RISK POOLING IN HEALTHCARE FINANCING

CMS view on meaningful risk pooling in pursuit of Universal Health Coverage

CMS NHI Advisory Committee

INTRODUCTION

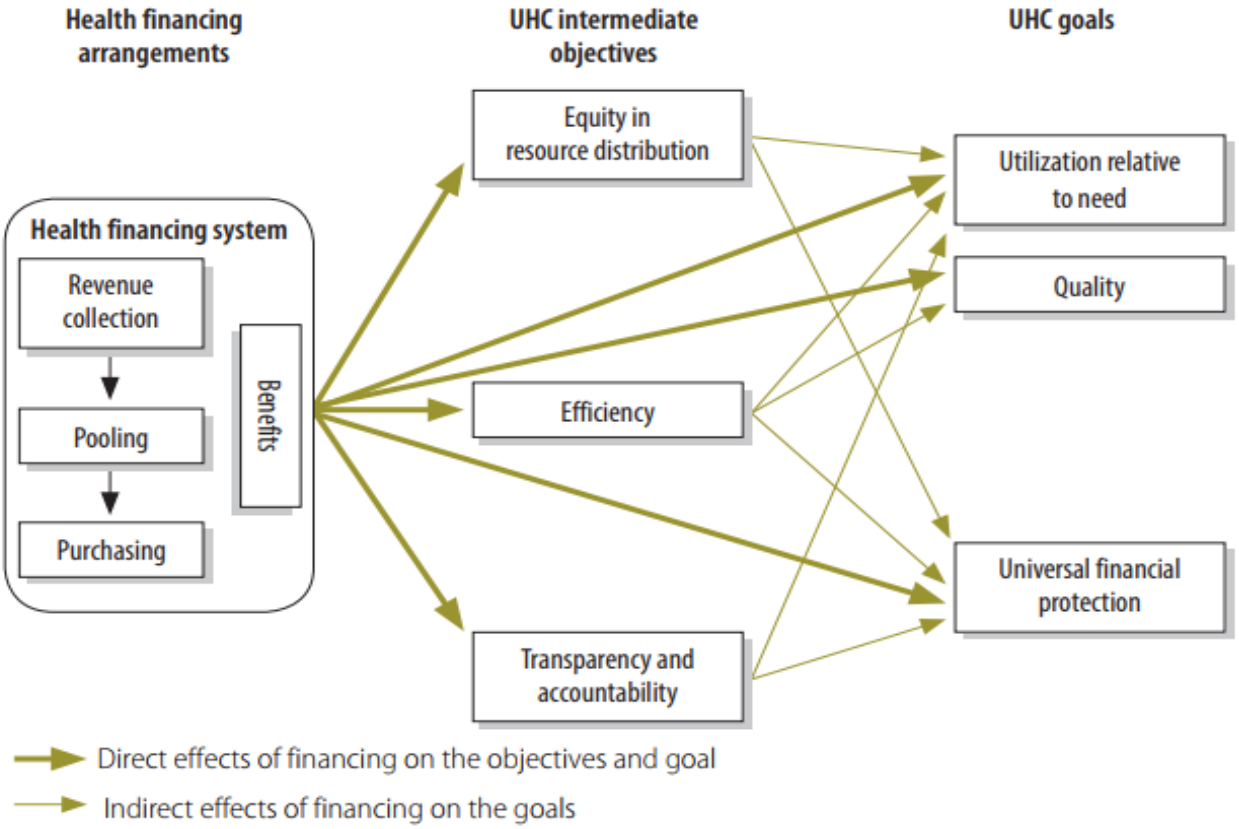
Risk pooling is traditionally viewed as an insurance function, where financial risk associated with health interventions for which the need is uncertain is equitably shared within the covered population. The World Health Organisation (WHO) defines pooling as *"...accumulation and management of revenues in such a way as to ensure that the risk of having to pay for healthcare is borne by all members within the pool, not by each contributor individually..."* (WHO, 2000).

Within health insurance systems, large risk pools tend to take advantage of the economies of scale where the law of large numbers often leads to substantial cross-subsidies from low-risk to high-risk individuals. This form of pooling within a community rated environment leads to equalisation risk and contributions amongst members of the pool. Those with high income and low expected healthcare expenditure often cross-subsidise the old and sick and premiums are not proportional to risk, demonstrating the impact of risk pooling within a community-rated environment.

