MMI Health submission to the Health Market Inquiry

Comment and input in preparation for the seminar on the regulation of healthcare financing

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1 Introduction

1 In preparation for a seminar on the healthcare financing regulatory environment to be held on 1 February, this submission addresses some of the questions raised in the discussion document published by the HMI late in 2017. The seminar aims to discuss interventions that will improve competition in the medical scheme environment that should drive down prices as the country moves towards NHI. This submission addresses questions raised in the discussion document on anti-selection, risk pooling and the regulation of benefit options.

2 Throughout the discussion document mention is made of NHI, and consideration is given to the value of some regulatory interventions in relation to the introduction of the NHI policy. The end state envisaged in the NHI policy will leave medical schemes offering only supplementary cover, which would require a regulatory framework that is entirely different from the current medical scheme framework, and some of the interventions suggested in the discussion document may become irrelevant. This submission speculates on a potential trajectory that may be followed by South Africa on the road to Universal Health Coverage (UHC). The purpose of this speculation is to assist the HMI in presenting proposals to regulate the healthcare financing in a manner that may be supportive of and responsive to an alternative trajectory towards UHC.

2 Policy uncertainty: Transitory regulatory framework

3 The NHI policy has been introduced to Nedlac at the end of 2017 and will be debated by labour, business, government, and community representatives during 2018. The seven implementation structures proposed by the NHI white Paper in June 2017 have not yet been established.

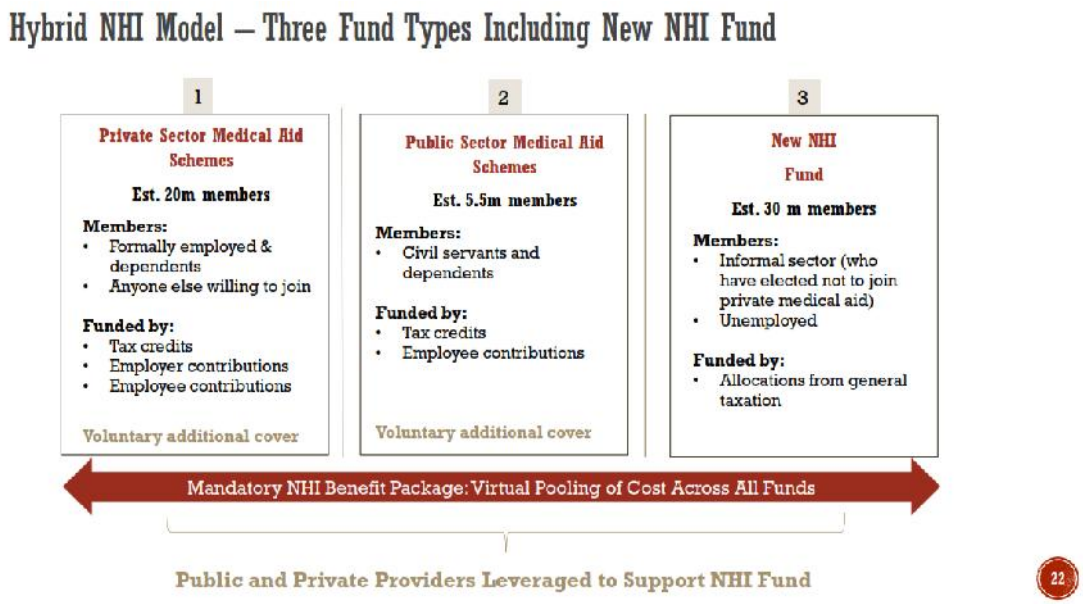
4 The High-Level Panel (HLP) on the Assessment of Legislation and the Acceleration of Fundamental Change was chaired by former president Kgalema Motlanthe and was formed by the Speaker's Forum of Parliament. It held public hearings and reviewed written submissions over the period since early 2016 and has delivered a formal final report in November 2017.

