CMS submission to the HMI discussion document on healthcare financing regulatory framework and its impact on competition within the South African private healthcare sector

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1. INTRODUCTION

The Council for Medical Schemes (CMS) welcomes the opportunity to make input to the recently published report the healthcare financing regulatory framework and its impact on competition within the South African private healthcare sector. Observations presented by the Health Market Inquiry (HMI) mostly concur with our observations. Whilst CMS does not have access to claim line data at a beneficiary level, we have undertaken research on some of the issues highlighted in the report. This submission seeks to provide answers to the questions put by the HMI publication as follows:

1) Why are benefit options that are in financial deficit for consecutive years, allowed to exist?
2) What interventions, if any, are required to address anti-selection, if it occurs, to increase meaningful competition?
3) How could changes to medical scheme benefit options improve competition in the market?
4) How does the current degree of risk pooling impact competition between medical schemes?
5) How to improve risk pooling in the market so as to improve competition;
6) What impact does the lack of a medical scheme wide mechanism to equalise for risk have on medical schemes and the cost of cover?
7) Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?
    - What changes would allow members to compare the real value of medical scheme benefit options?
8) How can benefit options be simplified to allow meaningful comparisons and increased competition?
9) What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?

2. MEDICAL SCHEMES DEMOGRAPHICS

Paragraph 9 and 10

2.1 Number of options

With the objective of responding to the questions raised above, a medical schemes demographic analysis was undertaken. As shown in Figure 1, the number of beneficiaries increased significantly over the period between 2006 and 2015. Medical scheme beneficiaries also increased by 23.6% between 2005 and 2015, or an annualised growth

of 2.1%. By 2016, CMS observed a year-on-year increase of 0.78% (Council for Medical Schemes, 2017). The observed growth in the industry seems to have been due to the uptake of new beneficiaries by restricted medical schemes, and more precisely, the growth in the Government Employees Medical Scheme. It is important to also point out that although there was positive growth in 2016, around the year 1992, an estimated 17% of the South African population were members of the medical schemes, compared to 15.9% in 2016. This seem to suggest that overtime, the growth in the number medical scheme beneficiaries appears to have reached its plateau, with the industry experiencing the first negative growth in 2015 after many years of sustained growth. Overall, the number of beneficiaries dropped by a negligible -0.06%in 2015. Open medical schemes continue to cover a larger proportion of all medical schemes members and beneficiaries.

Figure 1: Medical schemes beneficiaries (2006 -2015)

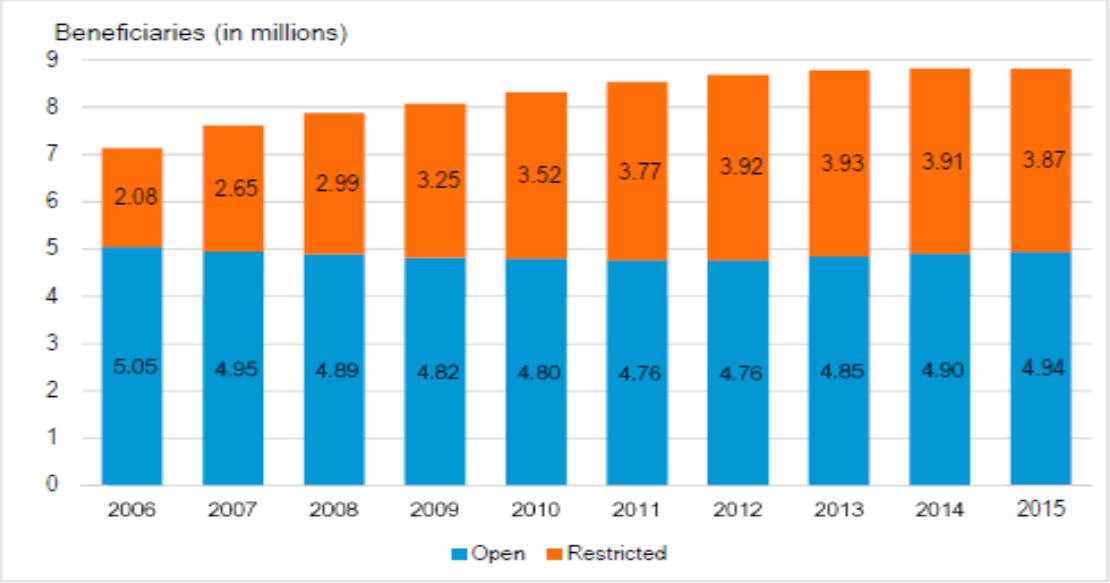


Figure 2 below demonstrates the decline in the total number of benefit options to 276 in 2015, compared to 392 in 2006, with a slight increase to 280 in 2016. The decrease in the number of options was slower compared to the reduction in the number of medical schemes. In fact, there has been a significant increase in the average number of options per scheme in open schemes (from 5.2 in 2006 to 6.5 in 2016) as will be noted, the number of option per scheme increased only slightly in restricted schemes (from 2.1 in 2006 to 2.3 in 2015) and is currently at 2.3 in 2016. Other than approval of new benefit options, CMS has also observed an increase over time in the number of Efficiency Discounted Options. The detail of the impact on EDO on risk pooling within our environment is included within the National Health Insurance Section attachments (see attached Appendix 2).

