Medscheme's Submission

Health Market Inquiry

Healthcare Financing Regulatory Framework and the Impact it has on Competition in the South African Private Healthcare Sector

Deadline: By 19 January 2018

1. Introduction

Medscheme Holdings (Pty) Ltd ("Medscheme"), an accredited managed care organisation and administrator of various medical schemes, hereby presents a response to the Health Market Inquiry's call for submissions on the healthcare financing regulatory framework and the impact it has on the competition in the South African private healthcare sector.

This document represents Medscheme's response to the Inquiry's call for submissions. We used a question and answer format in our response.

2. Anti-selection in relation to medical scheme membership

This section provides a response to the questions raised under the 'anti-selection' section of the HMI document.

We are in agreement that the non-optimal regulatory framework of the current medical schemes market is contributing to an increase in anti-selection, and therefore directly adding to the increasing contributions to a medical scheme.

The current framework which allows for open enrolment, without sufficient underwriting, risk rating or compulsory cover has led to individuals being able to choose when to join a medical scheme, and therefore doing so only once they believe they will need the cover.

This choice to defer cover will be very much influenced also by the high level of contributions currently in the market, and hence a spiral is created, where more anti-selection would lead to higher contributions and in turn, more anti-selection.

In order to stop anti-selection, it would therefore not be sufficient to only address the regulatory framework, but the affordability of the current contributions also needs to be considered.

1) **What evidence, if any, illustrates the extent of anti-selection in the medical market, what are the underlying drivers and how has this changed over time?**

   Response:

   Most of the evidence of anti-selection has been aptly stated in the document. However, when considering anti-selection it is also important to note that within an open scheme there will be both elements of mandatory cover by employer groups (similar to restricted scheme), and voluntary cover by individuals. Hence, the evidence of anti-selection might be clearer when comparing mandatory cover with voluntary cover, than when comparing open schemes with restricted schemes.

   For example, the average age of compulsory (or group) members in open schemes is typically lower than for the voluntary (or individual) members. This also leads to higher claims for individual members compared to group members. In an analysis performed comparing individual and group claims in an open scheme, using risk adjustment and allowing for similar benefits, we found that individual claims were on average 25% higher on a like-for-like basis. This suggests that the cost of anti-selection in open schemes is significant.

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Even within restricted schemes the high proportion of members in the lower benefit option as well as the existence of buy-downs could indicate a level of anti-selection within a compulsory structure – where without having the option of leaving the scheme altogether, the employees choose the cheapest option until they need more comprehensive cover.

This would suggest that affordability might be the main driver of anti-selection. And that anti-selection is likely to get worse as medical inflation exceeds salary inflation.

2) How is this evidence related to developments in income, employment and demographics?

Response:

Assuming that the disproportionate number of members in lower benefit options within restricted schemes, and the existence of buy-downs in these schemes indicate a level of anti-selection within restricted schemes – it might suggest that evidence of anti-selection is not related to income, employment and demographics. This is due to an expectation that within a restricted scheme one would find stable income, employment and demographic profiles. With the effect of buy-downs increasing in these schemes (as per the latest ITAP inflation reports), it would seem that affordability is the key factor in anti-selection.

3) Is the current level of underwriting effective at discouraging late joiners?

Response:

The level of the late joiner penalty does not compensate schemes for the additional costs of late joiners. In this sense it is not sufficiently effective. The present value of the late joiner penalties is less than the present value of the higher claims for older lives. Thus, *on average*, it is financially cheaper for lives to join late in life, if measured over the lifetime of the individual. This poses anti-selection risk.

Anti-selection is not only a problem with late joiners, but also with members joining when they have a specific healthcare need. One such example was for a scheme being one of only few offering a benefit for a certain procedure. It was found that of the 68 procedures performed in 2016, 32 (47%) were for patients who have been members of the scheme for less than 2 years. Although the sample size is small, this figure can be compared to the proportion of total scheme population with membership duration shorter than 2 years, which is around 19%.

