Discovery

Workshop 3: Key cost drivers

12 APRIL 2019 PROF ROSEANNE HARRIS

Agenda

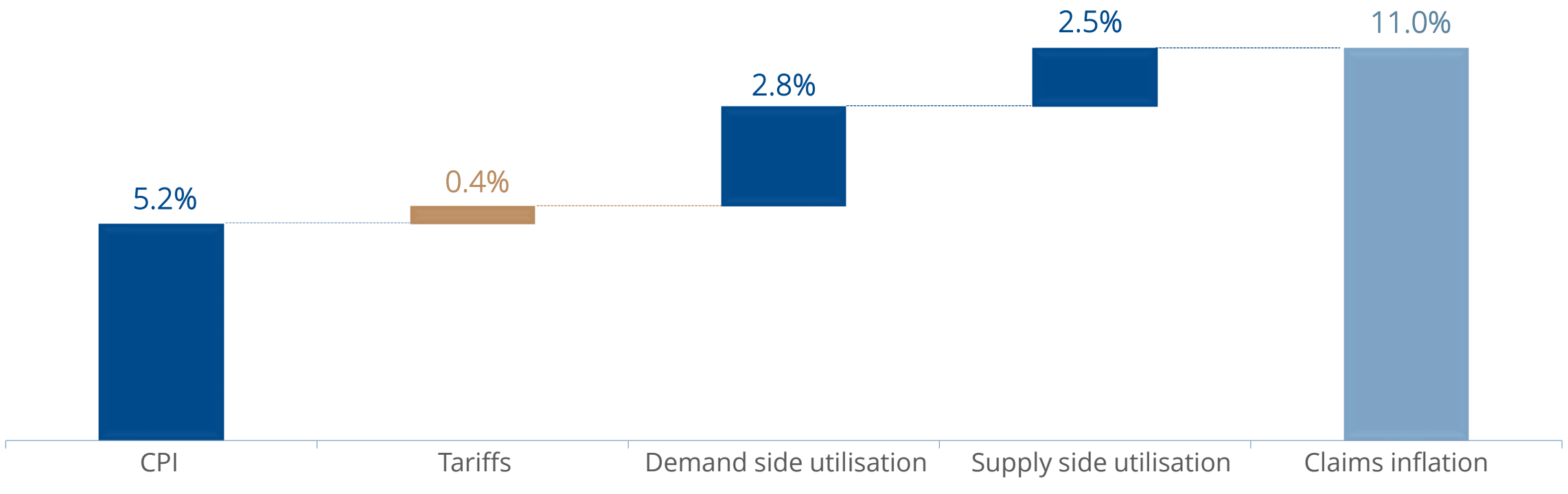
- Analysis of escalating costs
  - Evidence of over-utilisation
- Anti-selection in medical schemes
- Demand side factors
- Supply side factors
- Challenges to managing escalations
- Recommendations

DH view: HMI has overstated supply induced demand and understated demand side effects

DHMS Experience 2010-2018

Increasing healthcare claims utilisation is the main driver of claims inflation

Average annualised inflation rates (2010 – 2018)



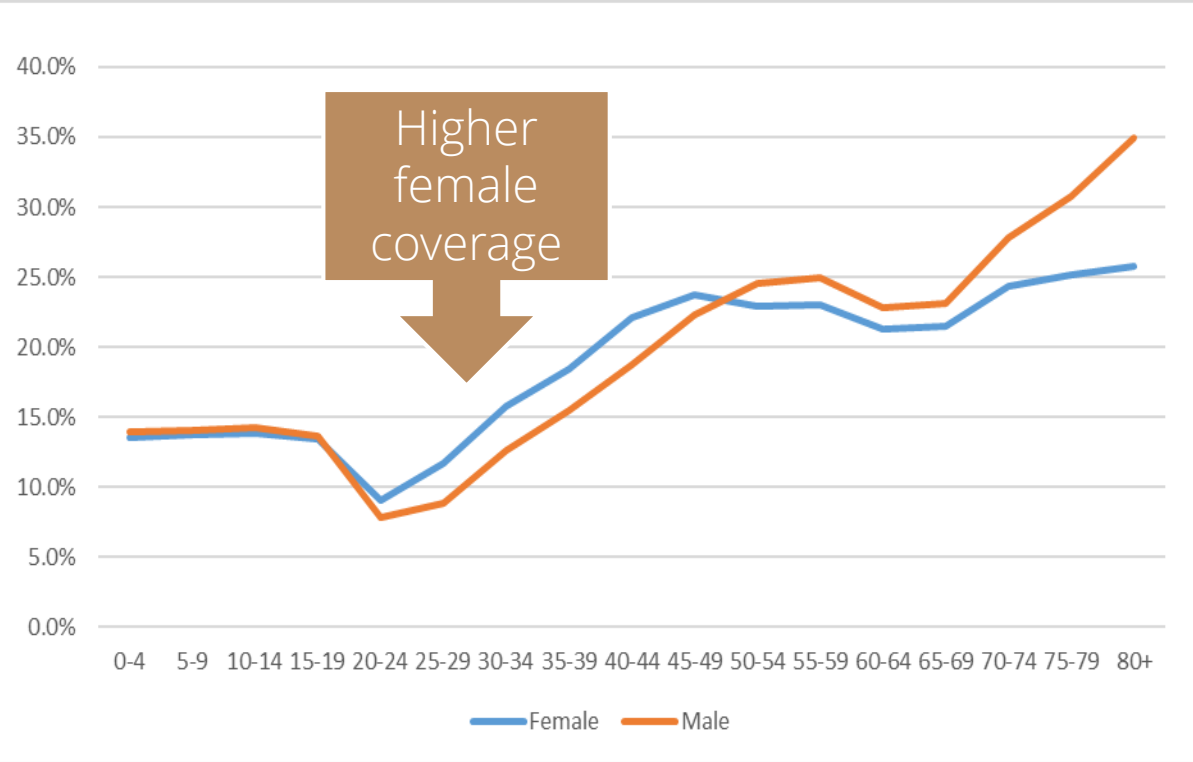
If tariff differential was 0% since 2010: Contributions would be **3.1%** lower