Figure 2: Number of benefit options (2006- 2015)

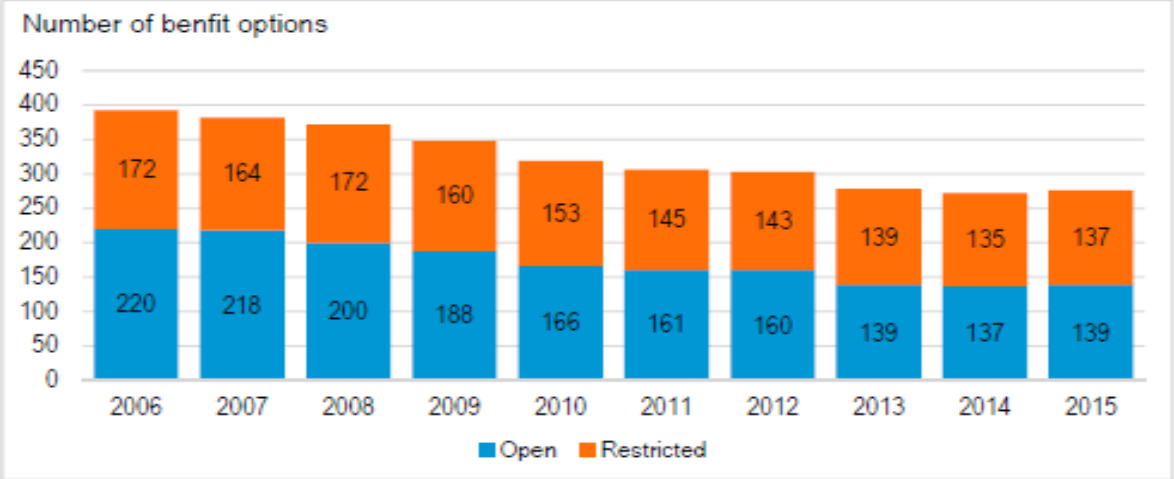


Figure 3 : Total number of dependents per member (2015)

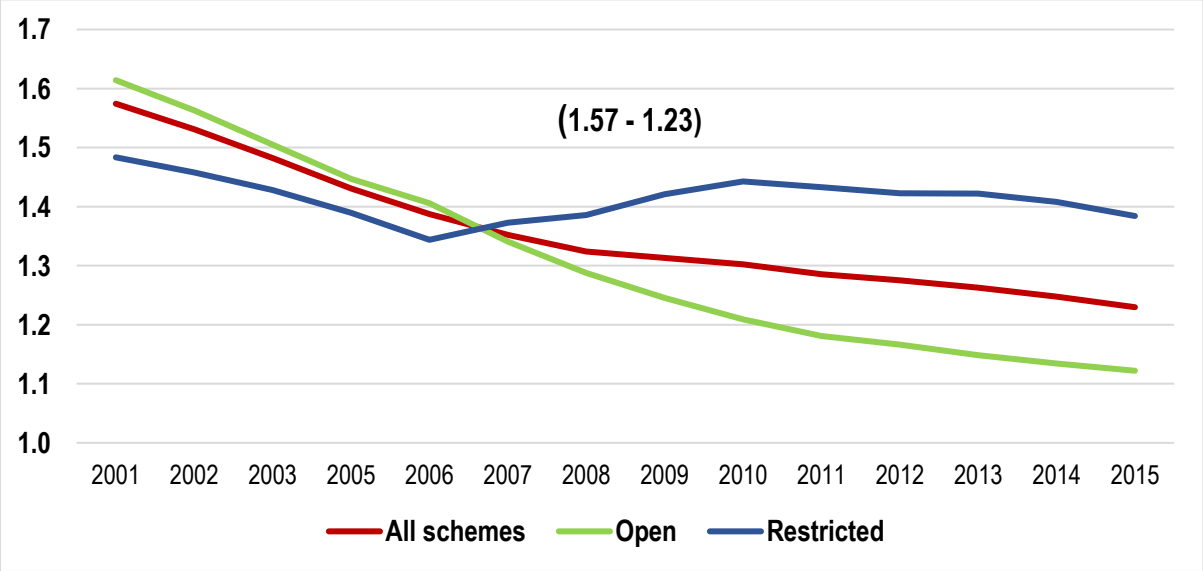
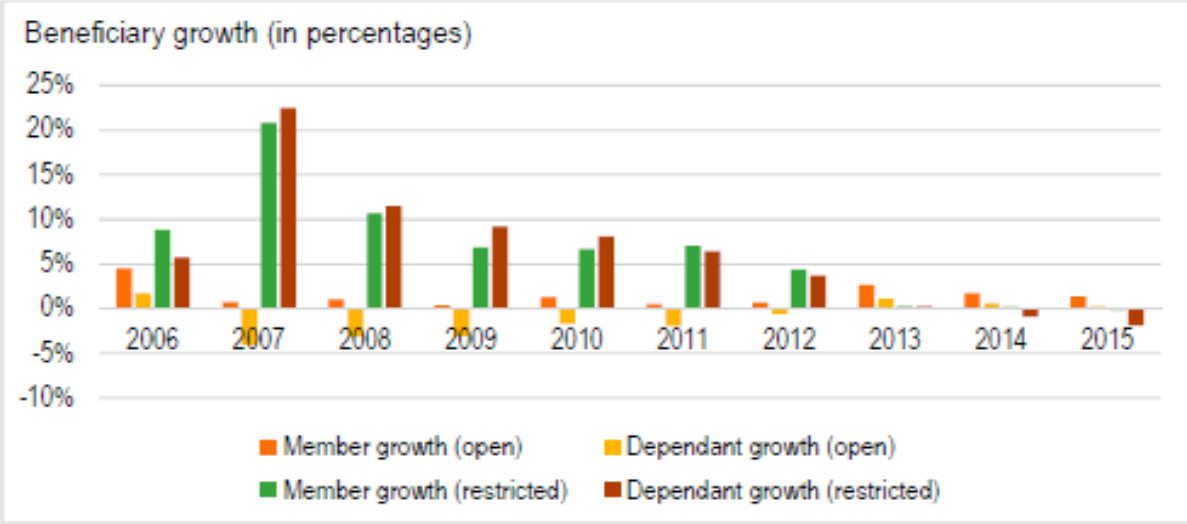


Figure 3 shows the number of dependents per member. The industry has experienced a decline in the size of the average covered family. This was more pronounced in open medical schemes which saw a drop to 1.12 in 2015 from a high of 1.42 in 2006. The family size for restricted medical schemes increased from 1.34 in 2006 to 1.38 in 2015. Overall, the average family size for all covered beneficiaries declined over the period under review.