Large risk pools are also not only prominent within single fund universal health coverage systems but also exist within multiple fund Social Health Insurance (SHI) systems. Countries such as Hungary, Iran, Norway & Korea are examples of a single fund National Health Insurance (NHI) systems where large pools enable an increase in resource availability for health care services and progressively offer better financial protection. Whilst countries with multiple funds such as Turkey, Brazil, Thailand and Peru have also adopted a health financing policy to expand the size of their risk pools (Atun *et al.*, 2013, Maeda *et al*,2014).

Figure 1 below also illustrates that progress towards Universal Health Care (UHC) can be promoted through meaningful actions in improving pooling, purchasing, efficiency, equity in the distribution of resources, transparency and accountability. The overall benefits of such policy considerations being to ensure that healthcare utilisation will be relative to the need and quality, thus ensuring financial protection of the covered population.

Figure 1 : Pathway and goals towards attainment of Universal Healthcare



Source: Kutzin J, 2013

INTERNATIONAL EXPERIENCE - FROM FRAGMENTATION TO INTEGRATED POOLS

The level of the fragmentation or integration of risk pools within any national health systems will have an impact on the following factors: the extent of financial protection provided, the richness of benefits, the extent to which the fund is able to strategically purchase healthcare services, use of alternative reimbursement methods, the reduction in administration costs, the impact on financial reserves and contribution payment. Risk pool fragmentation also limits the scope for redistribution possible from a given level of prepaid funds, and affects the extent to which health insurance entities can efficiently coordinate healthcare services for the covered population.

Unless addressed effectively through market reform or regulation, risk pool fragmentation can become a barrier towards progressive achievement of the key objectives of universal coverage. It is within this background that the World Health Organisation recommends that health financing reforms should not only focus on increasing the level of prepayment funding for the risk pools, but should also consider policy options to encourage risk pool consolidation, otherwise, implementing such measures (increasing the level of prepayment funding) without paying proper attention to changes in risk pooling can result in increased fragmentation and compromised equity and efficiency goals (WHO 2010). International experience also reveals that the consolidation of multiple small risk

pools into fewer large pools or single funds is not something new nor unique for the medical schemes industry in South Africa (SA). Countries such as Iran, Argentina, Turkey, South Korea, Brazil, Thailand, Ghana, Peru, Estonia, Lithuania and Indonesia are just a few examples of how the national health systems have evolved to consolidate risk pooling to improve the level of financial protection for the population (Mohammad B *et al*, 2016, Atun *et al*., 2013).

BRIEF OVERVIEW OF RISK POOLING WITHIN THE SA MEDICAL SCHEMES MARKET

In 1997, the private health financing policy document published by the National Department of Health (NDoH) outlined the following problems with regards to risk pooling in the South African medical schemes environment:

> *"…medical schemes had risk pools that were too small…the benefits of economies of scale were lost. This trend posed challenges in spreading the risk of illness across a larger risk pools…"*
>
> *"…many medical schemes offered differentiated set of benefits …."*
>
> *"... limited information available for members with regards to comparing different benefit options..."*
>
> *"…inadequate funding and oversight over many benefit options."*
>
> *"..the tension between proliferation of benefit options and minimising cream skimming.."*

It will also be noted in the 1997 policy document that, the legislative review and policy debates at that time acknowledged that multiple benefit options within medical schemes created challenges associated risk selection, adverse selection and inadequate funding of certain (small) risk pools. In order to address these challenges, the following recommendations were made:

- All options will include prescribed minimum benefits (PMBs).
- Each benefit option was expected to be self-funding. No cross-subsidisation will be allowed between benefit options.
- Each benefit option was expected to maintain a minimum membership requirement of 2500. In addition, the Registrar was given legislative power to call for sufficient financial guarantees for each option.
- Options that medical schemes created for the sole purpose of hosting defined groups on an exclusive basis may not be registered.
- Movement between options will only be affected with the express permission of the Registrar.

