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Dear Paulina and Pamela

HMI'S HEALTHCARE REGULATORY FRAMEWORK DOCUMENT OF 1 DECEMBER 2017 / MEDICLINIC'S SUBMISSIONS

We refer to the HMI document "*Call for Submissions and Participation in Seminar - A discussion of the need and impact of selected interventions to address regulatory gaps within healthcare financing, with the aim of strengthening competition*" published on 1 December 2017 for comment ("**HF R Framework**").

As a provider of private hospital services purchased by medical schemes, Mediclinic is affected, *albeit* indirectly, by the medical schemes regulatory environment. Mediclinic provided the HMI with comments on the medical schemes regulatory environment in its submission dated 31 October 2014 in response to the HMI's call for submissions dated 1 August 2014 ("**Mediclinic's Initial Submission**"). It is assumed that the HMI has reviewed Mediclinic's Initial Submission.

These submissions supplement the relevant aspects of healthcare financing regulation addressed in Mediclinic's Initial Submission that pertain to the matters raised in the HFR Framework.

The HFR Framework refers to the HMI's own research. This research has not yet been made available to stakeholders. In the interest of a transparent and fair process, Mediclinic requests that the HMI provide more clarity on its research and make same timeously available prior to the intended seminar of 1 February 2018.

1 National Health Insurance, single risk pool and REF

1.1 Referring to the National Health Insurance ("**NHI**") system, the H FR Framework provides that "*one aspect of the NHI is that it creates one single risk pool for all South Africans*."[1]

1.2 Mediclinic would caution against possible recommendations which propose not exploring the potential of a risk adjustment mechanism due to NHI policy documents. The NHI white paper envisages the implementation of an NHI system over a 14 year period. A variety of legislative reforms and consultative engagements will be necessary prior to the full implementation of NHI by 2026 (at the earliest). These numerous tasks are alluded to within the "NHI Implementation: Institutions, bodies and commissions that must be established" document.[2] It is likely that there will invariably be a transition period whereby medical schemes will continue in their current supplementary role. Insofar as this period is concerned, a single risk pool under an NHI model will not be in place and regulatory reforms to the financing of private medical insurance may prove necessary to improve affordability and ensure the market functions appropriately to the benefit of the consumer.

1.3 The NHI in its full implementation format provides scope for private sector insurance under a complementary insurance framework. Accordingly, a risk adjustment mechanism should be considered regardless. Furthermore, the NHI white paper is silent on the explicit package of services, including depth and breadth of services, with assumptions about contribution level, utilisation and rationing. In the absence of these, the role of private medical schemes remains indeterminate.

1.4 The Davis Tax Committee's Report on *Financing a National Health Insurance for South Africa* indicated that the NHI White Paper's cost scenario could "vary markedly" based on the assumptions which underpin it.[3] Importantly, "*The White Paper also implicitly assumes a high degree of substitution of expenditure from medical schemes to the public sector – in other words, that households will simply redirect their health spending from medical aid scheme membership tariffs towards NHI funding or increased tax payments. However, if higher income earners retain private medical cover despite mandatory contributions to NHI, this would substantially increase the proportion of GDP devoted to health – which would have macroeconomic consequences for household disposable income, consumption and economic growth*."[4] It is thus critical that an appropriate risk adjustment mechanism be in place to mitigate against the effects of anti-selection and its commensurate impact on the medical scheme contribution rate of inflation.

2 Anti-selection and associated costs

2.1 There is clear evidence of anti-selection in the South African medical scheme market. In Mediclinic's Initial Submission, Mediclinic provided evidence of the effects of this dynamic insofar as it impacts in-

[1] HFR Framework, paragraph 21.
[2] Department of Health. 2017. NHI Implementation: Institutions, bodies and commissions that must be established available at: http://www.health.gov.za/index.php/component/phocadownload/category/383.
[3] Davis Tax Committee. Report on Financing a National Health Insurance for South Africa, March 2017, page 43.
[4] Ibid, page 31.

patient admissions and associated expenditure.[5] Importantly, the submission highlighted research which at the time had shown the effects of anti-selection and its commensurate impact on the medical scheme contribution rate of inflation.[6]

2.2 McLeod and Grobler[7] estimated the effect of anti-selection on the medical scheme contribution rate using 2007 data. They found the costs of minimum benefits in a mandatory environment could be 23% lower than costs in the current voluntary environment. The effect on costs of the voluntary environment is also evident in the pricing differential between open and restricted schemes. Over a ten year period, open schemes had an estimated 30% higher increase in contribution rates than restricted schemes. Restricted schemes are usually employer based or industry specific, and operate in a more mandatory environment and therefore have less exposure to the risk of anti-selection than open schemes. This gives some indication of the magnitude of the effect that anti-selection is having on overall scheme monetary contribution levels.