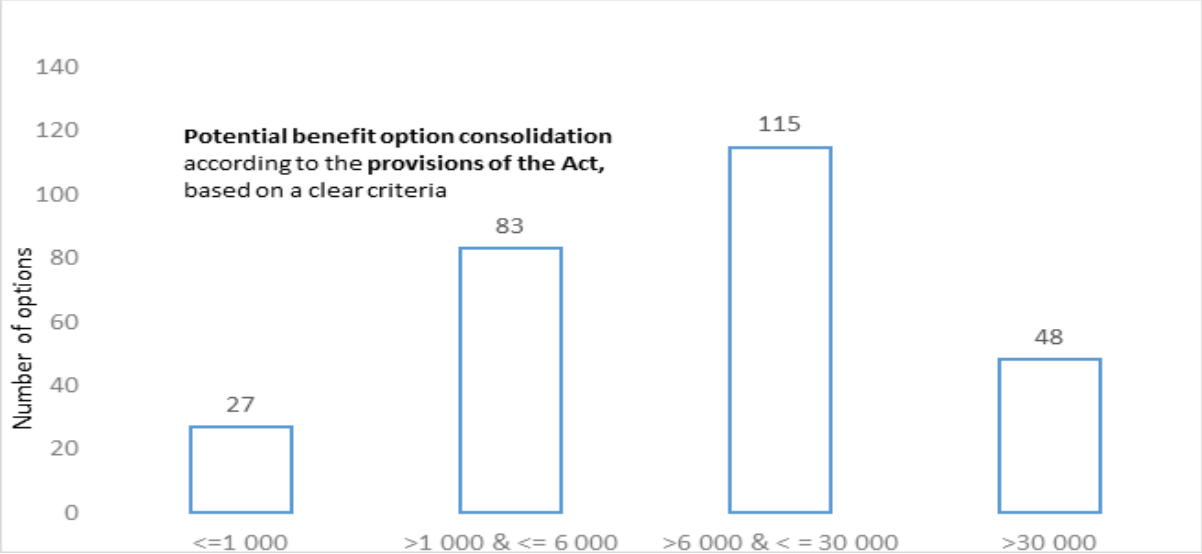
What will be noticed from Figure 4 is that, to a large extent, restricted schemes have experienced relatively higher growth in beneficiary and dependent numbers between 2007 until 2012 compared to open schemes (largely GEMS related). The open schemes market experienced contraction in dependent numbers between 2007 and 2011 and an increase between 2013 and 2015. At the same time, 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 benefit options (those with less than 2500 members).

Figure 4 : Beneficiary growth (in percentage)



As will be observed in Figure 5 below, some risk pools are relatively big but CMS' immediate concern is on risk pools than have less than 2500 members at a benefit option level, as well as the medical schemes with overall risk pools that have less than 6000 members at a scheme level. There are some examples of options with coverage far below these levels. In small options, one incident of a catastrophic medical event such as Gaucher disease can cripple the financial position of the benefit option (see Section 10 and NHI attachments).

Figure 5 : Number of beneficiaries within benefit options (2015)

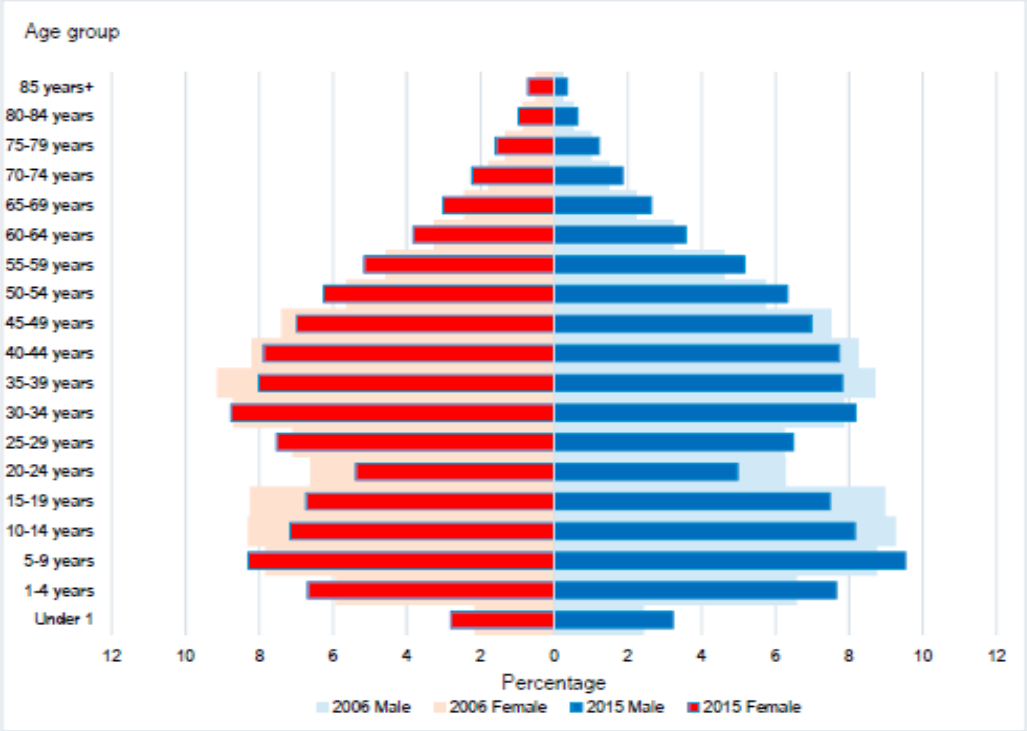


2.2 Trends in age and gender of medical scheme beneficiaries

It is well known from literature that the demographics are important predictors of benefit option mobility. For example, families with older members are much more likely to switch to specific benefit options than other families. This context shows the importance of age and gender on spending differentials and benefit option mobility decisions. Figure 6 demonstrates the trends in demographic changes by major age groups. The percentage of beneficiaries in the under 1-year-old age category increased to 3.5% in 2015 from 2.3% in 2006.