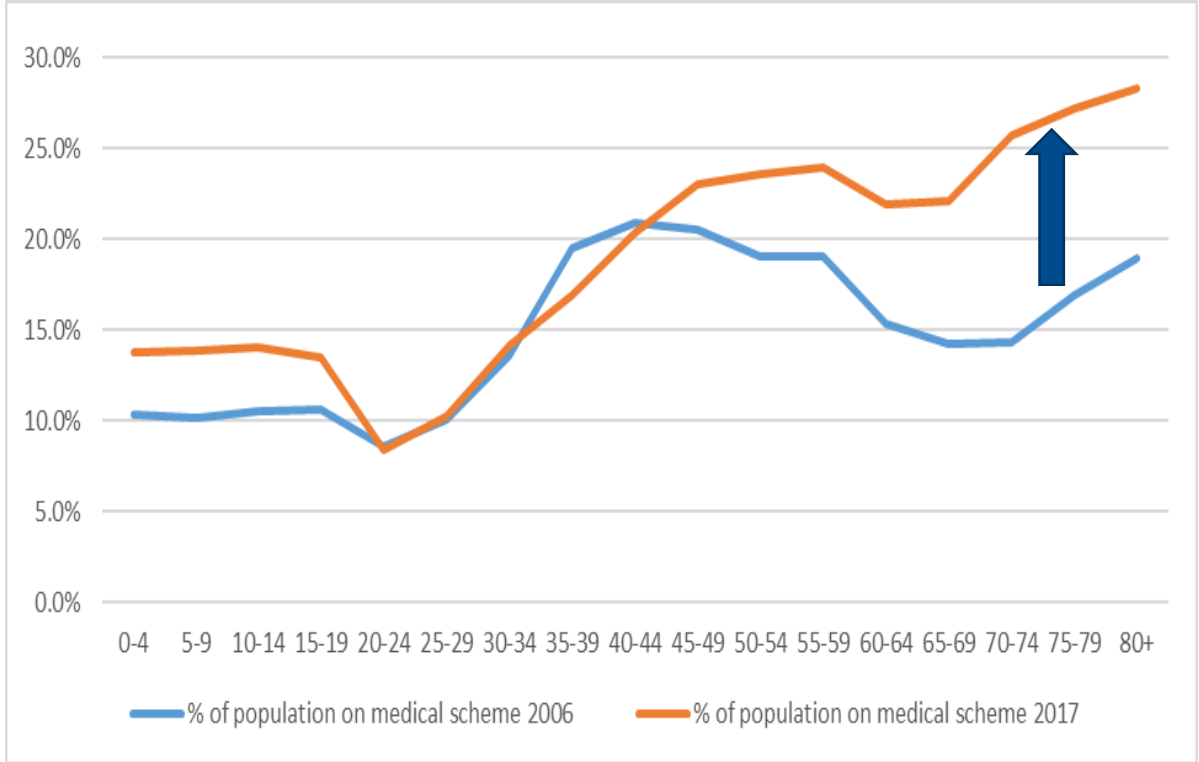
If utilisation was constant since 2010: Contributions would be **33.8%** lower