Some of the above-mentioned recommendations translated into different regulatory provisions within the Medical Schemes Act, No. 131 of 1998 (the Act) such as: Section 7, Section 8 (f), Section 24 (2) (b) (c) (d) (e), Section 27 (1), Section 29 (n), Section 33, Section 35, Regulation 2 (3), Regulation 4 (4) and Regulation 29. It is clear from these regulatory provisions that the Act envisaged a regulatory environment in which access to healthcare would be enhanced by the pooling of health risks within a community-rated environment. Although, over the years, CMS

has observed that consolidation of the risk pools leading to sufficient cross-subsidies has however moved at a snail pace. Figure 2 below shows the extent of growth in beneficiary and dependant numbers within restricted and open schemes, while Figure 3 shows the number of dependants per member. What will be noticed is that to a large extent, restricted schemes have experienced relatively higher growth in beneficiary and dependant numbers between 2006 until 2012 compared to the open schemes. Whilst the open schemes market experienced contraction in dependant numbers between 2007–2011 and an increase between 2013 and 2015. At the same time the restricted schemes experienced a drop in dependency numbers. This contraction in growth numbers is not ideal within a social solidarity space especially when one considers the number of beneficiaries within small, medium and large benefit options (see figure 4, 5 & 6 below). This trend necessitates a review and consideration of different policy options to reduce fragmentation and improve financial protection within the current community rated environment, within the existing provisions of the Act.

Figure 2: Growth in beneficiaries and dependants (2016)

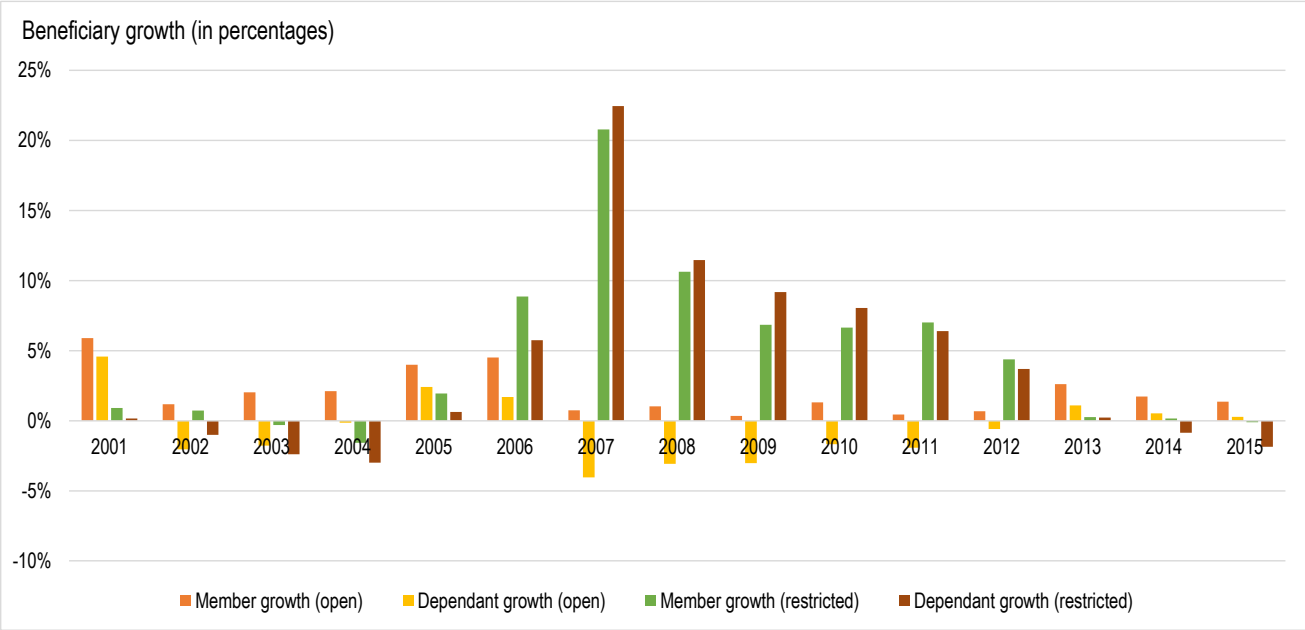


Figure 3: Total number of dependants per member (2016)

