anti-selection is the key risk associated with a voluntary environment where open enrolment and community rating apply. We are therefore concerned that the HMI has not given due weight to this factor particularly as additional measures to protect the risk pools of medical schemes can have an immediate benefit. Such measures include the nature of waiting periods and late joiner penalties as well as the role of mandatory membership in supporting the social solidarity framework.

We note that the role of mandatory membership is acknowledged by the HMI and we are disappointed that it is not considered as a remedy. We support that current areas of inefficiency need to be addressed, and there are immediate opportunities to do this through the amendments to the HPCSA rules. However, while we acknowledge the high levels of unemployment, introducing mandatory membership above a specified income band will have significant benefits in terms of affordability and that progressive introduction of income-based mandates will increase access to those who are unlikely to see the benefits of the NHI Fund for some time.

9. Supply-induced demand

The HMI notes that the bulk of the increase in claim expenditure can be attributed to expenditure on private hospitals and medical specialists. The HMI also notes that expenditure increases do not seem to all be due to aging population/disease burden and additional increases in expenditure are attributed to supplier induced demand.

However, there are a number of areas of technical concern with the supply-induced demand analysis. These include the following:

- The analysis is based on municipalities and not on the catchment areas determined elsewhere in the report;
- The analysis draws conclusions based on correlation and not causality; and
- The analysis is based on a static view of the market and does not consider the impact of changes in an area.

We therefore recommend that the supply and demand side contributors to the cost escalations are addressed in a more balanced way.

10. Pharmacies and pharmaceutical companies not included

We note that the role of consumables and pharmaceuticals as cost drivers has not been addressed in detail by the Health Market Inquiry. These costs are a significant component of health care costs. There are also distorting factors in the market such as patent protection, regulated pricing and the impact of state tender pricing on private sector prices. It is our submission that the impact of these measures on driving costs should have been considered. In particular, we are concerned that the current price

regulation framework only considers price increases (based on a formula) and does not incorporate any assessment of the level of the original single exit price plus increments for each product.

11. Implications of risk transfer

The recommendations published in the provisional report include some reference to reinsurance and also references to alternative reimbursement mechanisms. There are some current examples of risk transfer from medical schemes to managed care organisations in operation in the market with these arrangements intending to align incentives between healthcare providers and medical schemes in managing the cost of care. From an actuarial perspective it is important that where risk is transferred there are adequate reserves in place to ensure that consumers have adequate protection against price shocks, or even financial failure associated with adverse experience.

The Actuarial Society has made a number of representations to the Council for Medical Schemes subsequent to the implementation of the current Medical Schemes Act regarding the need for a risk based solvency framework that will result in a more efficient use of capital and thus be to the benefit of members in terms of adequate protection balanced with appropriate reserve levels. Linked to this is the need to ensure that there is adequate reserving to support risk transferred to other entities such as reinsurers, managed care organisations and healthcare providers. Such reserves can be held by these parties themselves or through an industry protection mechanism. the holding of reserves by the medical scheme is not adequate for risk transferred to entities (as a number of case studies have demonstrated where medical schemes have carried the losses of the total premiums paid plus the claims shortfall as opposed to only the latter if the risk had not been transferred).

The provisional report refers to reinsurance supporting regional schemes but there is insufficient detail included on this proposal for us to comment. We do support the use of reinsurance as a mechanism to support smaller risk pools and new entrants into the market.

The Actuarial Society therefore suggests that the following issues are considered by the HMI in finalizing the report:

- The need for a revision of the solvency framework for medical schemes and other healthcare funding risk takers to ensure appropriate levels of capital to provide protection to members; and
- The role of reinsurance as a mechanism to support new entrants into the market, as well as to support the risk transferred to other entities such as managed care organisations and healthcare providers.

12. Regional analysis

We note with concern the use of the different geographical areas in the various regional analyses undertaken by the HMI. The concentration analyses are based on suburbs (motivated based on the “deficiencies of the EAs that have been identified in the process of our analysis”), whilst the use of Enumerator Areas (EAs) is retained in the Facilities report. The supply-induced demand analyses are based on municipalities. This inconsistency reduces the reliability of the regional analyses.

We note the following description regarding the determination of catchment areas: "catchment areas will be determined using patient flow data, which we derived from hospital admission data and medical schemes claims data". The use of these two different data sources is of concern due to material differences in data definitions (for example, the definition of an admission) and the data quality (patient location data in funder data is of a lower quality than patient location data in admission data). We also note that the only 195 hospitals are included in the concentration analyses (as compared to the 409 facilities referred to in Chapter 3). It is not clear from reading the report if the difference between these two figures is purely due to the market product definition used. We suggest that more clarity on this is provided.