Note: Updated with 2018 data

Increasing risk in covered population vs general SA population

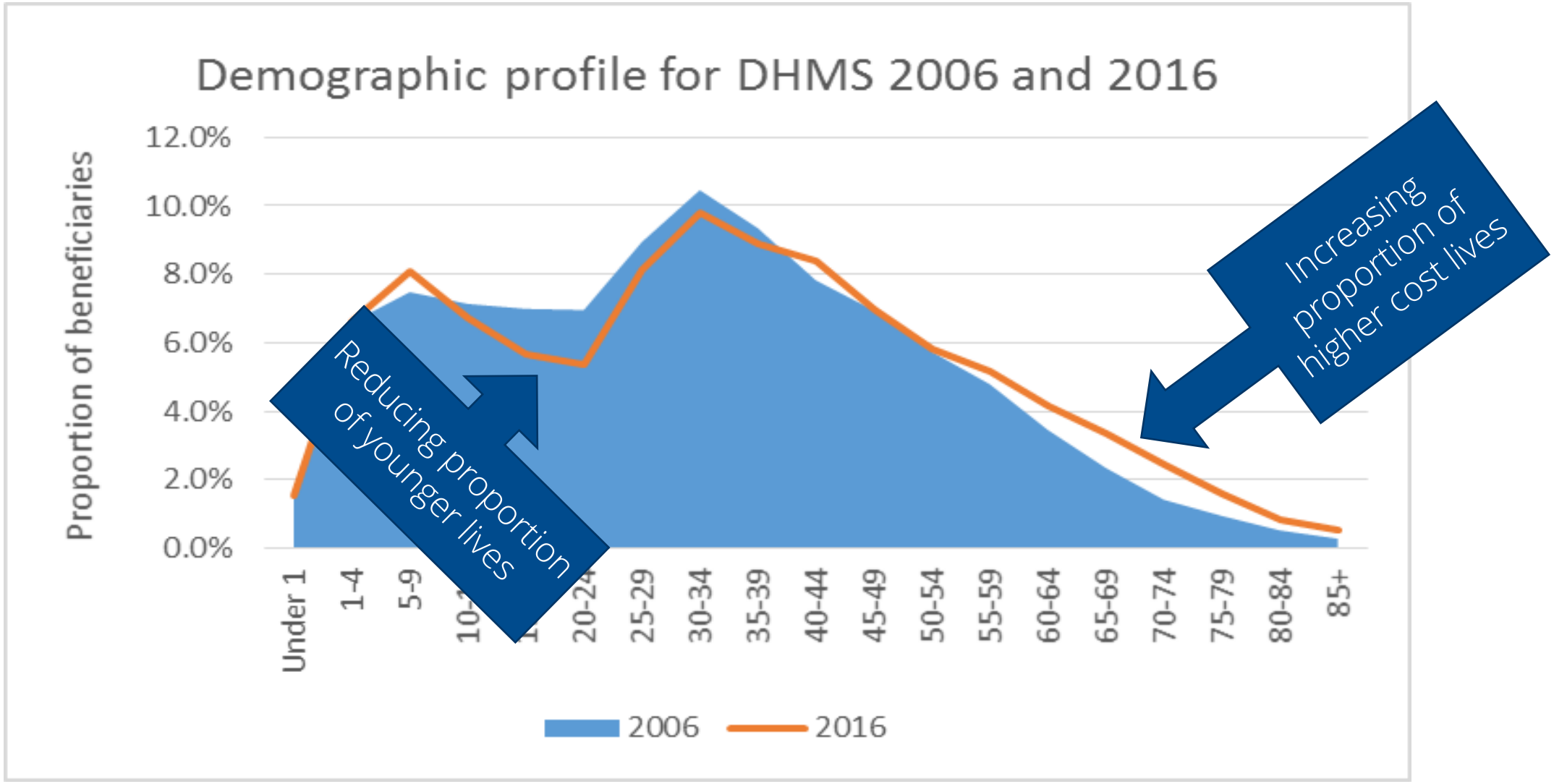
- % of population on medical scheme by age
  - 26.8% of SA population is older than 40 but
  - 39.2% of medical scheme population older than 40
- Change In % coverage 2006 to 2017
  - Uptake has increased significantly at older ages