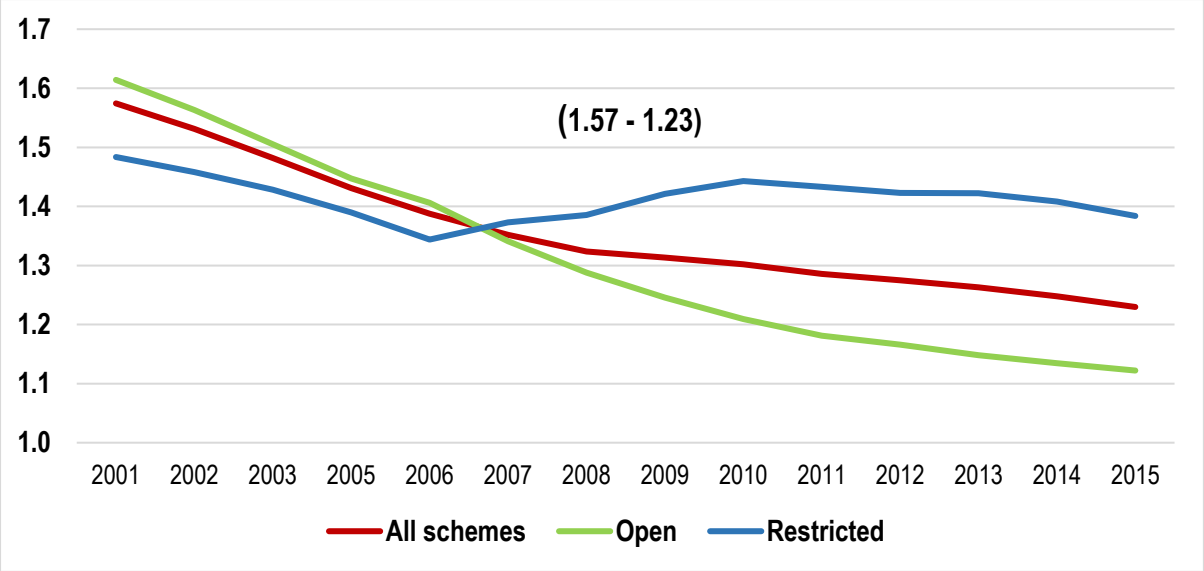
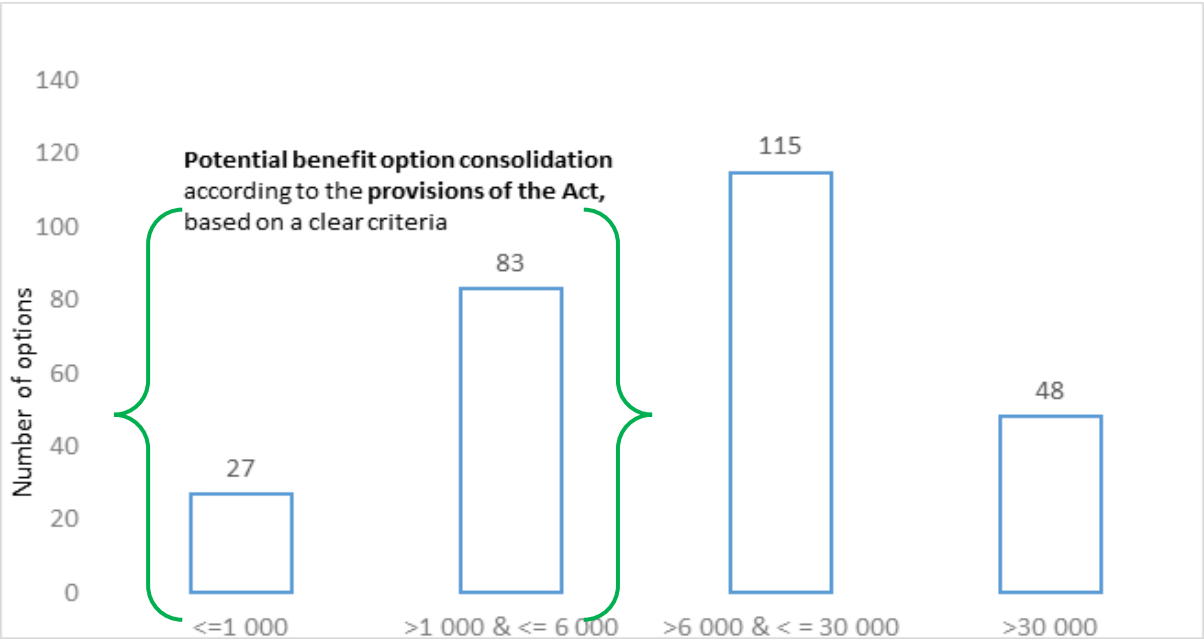