13. OECD international comparisons

We note that on page 236 of the provision report, the HMI makes reference to the results of OECD working paper 5. Various members of the profession have been involved in extensive critiques of this working paper – these critiques have not, to the best of our knowledge, been addressed.

In general we note that international comparisons of this nature should be dealt with cautiously due to differences in population distribution and income levels, health system design and data definitions.

14. Notes on recommendations

a. Improving transparency and competition

We are fully supportive of the principles of transparency and disclosure. We note the recommendation that all administrators must report publicly on the outcomes and value of all ARMs, PPNs and DSPs. The calculations of managed care savings and supply-induced demand are both technically complex areas as evidenced by the challenges faced during the analysis conducted by the HMI in isolating cost drivers. We recommend that increased transparency be accompanied by clear guidelines for these calculations (or mechanisms to develop such guidelines) to ensure comparability. Standardised methodologies will need to be developed and implemented across the industry for a consistent and fair comparison across stakeholders.

b. Risk adjustment mechanism (key learnings)

As noted in Section 3 above, we expressed our support for the implementation of a risk adjustment mechanism. Given that the Actuarial Society has been actively involved in the previous risk adjustment mechanism shadow process, we have great insight into the complexities associated with the development of such a model, and the arbitrage opportunities that may arise if the system is not designed properly. The members of the Actuarial Society Healthcare Committee would therefore welcome an opportunity to provide the HMI with the analytical support required for the development of such a model.

c. Anti-selection protection

We appreciate the HMI's acknowledgement of anti-selection in the market, but from our evaluation of the HMI's analyses, the HMI incorrectly attributes a large degree of anti-selection to supply induced demand, underestimating the degree of anti-selection in the market. Selection effects between schemes

drive differences in claims costs, and this is best mitigated by a risk adjustment mechanism. Selection effects into and out of the scheme market have the overall effect of higher claims for the whole market, open schemes in particular, and would be best mitigated by mandatory membership. We acknowledge the HMI's concern of mandating lower income households to buy cover, however this risk could be mitigated by choosing an appropriate base income level and by mandatory income banding. Mandatory membership with risk equalization is a key feature of the social solidarity framework.

d. Need for economic value assessment

In principle we are supportive of a supply side regulator to perform the function of economic value assessment of new technology. We note however that this is a complex analytical process, requiring careful consideration before such an authority is established.

e. Payment models and coding systems (importance of data)

We are supportive of mechanisms to facilitate alternative reimbursement contracting, including the abolishment of the HPCSA rules which prevent the employment of doctors by private health facilities. As discussed in Section 5 above, risk transfer arrangements including alternative reimbursement models, will require an actuarial assessment of reserves required by each contracting party to ensure members are adequately protected from risk shocks.

We note that both the proposed mechanisms for price determination (regulated pricing and multilateral tariff negotiation) focus on FFS tariffs. We note that increased use of ARMs will make it increasingly difficult to consider issues of price without simultaneously considering issues of quality of care and the nuances of contract design. The actuarial profession is well placed to make a positive contribution to the development and increased use of ARMs.

We are fully supportive of centralized coding procedures to update and maintain coding systems for the industry.

f. Role of networks/DSPs

We are supportive of an environment that facilitates the development of networks, including DSP arrangements, as these are effective tools for stimulating price competition in the provider market. We note however, that the effectiveness of these networks are constrained by medical scheme members, where the majority of members prefer to retain their freedom of choice in provider choice.

g. Solvency

We note that there are no explicit recommendations made for the medical scheme solvency framework to be reviewed. We support the implementation of risk-based solvency as a mechanism to ensure that the capital held is commensurate with risk. This is both a more efficient use of capital, and a stronger protection mechanism. As noted in the provisional report, the barrier to entry created by capital requirements can be offset through the appropriate use of reinsurance.

h. Standardised benefit packages

We are supportive of a revised PMB package, which focuses on services that protect members from serious medical conditions. We also support the inclusion of primary care in the PMB package. It is however essential, that any revisions to the PMB package do not increase the floor price of medical

scheme cover. As noted above, standardized benefits are a requirement for the implementation of a risk adjustment mechanism.

We support the proposal for the development of supplementary packages, and the opportunity to risk-rate these products on a fair basis. Careful consideration must be given to risk rating mechanisms to ensure those requiring cover the most are not excluded from the system, while protecting the scheme from anti-selection.

i. Outcomes reporting

The need to make progress on market wide quality measurement is strongly supported. We suggest a cautious approach regarding how this information is used for consumers, healthcare professionals and healthcare facilities so as to avoid unintended and potentially harmful consequences. Quality data is notoriously more difficult to standardize and communicate than cost data.

Yours sincerely

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