2.3 Mediclinic also draws the HMI's attention to further research undertaken by Insight Actuaries and Consultants for Finmark Trust which shows that whilst medical scheme membership constitutes 16% of the population, coverage patterns are dependent upon formal employment and affordability. The research indicates that "*during the LCBO industry engagements it was indicated that an additional 4 million to 8 million South Africans that do not currently have cover would be* ***willing and able*** *to pay for a primary care product. Other estimates have put the number of uninsured but willing and able to fund a low cost product as high as 10 million*."[8]

2.4 An important finding of this research is that the various "*onerous regulatory requirements*" of the medical scheme industry that ensure some of the high levels of financial protection inadvertently also drive costs to the extent that the majority of South Africans are excluded from cover.[9]

2.5 **Estimates provided in this research indicate that the cost of anti-selection is approximately R13.5 billion (2016) or 23% for open medical schemes**. Importantly, the findings note that "***the differential in age profile exists even when comparing the medical scheme population to the formally employed population****. This is a natural effect of a voluntary environment: people are more likely to seek cover when they need care*."[10]

2.6 These findings are further supported by Discovery's analysis which clearly demonstrate that over the period 2008 to 2015, the membership has become "*older, sicker (using the chronic prevalence as a proxy for health) and the proportion of non-claiming members is lower. These trends have a direct impact on the costs to the industry*."[11]

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[5] Mediclinic's Initial Submissions, pages 35 -40.
[6] Ibid, page 39.
[7] IMSA, NHI Policy Brief 2, Expanding Health Insurance Coverage, May 2009, www.imsa.org.za.
[8] Erasmus D, Ranchod S, Abraham M, Bloch J, Carvounes A, Dreyer K. Challenges and opportunities for health finance in South Africa: a supply and regulatory perspective. Johannesburg: FinMark Trust; 2016. Available at: http://www.finmark.org.za/wp-content/uploads/2016/06/south-africa-health-finanince-overview.pdf.
[9] Ibid, page 57.
[10] Ibid, page 67.
[11] Ibid, page 67.

3 Incomparability of Benefit Options

3.1 The HFR Framework highlights that the wide range of benefit options offered by medical schemes contributes towards information asymmetries in the market making it nearly impossible for consumers to compare and make rational choices based on value (price and quality) between all of these options[12]. The impact of the complexity of medical scheme benefit design on consumers is addressed in Mediclinic's Initial Submissions[13].

3.2 As a provider of hospital services, Mediclinic finds that the high degree of variation in the design of medical scheme benefit options also creates complexities for healthcare providers. Benefit designs are often complicated and riddled with features such as co-payments, deductibles, exclusions, formularies and networks. These features have implications for the reimbursement of providers and often influence the way in which providers deliver care to patients, for example the choice of pharmaceuticals used and the type of facility in which a clinical service is provided. Many benefit options incorporate a combination of these features, each with its own intricacies. This makes the assessment and comparison of provider reimbursement structures between schemes highly complex. It also adds complexity and confusion in the provision of healthcare as providers need to take into account the design features of the specific benefit option when administering care to a patient.

3.3 Mediclinic's Initial Submissions recommend that a standard basic benefit package will address the shortcomings of the current differentiated market. Industry experts have recommended that a standardised Basic Benefit Package be implemented across all medical schemes, in order to address the above shortcomings. The International Review Panel of 2004[14] proposed defining a larger Basic Benefit Package, including the PMBs together with primary care.

3.4 Over and above such Basic Benefit Package, all schemes should only be allowed to sell three or four more standardised and defined Supplementary Benefit Packages. This increased standardisation of products would drive competition to a more productive activity; namely the cost and quality of healthcare delivery, as opposed to the current focus of risk selection. A risk-equalisation mechanism for the basic benefit package should be implemented to further equalise the risk taken on by schemes due to the health profile of its members, steering schemes away from competing by attracting members with favourable risk profiles.

3.5 With a Basic Benefit Package across all schemes, consumers will be in a better position to make price comparisons between options within a scheme and between schemes, with less reliance on brokers. It will also make it easier for members to switch between schemes, increasing the level of competition within the industry.

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[12] HFR Framework, paragraph 4.
[13] Mediclinic's Initial Submissions, pages 76-80, 96-98.
[14] Armstrong J., Deeble J., Dror D.M., Rice N., Thiede M., Van de Ven W.P.M. (2004) *The International Review Panel Report to the South African Risk Equalization Fund Task Group.* 16 February 2004.

3.6 A framework consisting of a basic benefit package accompanied by a limited number of defined Supplementary Benefit Packages will remove some of the complexity that providers face when assessing reimbursement structures and delivering care to patients.

Yours faithfully

ANDRE DE LANGE / SUSAN MEYER
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