The rate of termination following the procedure was also higher for the group with short membership duration. Twelve out of the total 68 patients terminated their membership within a year following surgery, even though many of them would not yet have completed the programme of post-operative consultation follow-up. In fact, there were four instances of members terminating at the very first monthly opportunity following surgery.

A 12 month condition specific waiting period with a late joiner penalty is not sufficient to cover the cost of this procedure for members who joined and left shortly after the procedure. It also does not provide a sufficient incentive for an individual to insure against a health event, as the option to join the medical scheme will always be there for the period required.

It is debatable, however, whether more stringent underwriting will actually improve uptake in earlier membership, or whether this will just leave the individuals without the necessary cover in the event of a health event. Looking at the current ineffectiveness in incentivizing members to save appropriately for retirement, or adopting healthy lifestyles for better future health outcomes, one might conclude that individuals are unlikely to make any current changes where the benefit is only realized much later in life.

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Begging the question whether any underwriting will be effective in incentivizing members to join earlier, instead of just reducing the impact of anti-selection through reduced funding.

4) Assuming that anti-selection is real and important phenomenon in the South African healthcare market, what mechanisms can be introduced to limit anti-selection (particularly keeping in mind the overall country objective of moving towards a NHI)?

Response:

To limit anti-selection, there are effectively two routes:

i. In a voluntary system, allow for full underwriting and risk rating. This may not be considered acceptable on the route towards NHI, as it may leave the older lower income lives, in particular, vulnerable and unable to afford cover.

ii. The preferred approach is to introduce compulsory cover, or at least compulsory contributions (i.e. members are required to pay according to income, but may decide to join a medical scheme or not).

The inclusion of employer groups within open schemes contribute significantly to the sustainability of these schemes, and ensuring that employer groups remain committed to providing compulsory medical scheme membership, and perhaps increasing the number of employers providing subsidies to compulsory scheme memberships, could go a long way in ensuring the sustainability of the healthcare market.

Compulsory cover would need to allow for the impact on lower income lives. Thus, compulsory cover would need to be accompanied by income banded contribution rates. Else, a compulsory contribution framework, based on income and possibly collected through SARS, could be considered.

5) How would these proposed mechanisms affect the number of beneficiaries and the level of contributions?

Response:

The inclusion of mandatory cover or contributions, with (1) the improved average profile of lives and (2) the resulting reduction in anti-selection, would reduce the contribution rates on average. Previous estimates suggest that this impact could amount to a 10% to 15% reduction in contributions.

High income earners, however, will probably experience an increase in contributions, through the introduction of income bands or income based contributions.

6) What impact would these mechanisms have on low income earners that may spend unsustainable proportions of income on medical insurance (and in the absence of a low income benefit option)?

Response:

Ideally the use of income bands should limit the burden on low income earners. Also through regulating the level of income differentiation there will be some assurance the level of income cross-subsidisation can be effective to reduce the burden on the lower income earners.

However, the addition of a compulsory medical aid contribution will still reduce their disposable income.

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The only possible method through which these members would be unaffected would be through subsidies either by the employer or the state. It could be argued that the burden on state health care delivery will be reduced should these members move to private facilities, and also that an increase in access to primary health care might reduce the cost of health care in the long term.

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3. Risk pooling

This section provides a response to the questions raised under the 'risk pooling' section of the HMI document.

1) How does the current degree of risk pooling impact competition between medical schemes?

Response:

In practice, risk pooling is currently effected at scheme level. Although the MSA states each benefit option should be self-sustaining and that risk pooling should thus occur at benefit option level, cross subsidies do exist between the benefit options of most schemes. This is done mainly to ensure cover can remain as affordable as possible for the most vulnerable segments of society, i.e. the sick and elderly, and low income segments.

Although there has been a trend of scheme consolidation over the years with the number of medical schemes reducing, no formal mechanism currently exists to pool risk at an industry level.