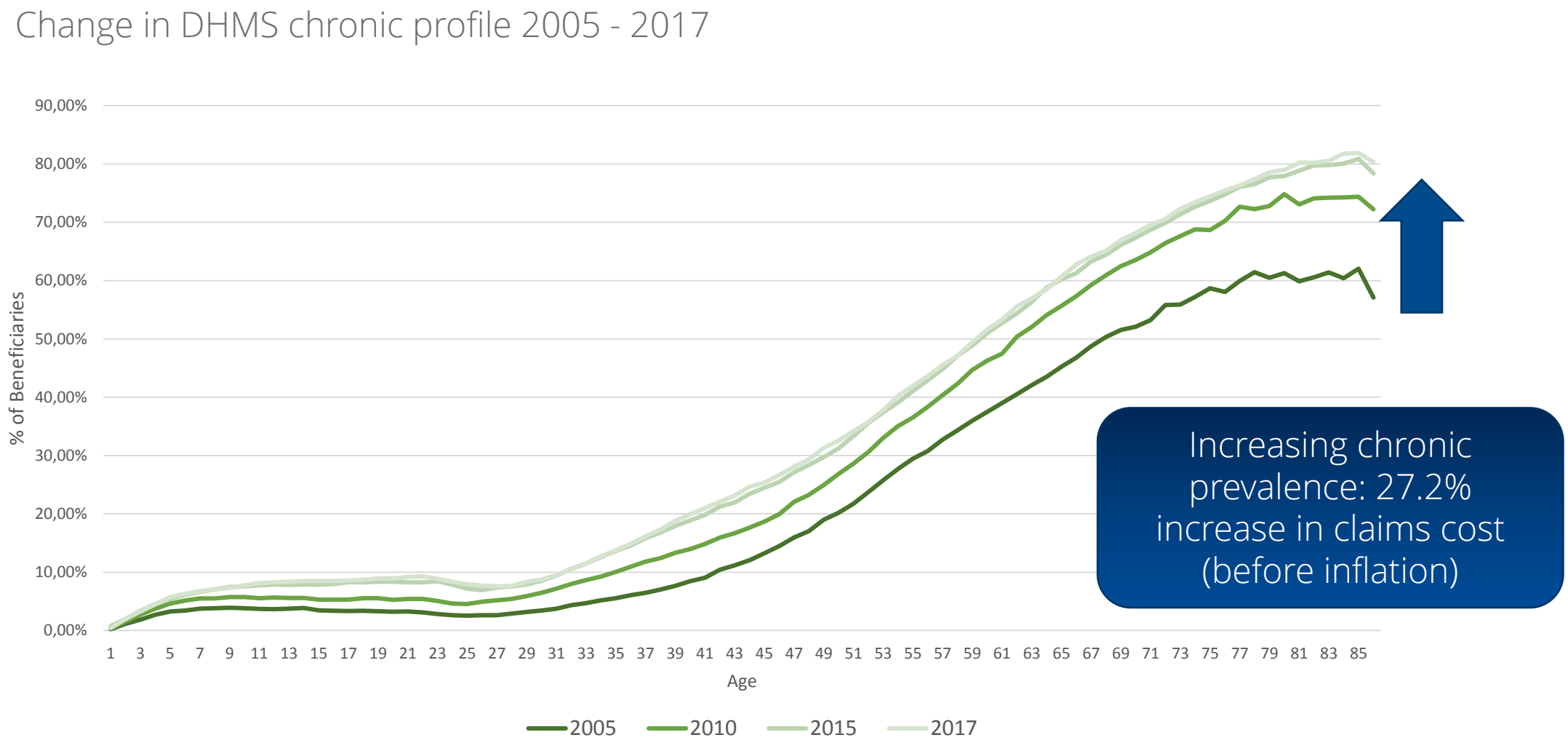


Source: CMS and Statistics South Africa

Dramatic demographic deterioration over past 10 years



Compounding effect of increasing disease burden



Extensive evidence of anti-selection in submissions

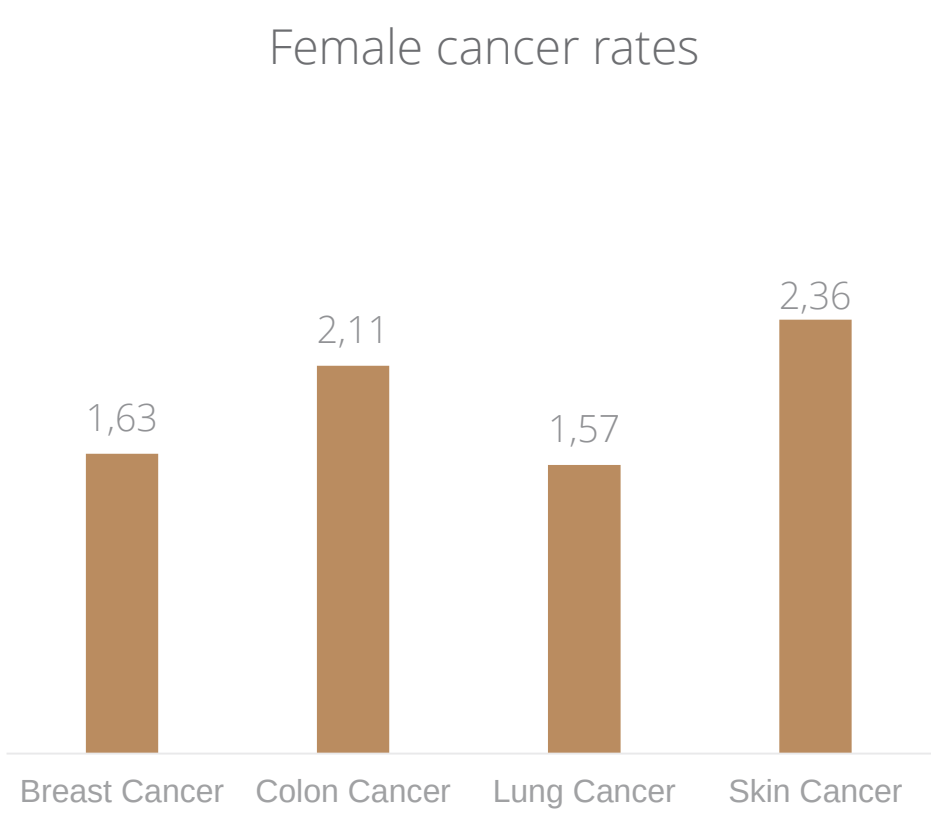
Note that anti-selection refers to the rational behaviour of members in the context of the current regulatory and benefit framework

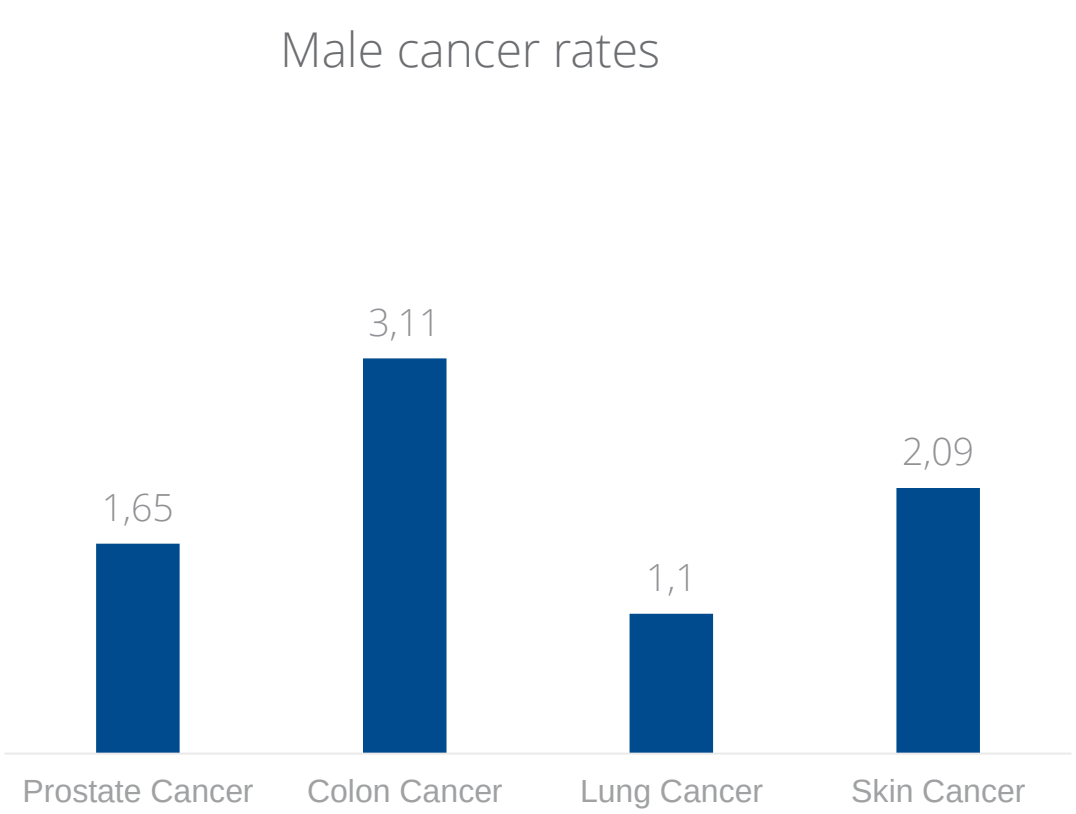
- HMI has noted that incomplete implementation of social solidarity creates anti-selection - more significant for open schemes.