The proportion beneficiaries in the 1 to 14 years increased significantly by 4.1 percentage points to 27.4% in 2015, whilst the 15 to 35 years age group increased by 2.1 percentage points to 32.2% in 2015. The proportion of beneficiaries aged 65 years and older increased by 2.6 percentage points to 8.9% in 2015. It is therefore expected that the observed increase in older beneficiaries will have an impact on claims costs.

Figure 6: Demographic changes



3. RISK POOL REGULATORY FRAMEWORK

Paragraph 25, 28, 31 and 39 - legislative context

Paragraph 25 on the HMI publication evokes Section 33 of the Medical Schemes Act, which states that *"...each benefit option needs to be self-sustaining..."* whilst paragraph 28, 31 and 39 seeks to explore why CMS has been approving benefit options that are in financial deficit, as well as exploring possible changes that could be recommended at a benefit option level to improve competition. Below is an account of CMS' regulatory framework on benefit option registration, withdrawal, as well as monitoring. Attached to this submission is a Legal Opinion on the interpretation of Section 33.

The Council for Medical Schemes ('the Council') is an organ of state established in terms of the Medical Schemes Act (131 of 1998). The Council is, therefore, in performing its functions as provided for in Section 7 of the Medical Schemes Act obliged to discharge its legislated mandate in a coherent manner, which is consistent with national policy. The functions of the Council are among others to: -

- (*a) Protect the interest of the beneficiaries at all times*
- *(b) Control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy*
- *(g) Advise the Minister on any matter concerning medical schemes; and*
- *(h) Perform any other functions conferred on the Council by the Minister or by this Act.*

Section 24 (2), states that no medical scheme shall be registered unless the Council is satisfied that:

- (b) *medical scheme complies with the provisions of the Act*
- *(c) the medical scheme is and will be financially sound*
- *(d) sufficient number of members (Reg. 2 (3))*
- *(e) no discrimination*
- *(f) registration of the medical schemes not in conflicting to the public interest*

Section 27 (1) requires that the Registrar may, in concurrence with the Council after investigation and after having afforded the medical scheme or its legal representative an opportunity to be heard, cancel the registration on a medical scheme:

- (c) *if the medical scheme is unable to maintain a financially sound condition as per the Act*
- *(d) if the medical scheme is unable to …. maintain the minimum number of members required for the registration of a medical scheme*
- *(e) if the medical scheme after written notice from the Registrar persist in violating any provisions of this act.*

Section 33 - Approval of benefit options outlines the following: (1) A medical scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option. (2) The Registrar shall not approve any benefit option under this Section unless the Council is satisfied that such benefit option:

- *a) includes the prescribed benefits;*
- *b) shall be self-supporting in terms of membership and financial performance*
- *c) is financially sound; and*
- *d) will not jeopardise the financial soundness of any existing benefit option within the medical scheme.*

(4) The Registrar may, because an inspection or investigation in terms of this act or an account of any report, document, statement or information furnished to him/her is he or she believes the benefit option is or may not be financially sound,

withdraw the approval of such benefit option and the medical scheme shall amend its rules accordingly. (5) The Registrar may amend the rules of the medical schemes based on subsection (4).

Section 35 – with regards to financial arrangements, the Medical Schemes Act clearly states that medical schemes shall at all times maintain its business in financially sound condition:

- *Stricter controls to extend financial stability of the schemes*
- *Financial soundness*
- *Detailed financial reports,*
- *Meeting liabilities, mandatory net assets*

Section 42 states that the Registrar may require additional information from the medical schemes, such as the one outlined in subsection (c), which includes: any statement, account, return or document relating to the financial condition of a medical scheme. Section 42 (3) further states that the Registrar may require such information as to enable the Council to make recommendations to the Minister on the matters referred to in Section 7 (c).

Section 53 (2) The Registrar may, with the concurrence of the Council and with the approval of the High Court make an application under Section 346 of the Companies Act, 1973 for winding up of a medical scheme if he or she is satisfied, that it is in the best interest of the beneficiaries of the medical scheme to do so.

Regulation 2 (3), states the minimum number of members required for the registration of a medical scheme established after the promulgation of the regulations. The Act explicitly states that each scheme needs to have 6000 members and this number must be admitted within a period of three months of registration.

Regulation 4 (3) A medical scheme must not, in its rules or in any other manner, structure any benefit option in such a manner that creates a preferred dispensation for one or more specific groups of members…

Regulation 29 (2) states that Subject to sub regulations (3), (3A), and (4) a medical scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%.

4. CMS BENEFIT OPTION REGISTRATION PROCESS

Conditions for Registration

CMS agrees that multiple benefits options not only fragment and/or dilute effective risk pooling, they also create information asymmetry problems, influence adverse selection and provider moral hazard. As per the current regulatory framework, when application of new benefit options is received, CMS subscribes to Section 33 (1) and (2). The registration letter confirming registration of a new benefit option normally includes approval conditions as per the provisions outlined above, also requiring that a medical scheme must submit quarterly management accounts, reporting on the performance of the new option.

Monitoring and Evaluation

Monitoring and evaluation of the new options is undertaken as per the requirements of Section 33(2), in this regard, the benefit option will be monitored mainly for financial and membership performance. The tools used to monitor the new option include the quarterly statutory returns and the actuarial reports submitted annually to the Registrar for annual registration of options. Lastly, every year, medical schemes are required to submit their benefits option for review and registration.

Deregistration of options

All other things being equal, options that consistently fail to comply with the requirements of Section 33(b) i.e. (membership and financial performance) may be deregistered. However, deregistration of an option is normally considered as a last resort, such regulatory intervention has a potential of impacting on beneficiary movement between options and can also create pricing uncertainty. In addition, closing a top-end option can drive up the cost of all other options, with the potential of creating affordability challenges for members and thereby destabilising the scheme. Striking the balance between overall scheme stability and financial soundness, and the requirement for options to be self-sufficient i.e. enforcing risk pool at an option level, may actually reduce overall social solidarity.