Figure 4 depicts the total number of beneficiaries within the benefit options. As will be observed, whilst some of these pools are relatively big, the immediate concern for the CMS is the risk pools with less than 2500 members at a benefit option level, as well as the medical schemes with risk pools that have less than 6000 members at a scheme level. Within such pools, the CMS has observed extreme cases where some pools have less than 50 or even 30 beneficiaries. In such benefit options, one incident of a catastrophic medical event such as Gaucher disease can cripple the financial position of the benefit option especially those options with low beneficiary numbers.

Figure 4: Number of beneficiaries within benefit options



A CASE FOR CONSOLIDATION OF BENEFIT OPTIONS

CMS is currently developing a framework for benefit option classification and standardisation. It is our view that this framework will enable better risk pooling and cross subsidisation. Once benefit options have been properly classified and standardised, consumers will be empowered to make informed choices when purchasing medical schemes cover. Fewer benefit options will also enable members to compare benefit entitlements, limitations and penalties against premiums charged per option. It is also envisaged that instances where there are duplications in benefit designs within the schemes, medical schemes will have an opportunity to consolidate those benefit options in pursuit of bigger and sustainable risk pools that are compliant with the provisions of the Medical Schemes Act.

Figures 5 and 6 below provides an outline of differences in average between restricted and open schemes across different benefit option sizes. Small and medium sized options have the highest average whilst large and very large benefit options have relatively lower average. To a large extent, the same observations exist for the pensioner ratio and the claims experience within option sizes. These observations necessitate the need to consolidate benefit options for small to medium sized options in order to enable economies of scale which will provide better financial protection for the covered population.

Figure 5: Open schemes (2016)

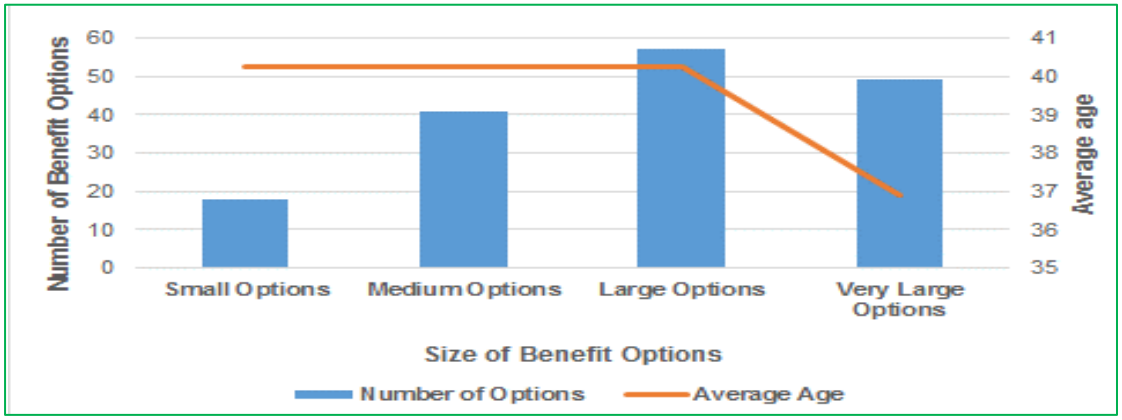
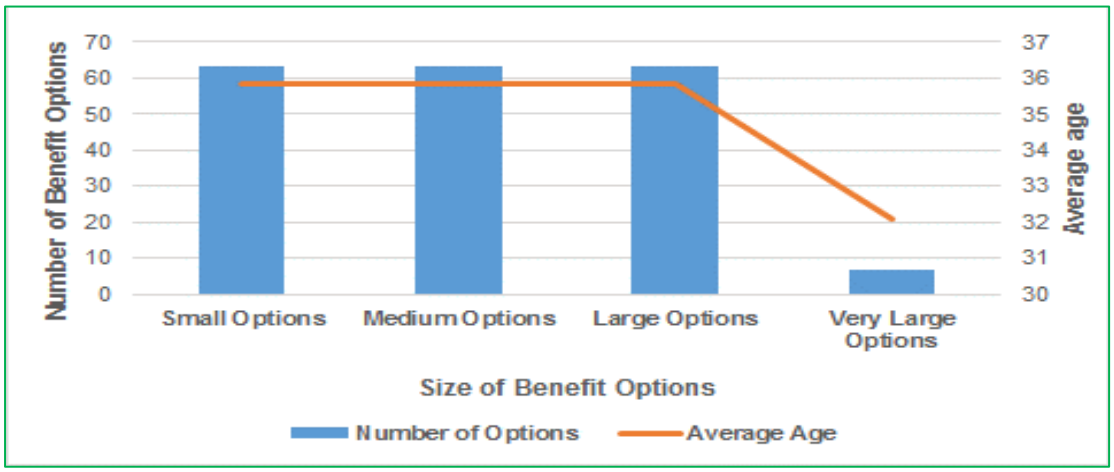