- On DHMS individual members have claims experience that is 36.6% higher than group members after adjusting for age, gender and chronic status

- Evidence of anti-selection
  - Escalating high-cost case prevalence
  - Open schemes more exposed
    - DHMS chronic prevalence rates higher than industry averages for most high cost chronic diseases
  - Claim ratios of upgrading and downgrading members
  - Inadequacy of late joiner penalties (LJPs)
  - High claim expenses after 12 month waiting periods expire

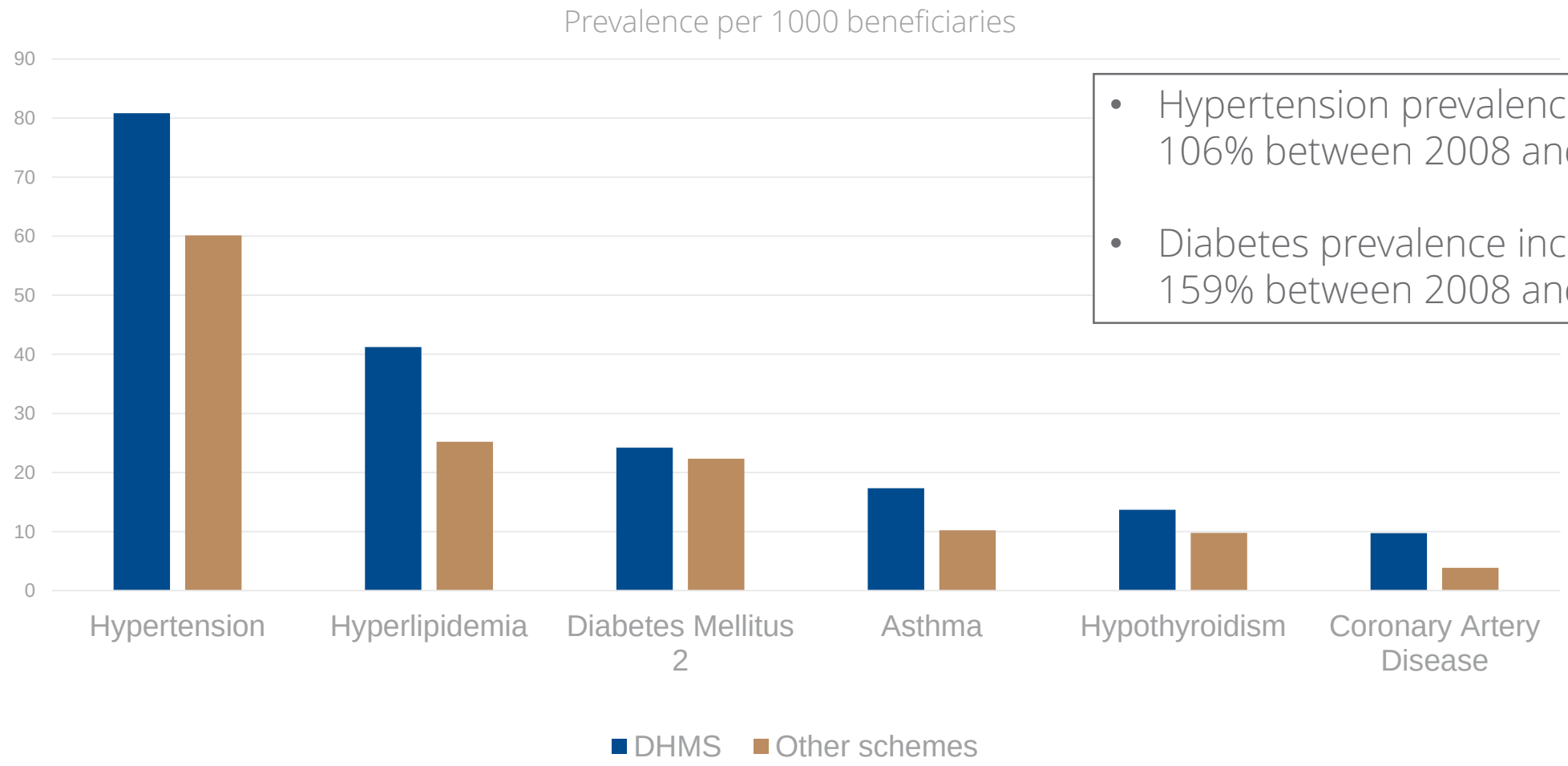
Escalating cancer rates: 2008 to 2017





The prevalence of high cost cases has increased – cumulative effect in excess of R15bn