Non-compliant schemes including loss making options are often required to submit a turnaround strategy in the form of a business plan. The scheme is then given sufficient time to implement the new measures. However, if the benefit option continues to be non-compliant as per provisions outlined above, the Registrar reserves the right to deregister those benefit options. Circular 45 of 2017 clearly outlines how CMS will be improving the scheme rule approval process in light of the current policy developments. *Recommendations*

(a) Amendment of the current legislative provisions on risk pooling requirements at a scheme and benefit option level:

- Regulation 2 (3) to explicitly state that all registered medical schemes should always have the minimum of 6000 members whether or not these medical schemes were registered before the amendment of the 1967 Act.
- Furthermore, this provision should explicitly state corrective measures to be followed by the Regulator in addressing noncompliance since currently there is no consensus within the industry on the interpretation of Regulation 2 (3). This exposes CMS to litigation by the regulated entities (see Appendix 3: Suremed case).
- Explicit outline of the required membership base at a benefit option level. Section 33 (2) (c) does not permit withdrawal of the benefit option if that option is financially sound, even if that benefit option has low membership.
- A clear directive from the Act in terms of membership requirement at a benefit option level would assist CMS to effectively regulate risk pools within the industry.
- A clear interpretation of "public interest" as outlined within Section 24 (2) (f) is also required. Such interpretation needs to take into consideration membership growth requirements, consumer preference and the impact of option selection by employer groups.

(b) CMS will, through a consultative process with the industry, develop a framework for the consolidation/ standardisation of benefit options, to reduce these to a basic number. This framework will be also be implemented in consultation with the industry in a phased-in approach. This will go a long way in assisting current and prospective scheme members to make rational purchasing decisions.

(c) It is also worth noting that the effects of consolidation will need to be carefully managed to minimise second order effects. This can result in changes to income cross-subsidies and hence affordability. It may also aid the possibility of price shocks, which is why this process will require careful modelling to anticipate the potential risks.

The above recommendations will assist CMS in meaningful regulation of the current risk pools. Without such, the Regulator will continue to encounter legal challenges from the industry with regards to consolidation (see attached Appendix 1: Legal Opinion).

5. ADVERSE SELECTION

Paragraph 7, 9, 11, 19

Although there is limited empirical evidence on the factors influencing and impacting on plan switching by members, different medical schemes have presented to the Council the impact of anti-selection on health inflation. There is also anecdotal evidence which describes the impact of anti-selection within particular conditions and circumstances (see three case study illustrations below). This behaviour can be analysed according to the following categories:

- Age: young people defer scheme membership
- Gender: females during child-bearing ages
- Disease burden: people with expensive illnesses to treat or multiple illnesses
- Benefit options: members selecting options with higher benefits only when their likelihood of needing those benefits is high
- Individuals: voluntary membership where mandatory participation is not enforced through legislation
- Employer group preferences and splitting of the risk pools

Case study 1: Chronic Renal Failure (CMS, 2008)

"There is anecdotal evidence that older people with chronic renal failure needing dialysis are encouraged to join medical schemes in order to get dialysis in the private sector, as there are limited resources in the public sector..... The impact on a medical scheme is substantial: for example, in 2008, a healthy 60-year old male was expected to cost R583.28 per month but one with chronic renal failure needing cost about R19, 291.96 per month. Amongst other things the effect of this is that contributions need to be increased for all members of medical schemes to cover costs associated with such behaviour."

Case study 2: Pregnancy

"There are instances where medical scheme cover will be taken by couples or single women who are planning to have children. The medical and accommodation costs associated with the pregnancy will be covered by the medical scheme. Because of information asymmetry, plans to start a family are considered privileged information and deliberately not disclosed to the medical scheme."

A study undertaken by Fifth Quadrate between 2006 and 2007 revealed empirical evidence of the impact of age-related anti-selection behaviour (Fin Mark Trust 2009). The study objective was to "explore cost drivers and factors contributing to the sustainability of the low-cost options market in SA". Below is a summary of their key findings.[1]

Case Study 3: Age specific anti-selection behaviour: Polmed experience (2006-2007)

At the time when the study was undertaken, Polmed had high and low plan options. The main difference between them was the level of the sub-limits that apply to certain in-hospital benefits, such as prostheses, and the level of out-of-hospital benefits that they provided. Other than the hospital sub-limits, both options provided unlimited hospital cover. The analysis of Polmed claims data for the years 2006 and 2007 showed that various categories of anti-selection have affected the cost of Polmed options, namely: "Buy-downs" from the higher to the lower plans by older members. This category of anti-selection shows that the number of members in age categories from 35 upwards remained constant or declined in the higher plan, while growing in the lower plan. The data also showed that the level of hospital costs per beneficiary increased markedly with age. This trend was apparent in all the other benefit categories. Therefore, the increase in higher age categories in the lower plan had an adverse impact on its cost. "Buy-downs" from the higher to lower plan by middle-income (low-claiming) members. This category of anti-selection illustrated in the data showed that higher plans had seen a decline in low-claiming member income categories F, G and H. These categories are the lowest claimers in all benefit expenditure areas. Conversely, membership in these categories increased in the lower plan. While this form of anti-selection has a favourable impact on the low-cost plan, it removes cross-subsidies in the higher plan and has an adverse effect on its cost. The

[1] FinMark Trust 2009 "Making health insurance work for the low-income market in South Africa*: Cost drivers and strategies"*

study also observed that higher-claiming members select plans with richer benefits. In general, members in the same income category claim more when they are on a plan with more generous benefits.