Figure 6: Restricted schemes (2016)



CONCLUDING REMARKS

The CMS believes that the absence of product complexity will enable vulnerable risk groups to enjoy better protection. In such an environment, medical schemes will compete on efficiency as opposed to risk selection.

CMS also believes that partial regulation of multiple risk pools will continue to entrench the following inefficiencies within the current environment:

- Smaller risk pools with unfavourable profiles will continue to be passive purchasers of healthcare services with limited ability to influence provider behaviour and entering into value based contracting.
- Fragmentation of the risk pools will continue to create an opportunity to unfairly deny access to prescribed minimum benefits or to shift these expenses into self-insurance pools.
- Some medical schemes manipulate beneficiary entitlements through shifting claims that should be insured as part of risk benefits into the self-insured pools (i.e. medical savings account and equivalent benefits as well as out-of-pocket payments). For example, between 2014 and 2015 about 23 medical schemes contravened Regulation 10 (6). The average number of benefit options within these schemes was 4.3 with a range between 1 to 15 benefit options per scheme. Small risk pools within these schemes had on average 1 922 beneficiaries with a range between 326 to 5765 members.
- Fragmented risk pools will also continue to attract adverse selection behaviour by some members who will buy less cover when they are healthy, and more cover when they are sick and/or register and deregister their dependants as and when they require healthcare.
- Some medical schemes will continue to avoid poor risks and attract only good risks, in part to avoid adverse selection, but also to compete on price, with other schemes for equivalent levels of cover.
- Since the Act stipulates that community rating should only exists within the benefit options in the schemes, a degree of risk rating for essential benefits will continue to exist within certain medical schemes. This occurs because different option designs deliberately attract different risk groups.
- Members usually do not always have full understating of the various benefit options offered by the medical schemes; and sometimes members have difficulty engaging with their scheme's rules due to language barrier.

Within this background, CMS believes that partial regulation of the risk pools is therefore not an option since it is not in line with the provisions of the Act.

Pool out quote (1)

Large risk pools also take advantage of the economies of scale where the law of large numbers and substantial cross-subsidies from low-risk, to high-risk individuals will exist. This form of pooling also leads to equalisation of contributions amongst members of the pool, regardless of the financial risk associated with utilisation.

Pool out quote (2)

The level of the fragmentation or integration of risk pools within any national health systems will have an impact on the following factors: the extent of financial protection provided, the richness of benefits, the extent to which the fund is able to strategically purchase healthcare services, use of alternative reimbursement method, the reduction in administration costs, the impact on financial reserves and contribution payment. Risk pool fragmentation also limits the scope for redistribution possible from a given level of prepaid funds, and affects the extent to which health insurance entities can efficiently coordinate healthcare services for the covered population

Pool out quote (3)

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NB: The pool quotes will be used as fillers in case there is need to fill in some space allocated to the article.