Chronic prevalence:
Higher on DHMS than other schemes (top 6)

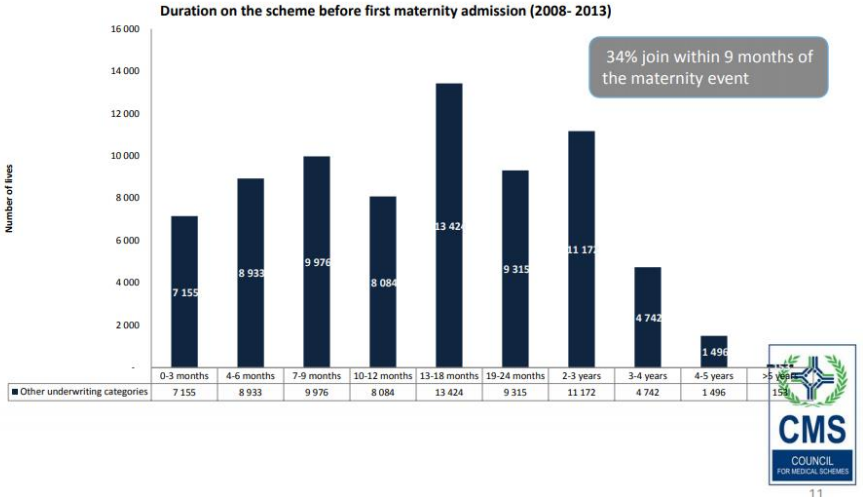


- Hypertension prevalence increased 106% between 2008 and 2017
- Diabetes prevalence increased 159% between 2008 and 2017

Source: CMS Annual report (2017)

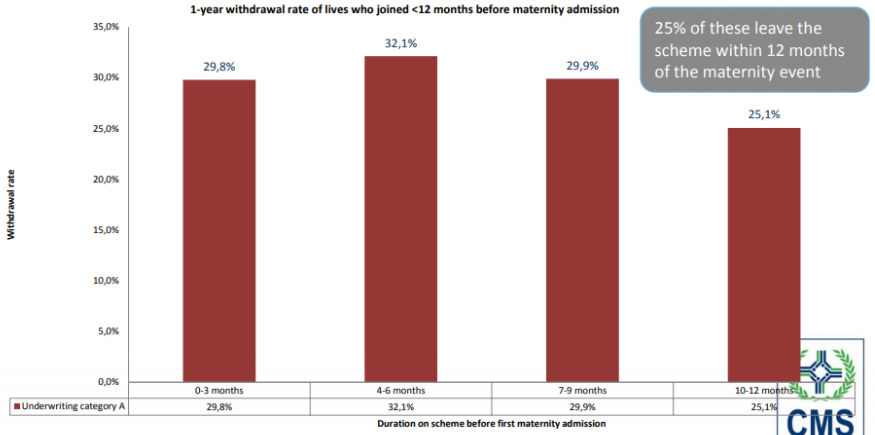
CMS
1 Feb 2018

Anti-selection evidence



34% join within 9 months of the maternity event

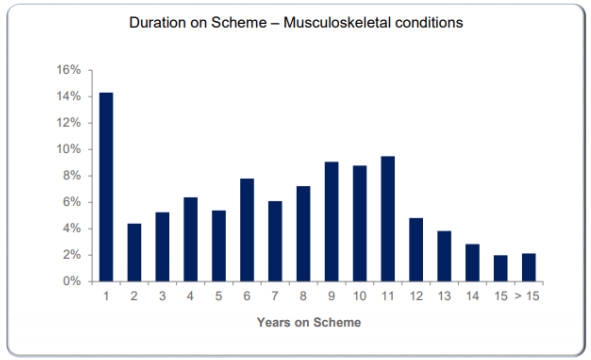
Anti-selection evidence



25% of these leave the scheme within 12 months of the maternity event

Anti-selection evidence

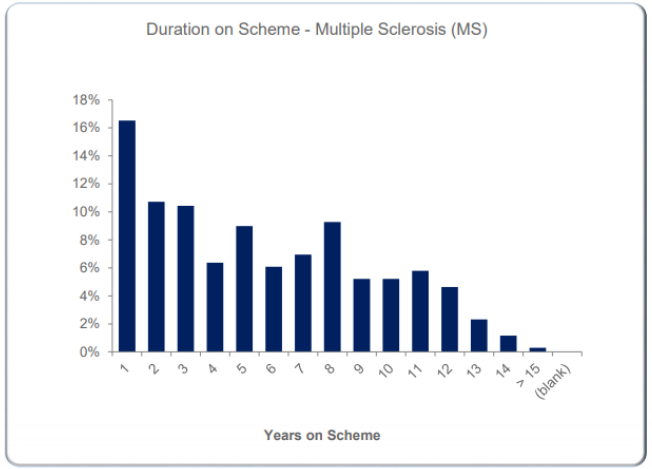
Case study 5 : Large scheme experience (2014)



14.31% who claimed biologics for musculoskeletal conditions had been on the Scheme for <1 year