5 A "Hybrid Model" for Universal Health Coverage, that proposes a three-tier model of private schemes, government schemes and a new NHI schemes is Included in the HLP's final report[1]. The full Annexures C2 and C3 to the HLP report accompany this submission.

6 Figure 1 below shows the three funds proposed in the HLP report for consideration as an alternative to the single fund proposed in the NHI White paper.

[1] High Level Panel Report available at https://www.parliament.gov.za/high-level-panel

Figure 1: Hybrid NHI model as proposed in the High Level Panel report[2]



7 In its comments on the Draft NHI White Paper, and in its comments to the Davis tax committee on funding options for NHI, MMI has proposed an alternate trajectory towards UHC. In common with the HLP Hybrid model, MMI's proposal requires a risk adjustment mechanism across medical schemes, the establishment of norms and standards for equitable provincial financing, and the establishment of a central fund for virtual risk pooling across the entire health sector for an affordable set of benefits. MMI has, however, suggested that more work needs to be done to prepare for a purchaser-provider split before an NHI fund should be established.

[2] High Level Panel Report available at https://www.parliament.gov.za/high-level-panel.

Figure 2: MMI proposed interventions towards NHI[3]

8 Figure 2 above lists the interventions as proposed by MMI. Of particular relevance to this submission on the HMI discussion document are the suggestions regarding a risk adjustment mechanism for medical schemes and the development of a single virtual pool (section 4.4, page 21 of the DTC submission), the priority setting function (section 4.5, page 21 of the DTC submission), and the coding, remuneration, and outcomes authority (section 4.6, page 22 of the DTC submission). The specific role of these interventions will be considered in the sections below that comment on anti-selection, risk pooling and the regulation of benefit options.

3 Interventions to overcome the impact of anti-selection on medical scheme membership, competition and the consumer

9 MMI's experience is that that anti-selection is a real and important phenomenon in the South African healthcare market, and considers the interventions below as important to reverse the negative effects of anti-selection.

10 Late joiner penalties and waiting periods in their current format are not sufficient to prevent anti-selection. However, toughening these measures is not likely to reverse anti-selection. Few young people are aware of them and even if they were, the negative impact on future personal costs will be discounted resulting in a reduced impact. This results in a politically unpalatable impact on older and sicker members of society who did not contribute when they were young. It is more effective to minimise the need for these measures through mandatory membership.

[3] MMI's submission and presentation to the Davis Tax Committee accompany this submission.

11 Mandatory membership is central to the achievement of UHC. Horizontal equity (cross-subsidisation from the young and healthy to the sick and old) and vertical equity (cross-subsidisation from higher income earners to lower income earners) can only be achieved through compulsion and subsidisation[4]. Anti-selection is not a uniquely South African problem, but is experienced internationally and the effective counter measure is mandatory membership.

12 A key challenge preventing mandatory membership is the resulting increase in employment cost, with a negative impact on employment. This impact must be minimised through the development of low cost benefit options that must become mandatory for specific classes of employees. The benefit for the low cost options should address public health challenges that are affordable to lower income employees, and should become the standard benefit that must be used for risk adjustment across all risk pools, as contemplated in section 4 below. Over time along with economic growth, these benefits should be expanded to eventually offer a more comprehensive benefit for all citizens.

13 It is important to note that the risk profile, or at least the claims profile, is often much lower in lower income individuals. To have a positive impact on equity, it is critical that suitable benefits are included in the low cost benefit options, and the development of a coordinated priority setting function in South Africa is critical to ensure that the appropriate benefits are included.

14 In the absence of an appropriate and affordable low cost benefit options, mandatory membership is not feasible. Mechanisms must be in place to ensure that middle and high income individuals who could afford full cover do not buy down to low cost benefit options

4 Interventions to equalise for risk

15 It is important that commonly occurring dangers associated with smaller schemes – claims volatility and unequal risk profiles – are not conflated when considering risk adjustment[5] mechanisms for medical schemes.