Mcleod and Ramjee (2007) also did a study which compared the relationship between income, age and gender to expose the anti-selection behaviour that occurs in the voluntary medical schemes environment. This analysis was undertaken in 2007 where CMS' Risk Equalisation Fund (REF) data was analysed. This study showed higher numbers of maternities than expected in the REF pricing each year. Furthermore, unpublished scheme investigations also showed substantially higher maternities than expected as well as some evidence of increasing numbers of women who join schemes before giving birth and leaving schemes thereafter (Mcleod & Ramjee, 2007). Within the same study, it was also observed that the proportion of eligible children covered was much lower than the proportion of people over age 35. There was also a noticeable decline in membership between 20 to 35 years as young working adults and those still studying remained out of schemes. Lastly, another significant finding was that more women than men choose to become medical scheme members in their childbearing years (Mcleod & Ramjee, 2007).

Table 1: Anti-selection in medical schemes

Highest Household Income	Tax Threshold of R2 917 per month in 2005		R1000 per month in 2005	
Proportion of households who join a medical scheme (%)	Male	Female	Male	Female
Under 20	49.4	49.4	29.7	9.3
Age 20-35	37.6	44.1	19.2	25.6
Age 35 – 65	54.9	62.1	36.1	42.
Age 65 +	66.1	65.2	53.5	53.0

Source: Derived using Stats SA, 2006; 10 CMS, 2007[2]

To conclude, whilst the impact of age related anti-selection behaviour is clearly outlined in these studies, it also has been acknowledged that the impact of anti-selection behaviour by those with chronic disease within the medical schemes industry is often speculated. Although the pattern of disease by age have been observed to show unusual bulge in the young adult years for some severe diseases such as multiple sclerosis, suggesting that families with someone with an expensive disease would try to join a medical scheme (Mcleod & Ramjee, 2007).

[2] (Mcleod & Ramjee, 2007).

Furthermore, the studies above seem to suggest that anti-selection is one of the factors contributing to increases in health healthcare costs for medical schemes. There are other important factors which need to be equally investigated, these can be summarised as follows:

- Affordability - other than the impact of unemployment which is a reality within the South African economy, young and healthier beneficiaries are often highly sensitive to contribution increase. The nature of risk cross-subsidies means that medical schemes offer lower value for money for younger/healthier beneficiaries (because they pay more than their risk rate in order to cross-subsidise the more elderly and sicker lives). In a voluntary environment, this will interact with affordability as those with affordability constraints are more likely to consider whether their cover offers them value for money or not. In addition, the risk of later incurring late-joiner penalties is not well understood by the public, and behavioural biases such as hyperbolic discounting reduces the effectiveness of Late Joiner Penalties. This is why income cross-subsidies are important to offset anti-selection.
- Benefit content entitlements – it is important to explore and understand the impact of "shrinking "benefits on member switching behaviour.
- Value and quality of services offered to members – members experience on quality of services offered by the scheme also affects member's decision to stay within the purchased option or to buy up or down. This includes the perceived effectiveness of the managed care programs for each scheme at a benefit option level.
- The impact of broker behaviour also needs to be explored. There are instances where brokers have been accused of facilitating plan and scheme switching behaviour. This conduct also encourages cream-skimming and has a negative impact on the overall risk pooling and cross subsidization within the industry.
- Impact of the health insurance market – evidence from the industry on the impact of health insurance products on buying down to low cost options by some members. Confidential data submitted by Discovery Health on demarcation showed a trend with regards to buying down to low cost options by beneficiaries with health insurance products.

6. RISK POOLING AND COMPETITION

Paragraph 1, 31

In instances where healthcare purchasing is at a scheme level with no role of an administrator or managed care entity, our view is that small schemes, especially those with unfavourable risk profiles will continue to be passive purchasers of healthcare services with limited ability or power to influence provider behaviour or entering value based contracting.

Fragmentation of the risk pools will also continue to create an opportunity to unfairly deny access to Prescribed Minimum Benefits (PMB) or to shift these expenses into self-insurance pools. Through our complaints database we continue to identify non-payment and short payment of PMB accounts. We have also observed 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 of 326 to 5765 members.

Unless addressed effectively, 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.

7. BROKER BEHAVIOR & HEALTH INSURANCE PRODUCTS

As indicated above, the role that medical schemes brokerage entities play in selling medical schemes cover and the incentives associated with selling of health insurance products along with member switching within the schemes and across the medical schemes also play a significant role in influencing the buy-down effect. These brokerage entities have a big influence in encouraging member movement and this behaviour is more prominent in the open schemes market.

As known health insurance products are marketed to healthier members of medical schemes, and they are encouraged to buy down to cheaper plan options and cover the differences in benefits by purchasing gap cover products at cheaper rates. According to a 2013 study presented in the Actuarial Society Healthcare Committee the data presented showed the extent of buy in the open schemes market was mainly within low claiming members who were more likely to leave the higher plans with richer benefits, and buy down to cheaper plans with fewer benefits. These are the type of members required for cross subsidies since they claim less than what they pay.

If these members buy down to cheaper plans their surplus contributions to the scheme will reduce as the general claiming behaviour of the member remains the same. This process leaves a larger number of sicker members on the higher benefit options therefore worsening the risk pool of the plan and reducing the cross-subsidies that are fundamental across the plans. To a large extent, this behaviour can influence some of the observations made in Table 1 of the HMI report.

8. AFFORDABILITY

High increase in health insurance premiums associated with the decrease in the value of coverage within health plans has become a major concern within countries where there is private health insurance (Newsom N, Fernandez B, 2011). Globally due to a variety of factors, the cost of health insurance has continued to grow faster than income levels of the population covered (Schoen C et al, 2010). For example, Schoen et al observed that within the US market, slower growth in wages lead to lower savings ratio by members and decisions on trade-off have been undertaken as means to preserve health benefits (Schoen C et al, 2010). Furthermore, adverse market conditions such as supply induced demand, lack of consumer rationality, information asymmetry, changes in demographic factors, moral hazard, monopoly etc. all adversely affect affordability for health insurance cover for most beneficiaries.