Medical Scheme presentation to CMS , 2014

Anti-selection evidence



16.52% who claimed interferon had been on the Scheme for <1 year

Plan movement decisions associated with claim ratio

Higher cost lives buying up

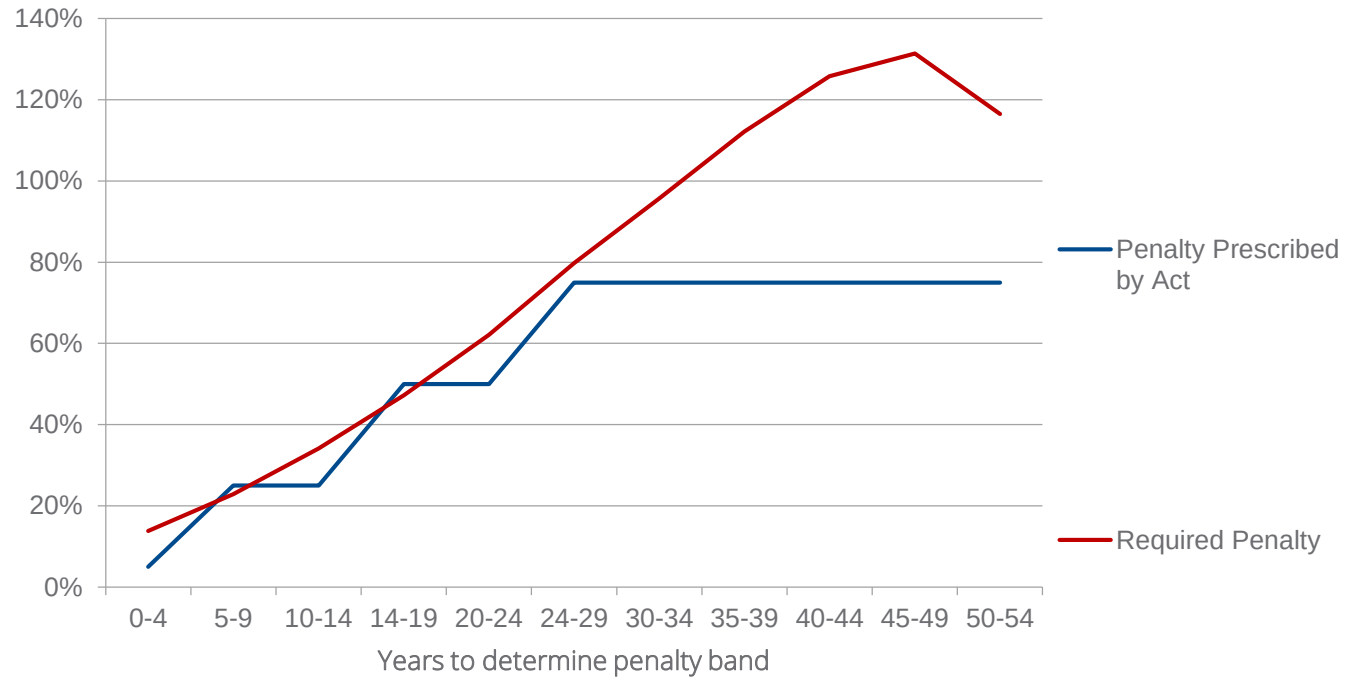
DHMS Benefit plan	Upgrading	Remaining	Downgrading	Withdrawing
Saver	106.0%	67.0%	57.5%	54.6%

Lower cost lives leaving

- Members are able to derive value from medical schemes, selecting cover to their advantage at the expense of the medical scheme risk pool.
- This is rational behaviour on the part of members since the regulatory framework allows this to happen.

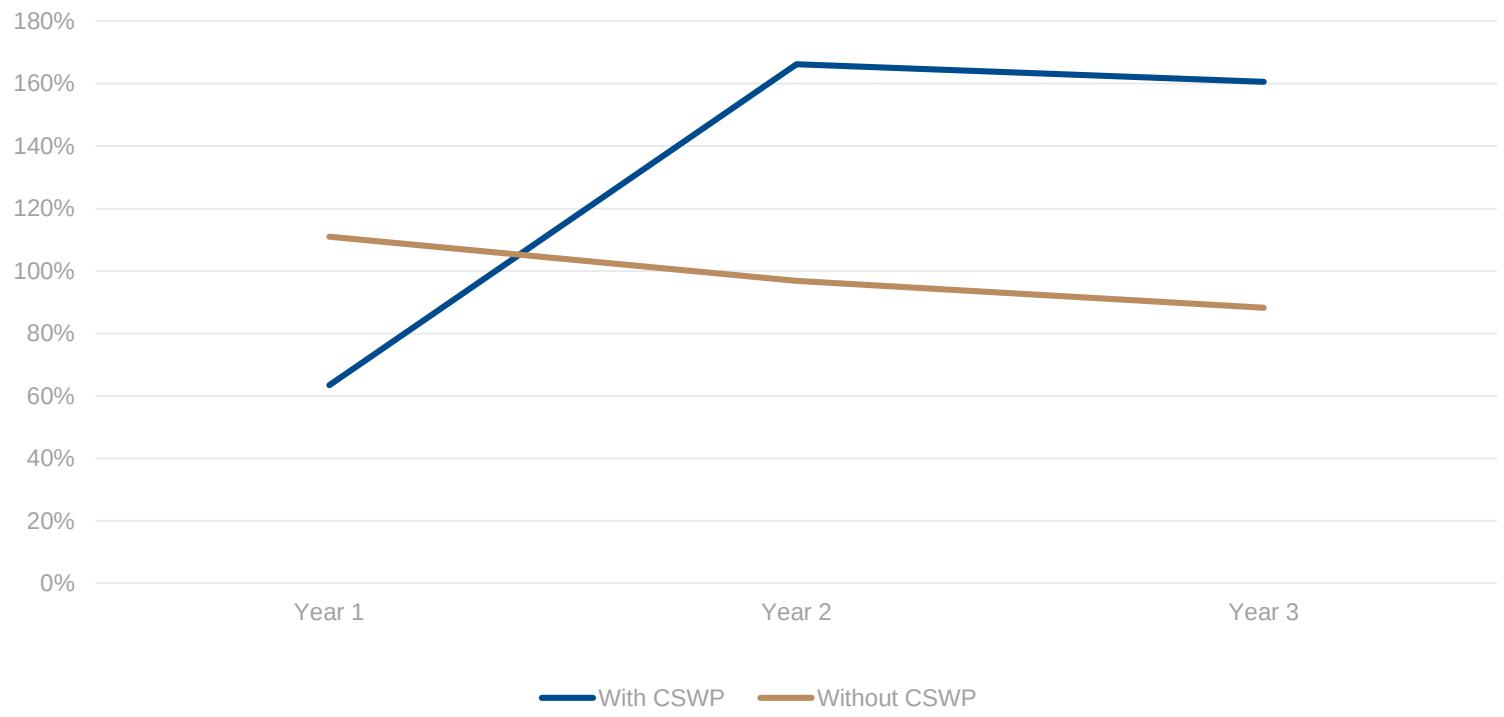
Late joiner penalties do not provide adequate protection to scheme risk pools