16 The importance of risk profile cannot be overemphasised. Risk profile plays a very important role in determining the cost of a medical scheme benefit, and largely overshadows efficiencies that could be gained through better care or lower administration costs.

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[4] The "Fuchs conditions" (compulsion and subsidisation) in health financing is a guiding principle for health financing policy oriented toward UHC, see **Kutzin, Joseph, Yip, Winnie and Cashin, Cheryl.** Alternative Financing Strategies for Universal Health Coverage. [ed.] Richard M Scheffle. World Scientific Handbook of Global Health Economics and Public Policy. s.l. : World Scientific Publishing Company Pty Ltd, 2016, pp. 267-309..

[5] Risk "adjustment" is the preferred term rather than "equalisation". In the South African REF that was piloted in 2005 to 2008, the "equalisation" was limited to the PMB portion of the benefit. A prospective system that does not correct for claims volatility problems was envisaged.

[17] The large impact of risk profile masks potential benefits that could be gained through competition on a cost or quality basis, and results therein that it is extremely difficult to compare the value that is offered by competing medical schemes.

[18] It is critical to consider the fairness of not having a risk adjustment mechanism in place, the absence of a risk adjustment mechanism effective allows for the discrimination against members belonging to medical schemes with sicker and older beneficiaries.

[19] In considering a risk adjustment mechanism a prospective mechanisms that only adjusts for clinical and demographic risk is important. Actual claims experience should not be corrected because this will remove incentives for individual schemes to control costs. Such a prospective system necessitates that claims volatility risk is protected though re-insurance mechanisms.

[20] During 2005 the process of preparing for a Risk Equalisation Fund was started by the CMS, by 2008 a Bill was introduced in parliament that could have resulted in the first transfers by 2010. It seems reasonable to estimate that it could be done within five years. At the time, the annual estimated operational costs of a fully functional REF system was less than R20 million per year.

[21] It is important to note that young and healthy schemes will be worse off after the introduction of a risk adjustment mechanism because they will cross-subsidise sicker and older schemes. This makes it critical that adequate vertical equity is maintained, and the tax credits must be re-evaluated to ensure that lower income members of medical schemes are not penalised.

[22] It is important to note that risk adjustment is central to the achievement of horizontal equity and is considered in both the attached HLP report and the submission to the Davis Tax committee.

5 Changes to benefit options

[23] The current complexities in selecting a benefit option is the result of the poor definition of PMBs, the absence of a risk adjustment mechanism, the fact that risk rating is limited to two bands only (adults and children), inadequate tariff determination and poorly developed alternate reimbursement mechanisms, varying priority setting and rationing mechanisms, no standardised quality metrics and others. Some of these were to be addressed through the 2008 Medical Schemes amendment Bill.

[24] As soon as these underlying factors are addressed, the complex environment will be simplified to some extent. Addressing the complexities by enforcing standardisation without addressing the underlying factors is likely to have serious negative consequences.

[25] For example, loss-making benefit options often exist as a mechanism to allow for cross-subsidisation from higher income members belonging to mid-level options. This results in pro-poor cross-subsidisation. Similarly, mid-level options subsidise loss-making high-risk comprehensive options. Most of this flow to high risk options is the result of higher risk, but some of it is associated with the funding of expensive cost ineffective healthcare interventions available in the high cost options. This

is probably not fair, but can be corrected through the development of a priority setting authority that limits-cross subsidies for only a defined set of benefits.

[26] Note the Circular 8 of 2006 arrangement of common benefits across a scheme with a single contribution table results in many low-income members of lower cost benefit options having to face significant increases because they will cross-subsidise the higher claims cost of higher risk (but often also higher income) members of more comprehensive options. This will only become feasible after significant economic growth or the introduction of low cost benefit options.

[27] The art of protecting both horizontal and vertical equity is very complex, and changing the regulation of benefit options without paying attention to the underlying reasons could have serious negative consequences.