As is the case internationally, within the South African context, medical schemes membership is also closely correlated to the employment statistics and contribution increase in excess to CPI continuously erode the real growth in income, especially for those households where medical schemes contributions forms a larger proportion of the household budget. High increase in contributions have also been observed to create an affordability challenge which then becomes a barrier preventing an increase in low-income members from participating meaningfully within the medical scheme market, limiting opportunities for real growth in the industry including increased risk pooling and cross subsidisation.

In addition, member sensitivity to price changes often influence the rate in which beneficiaries will either buy-up or buy down depending on the individuals expected healthcare costs. Young and healthier beneficiaries tend to be highly sensitive to price changes than old and sick. For some beneficiaries, contributions paid are typically not always related to their own expected spending. And this situation creates an environment which encourages anti-selection behavior whereby those with higher expected spending will select more generous benefit options. Rendering those options, a poor financial deal for healthier beneficiaries since the benefit option will have to charge higher premiums to cover the costs of the less healthy beneficiaries.

Other than issues related to price sensitivity, the reduction of employer subsidy for medical aid cover has contributed significantly to the affordability challenge experienced by most members in the industry. For example, in the 1990's, most employers offered approximately between 50 % to 65 % subsidy for medical aid cover and retirement benefits. This trend changed drastically leaving most members to pay their contributions in full or with a small subsidy from their employers. This change in remuneration philosophy meant that medical schemes membership is seldom offered as an additional benefit but it is included as part of the total cost-to-company. Within this background medical scheme members are therefore exposed to financial pressures associated with high increase in contributions, copayments, deductibles and some changes in benefit content. Some research shows that pensioners were amongst the groups experiencing high financial pressures leading them to demand of low cost options and capitation models[3].

Buchmueller et al study on price elasticity within the health insurance market in the US also revealed that price sensitivity was more prominent for the young and healthier beneficiaries and low for beneficiaries with higher expected medical expenses especially the old and sick or those who might have been recently hospitalised or diagnosed with a serious illness (Buchmueller et al, 1997). This study also observed that in cases where the switching would require beneficiaries to change medical providers due to provider network contracts, older beneficiaries with serious health conditions were less likely to switch plans because they have established relationship with their private providers

[3] Center for Actuarial Research: Low cost options in the medical schemes, 2001

(Buchmueller et al, 1997). All these studies show that affordability is another contributing factor to the buy- down behavior.

9. RISK EQUALISATION

Risk equalization is about monetary transfers between medical schemes, for more socially optimal equity outcomes. As part of the amendment of the Medical Schemes Act, the National Health Insurance White Paper states that"*...as part of interim arrangements, there will be a consideration for the creation of a single 'virtual' pooling arrangement for schemes not funded through the State…."* (NHI policy, 2015). CMS therefore believes that the introduction of risk adjustment system needs to be aligned with National Health Insurance policy trajectory and be accompanied by effective legislation of all current inefficiencies within benefit option design including supply side regulation.

Implementation of a risk adjustment in absence of the above, will dilute the impact of the risk adjustment and will also not assist in addressing challenges related to information asymmetry. In addition, the incentives driving healthcare provision should also be compatible with objectives of the regulator that is making transfers to medical schemes. For example, re-imbursement contracts, upon which risk equalization transfers are based, need to identify the true efficiency of healthcare providers as opposed to adjustment based on inefficient costs. We want to ensure that efficient healthcare providers remain efficient and those that are not are appropriately identified and regulated. Unless addressed appropriately through legislation, profits from such providers have a potential of eroding the social benefits of risk equalization (Economic Sciences Price Committee, 2014).

Therefore, if risk-equalization is implemented to improve market competition, it should also be enhanced by other interventions, such as those mentioned above to enable socially optimal outcomes. We have also observed through literature that multiple risk pools serving different population groups can be inefficient because they can duplicate effort administratively, operationally and through regulation leading to an increase in administration fees. Whilst we acknowledge that there is evidence on the impact of risk equalization on equity, financial protection, within countries where there are multiple benefit options, it is also argued that such system often requires considerable administrative capacity within the health insurance companies and/or their administrators as well as the regulatory. This process also requires extensive data mining expertise to enable continuous monitoring of risk factors to determine the transfers between different funds.

In conclusion, international literature also shows the importance of bigger pools noting that small pools are not financial viable in the long run, including within systems that have risk equalization. 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 health financing policy to expand the size of their risk pools (Atun *et al.*, 2013, Maeda *et al*,2014).

10. NATIONAL HEALTH INSURANCE

The Council for Medical Schemes is an organ of state established in terms of the Medical Schemes Act. In performing its functions as provided for in Section 7 of the Medical Schemes Act, the CMS is obliged to discharge its legislated mandate in a coherent manner, which is consistent with national policy to ensure that the medical schemes beneficiaries are always protected.

Risk segmentation is inefficient and has a potential of eroding the attainment of broader social solidarity within the national health system. Inadequate funding and inefficient use of current resources also has huge opportunity costs and need to be addressed through a significant overhaul of the current national health system. The CMS, therefore, supports the initiative to pool funds, and provide access to quality and affordable health services for all South Africans based on their health needs, irrespective of socioeconomic status.

The CMS also acknowledges that South Africa's health outcomes have not been adequately aligned to the Millennium Development Goals (MDG), although some progress has been made in this regard (DoH, 2015). This health financing reform is meant to provide sufficient financial protection for the population with the ultimate goal of realising improvements in the country's health outcomes, and significant progress towards attaining the Sustainable Development Goals. Lastly, remains committed to effective risk pooling with an objective of improving financial protection, deepening cross-subsidization and social solidarity. The Council for Medical Schemes has also undertaken several review and preliminary analysis on the state of fragmentation within the industry. Attached in this presentation is some of the NHI preliminary work (see attached appendix).