Theoretical LJP for someone joining after age 34 compared to the LJP as prescribed by the Medical Schemes Act



Older lives joining the risk pool are subsidized by existing members – even if LJP is applied.

Waiting periods: Claim ratios of new lives with and without CSWPs entering DHMS in 2014



Members with condition specific waiting periods (CSWP) have **ongoing claims** approx. 60% more than contributions.

Existing mechanisms need substantial strengthening

- Increasing general waiting periods from 3 months to 6 months or even 12 months
- Increasing condition specific waiting periods from 12 months to 18 months.
- PMBs should not be payable during general waiting periods
- Cost neutral Late Joiner Penalties ("LJP") should be implemented, with the LJP for new joiners above age 60 increasing.
- Benefit plan upgrades should be underwritten using the same rules as proposed for the underwriting of new members.
- Removing the current provisions of the Act that allow employer groups to join schemes without underwriting on 1 January of each year.

Mandatory membership would remove the need for underwriting and improve affordability of cover – reduce cost of cover by 20%

Managing supply side factors

- The FFS framework necessitates managed care interventions to ensure clinical appropriateness
- Submissions have demonstrated that aligning incentives is a better approach than hardline market interventions
- Need to promote value based contracting to align incentives – this will assist in addressing supply-side pressures
- Centralised licensing and capacity planning to address supplier-induced demand
- Co-ordinated scientific approach to technology assessment required
- The HPCSA rules on employment of health professionals contributing to anti-competitive practices and high costs
- The HPCSA restrictions that prevent multi-disciplinary practices and global fees have a similarly negative impact
- Partnering with providers to be accountable for utilisation levels, including admission rates

Effective management of care

- Schemes need to deliver comprehensive, yet affordable care – managed care is vital tool for delivering value to members

- CMS can do more to support schemes in:
  - Promoting value of risk management initiatives
  - Managing fraud, waste and abuse
  - Ensuring reporting framework is appropriate (ITAP)

- Reporting of outcomes will enhance transparency and accountability
  - Subject to protecting confidential and commercially sensitive information

- PMB provisions affect management levers:
  - Unclear definitions and inconsistent coding
  - Coverage at cost
  - Limits on co-payments for using non-DSP providers

Recommendations for managing utilisation escalation

- Supply side
  - Co-ordinated licensing
  - HPCSA rules to facilitate ARMs
  - Technology assessment
  - Tariff negotiation measures
  - Promoting ARMs
  - Transparency on outcomes
- Demand Side
  - Measures to address anti-selection
    - Mandatory membership
  - PMB review
    - Benefits and cover
  - Reporting on outcomes
    - To address information asymmetry

HMI Questions

- ✓ The introduction of a single comparable base scheme option with a risk adjustment mechanism to drive competition between schemes so as to force more vigorous supply side negotiations
  - But does not solve the problem of tariff complexity, or supply side factors
  - Still need provider networks to manage cost which adds complexity
- ✓ Measurement of and transparent reporting of health outcomes to allow for value purchasing and to improve scheme member ability to choose providers and interventions
  - Ensuring that competitively sensitive information protected to prevent reduction of value to members
- ✓ A health technology assessment function to curb inappropriate purchase and utilisation of health care technology or prevent third party payment when non-recommended technology is used
- ✓ Provision of guidance on best treatment options (collaborative development of guidance rather than stipulation)
- ✓ Methods to control prices through a Supply Side Regulator (maximum FFS for PMBs but allow bilateral negotiations on ARMs)
- ✓ Changes in the HPCSA ethical rules to promote innovation in models of care to allow for group practices and alternative care models so that fee-for service ceases to be the dominant payment mechanism
- ✓ Changes to training curriculum for health practitioners
  - Especially relating to working in multi-disciplinary teams and measuring outcomes