11. COMMON SET OF BENEFITS

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 subsidization (see attached appendix). 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. Standardised healthcare services would assist:

- Reducing the complexity of administration
- Limit buy-down behavior by members.
- Facilitate the process of decreasing the large number of relatively similar benefit options

The PMB review process amongst other things seeks to move forward Circular 8 of 2006 discussion. The objective of this review is to:

- Priorities communicable diseases (HIV, TB), non-communicable diseases, violence and injury
- Improve equity which will prioritisation of healthcare services for children, women, elderly, disabled and mentally ill.
- Control moral hazard, and cost escalation
- PHC gatekeeping, payment mechanism
- Improve allocative efficiency
- PHC gatekeeping
- Facilitate transparency in accessing healthcare
- Educate population covered about entitlements and their responsibilities
- In the long term to reduce burden of disease

Table 2 below provides an outline of the PMB review framework for additional information see attached document in the appendix.

Table 2: PMB framework

Primary Health Care Package	Hospital Level Package
Preventative Services	Preventative Services
Maternal and neonatal services	Maternal and neonatal services
Child Health Services	Child Health Services
Curative Services	Curative Services
Mental Health services	Mental Health services
Diagnostic: laboratory services	Diagnostic: laboratory services
Diagnostic: imaging services	Diagnostic: imaging services
Pharmaceutical services	Pharmaceutical services
Emergency medical services	Emergency medical services
Palliative services	Palliative services

12. KEY RECOMMENDATIONS

As outlined in Section 3 above, below is a summary of key recommendations from CMS.

- Amendment of the current legislative provisions on risk pooling requirements at a scheme and benefit option level:
    - Regulation 2 (3) to explicitly state that all registered medical schemes should always have the minimum of 6000 members whether or not these medical schemes were registered before the amendment of the 1967 Act.
    - Furthermore, this provision should explicitly state corrective measures to be followed by the Regulator in addressing noncompliance since currently there is no consensus within the industry on the interpretation of Regulation 2 (3). This exposes CMS to litigation by the regulated entities (see Seemed ruling).
    - Explicit outline of the required membership base at a benefit option level. Section 33 (2) (c) does not permit withdrawal of the benefit option if that option is financially sound, even if that benefit option has low membership.
    - A clear directive from the Act in terms of membership requirement at a benefit option level would assist CMS to effectively regulate risk pools within the industry.
    - A clear interpretation of "public interest" as outlined within Section 24 (2) (f) is also required. Such interpretation needs to take into consideration membership growth requirements, consumer preference and the impact of option selection by employer groups.

- CMS will, through a consultative process with the industry, develop a framework for the consolidation/ standardisation of benefit options, to reduce these to a basic number. This framework will be also be implemented in consultation with the industry in an phased-in approach. This will go a long way in assisting current and prospective scheme members to make rational purchasing decisions

- The above recommendations will assist CMS in meaningful regulation of the current risk pools. Without such, the Regulator will continue to encounter legal challenges from the industry with regards to consolidation (see attached Appendix 1: Legal Opinion).

- Whilst studies presented in this submission on anti-selection provide some evidence on anti-selective behavior, there are other important factors such as the role of brokers, health insurance products, affordability constraints, employer group preferences and perceived quality healthcare derived within the option which also

influence switching behavior within the industry. These factors need to be investigated so as to have a full understanding of cost drivers in the private health care market.

- Implementation of risk adjustment system to take into consideration supply side regulation including the establishment of Statutory Pricing Authority.

13. CONCLUSION

CMS continues to support the Health Market Inquiry processes and is available for discussion should a need be identified by the HMI technical team. It is also our view that unpacking all factors related to cost escalation within the industry, including the regulatory gaps will enable CMS to regulate efficiently.

14. REFERENCES

(a) Actuarial Society of South Africa: Low cost options in the medical schemes, 2001

(b) Buchmueller T C, Feldstein P J, 1997. The effect of price on switching among health plans. Journal of health Economics 16 231-247

(c) Colombo F, Tape N, 2004. Private health in Ireland: Case study. OECD Health working papers.

(d) Cutler D, Zeckhauzer R, 1997. Adverse Selection in Health Insurance. Working Paper 6107

(e) CMS Research Brief Number 2 of 2008

(f) Council for Medical Schemes (2017). CMS Annual Report 2016/17. Pretoria: Council for Medical Schemes.

(g) Economic Sciences Price Committee, 2014

(h) Department of regulatory agencies. Factors affecting health insurance premiums in 2010. Colorado.

(i) Douven R.C.H.M and Schut F.T. Pricing behaviour of non profit insurers in a weakly competitive social health insurance market. Journal of Health Economics: 30(2011) 439-449.

(j) Greb S et al, 2005. Criteria and procedures for determining benefit packages in health care: A comparative perspective. Health Policy: 73(2005), 78-91.

(k) Mcleod H, Ramjee S. Medical Schemes. In. Harrison S, Bhana R, Ntuli A, eds. South African Health Review 2007 . Durban Health Systems Trust 2007

(l) Mcleod H, Globler P. The role of risk equalisation in moving from voluntary private health insurance to mandatory coverage: the experience in South Africa. Advances in Health Economics & Health services Research Vol 19 2009.

(m) Medical Schemes Act 131 of 1998

(n) Newsom N, Fernandez B, 2011, Private health insurance premiums and Rate Reviews. Congressional Research Service, R41588

(o) Schoen C et al, 2010. State Trends in Premiums and Deductibles, 2003–2010: The Need for Action to Address Rising Costs. Commonwealth Fund pub. 1561Vol. 26

(p) The Competition Authority 2007. Competition in private health insurance market

(q) Ulmer C et al, ed. Essential Health Benefits: Balancing Coverage and Cost; Institute of Medicine of the national academies; 2011.

(r) WHO. Essential benefit packages: What are they for? What do they change? Draft Technical brief No.2. July 2008

Appendix 1: Legal opinion

Appendix 2: NHI preliminary analysis

Appendix 3: Suremed case

Appendix 4: PMB proposed construct and work plans