With the lack of risk pooling mechanisms beyond scheme level, schemes are primarily incentivised to attract young and healthy members in order to remain competitive. Attracting and retaining sick or elderly members within the scheme increases claims cost and therefore pushes up contribution levels, making the scheme less competitive.

Schemes with a younger member profile will be able to have more competitive contribution levels, while older/sicker schemes will have to charge higher contributions.

It has proven very difficult for schemes to improve their membership profile through organic growth due to the overall lack of growth in the industry. Older and sicker members tend to remain with their current scheme where they already utilise a high level of benefits, while younger entrants to the market will choose the most affordable option, which will likely be in a scheme which already has a good member profile.

2) Why are benefit options that are in financial deficit for consecutive years, allowed to exist?

Response:

Looking at industry statistics it is clear that a number of benefit options repeatedly incur a financial deficit and are thus subsidised by other benefit options within the scheme. These options tend to be the most benefit rich which cater for oldest / sickest members, as well as options which cater for the low income market. If these options were forced to be financially self-sustainable, contribution levels will have to increase making these products unaffordable for these most vulnerable segments of society.

The current cost of PMBs makes it virtually impossible to offer an affordable product to the low income market that would be self-sustainable. An urgent need therefore remains for an alternative low cost benefit option framework that would be exempt from PMBs to cater for this market and thus widen the reach of private healthcare cover in South Africa.

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3) What impact does the lack of a medical scheme wide mechanism to equalize for risk have on medical schemes and the cost of cover?

Response:

With no compensation for carrying higher proportions of high risk members, schemes are motivated to attract and retain younger/healthier members to keep their contribution levels competitive. Product and marketing strategies are typically designed to help achieve this objective and thus carry a cost which adds to non-healthcare expenditure within the scheme.

Schemes that already have a good member profile will typically have the lowest contribution levels and therefore be most successful at attracting even more young/healthy members. Schemes with older/sicker members are at a competitive disadvantage as they have to charge higher contributions to cover the higher cost of care and therefore struggle to attract younger members to improve their membership profile and affordability.

The lack of an industry wide risk equalization mechanism is also a hindrance for consolidation in the industry, as struggling schemes with a poor member profile find it difficult to identify a willing amalgamation partner with no compensation on offer for taking on higher risk members.

4) If there is a need for a risk equalisation mechanism:

a) What are the various mechanisms that can be introduced;

Response:

At a high level, risk equalisation frameworks could be designed on a prospective or retrospective basis. The proposed REF method in South Africa was a prospective method, whereby the amounts allocated to risk equalise where set upfront. Retrospective methods equalise risk by distributing funds in arrears based on actual expenditure.

b) How long will it take for them to be fully implemented; and

Response:

Most of the work around an initial design of a REF was done between 2005-2007, subject to review implementation could commence in a relatively short amount of time. A phased implementation will be preferred to limit the impact on schemes and members. Consideration for income cross-subsidisation is critical, else a risk equalisation framework may result in lower income healthier scheme members being negatively affected.

c) What impact will they have on competition? For example, will a mechanism that adjusts for risk across medical schemes allow for variance in price to relate to the different contracts medical schemes have with their service providers?

Response:

The earlier REF design used combinations of age, gender and chronic disease prevalence as risk factors to determine schemes' level of contribution to / receipt from the fund. Schemes would thus be able to compete on the efficiency of care delivery, and focus all their efforts on ensuring the most efficient and appropriate care is delivered to each segment of its membership. Schemes that are able

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to negotiate the best prices with service providers will be most competitive. This would be true for prospective risk equalisation models.

Retrospective risk equalisation models, where actual claims expenditure is re-distributed, would suffer from an inability to foster competition due to variances in prices with service providers. However, it would still help remove the issue of cherry-picking.

5) Who will benefit and who will be harmed by introducing these mechanisms to adjust for risk across medical schemes?

Response:

Schemes with good member profiles will be negatively impacted. While they currently have a competitive advantage by being able to offer lower contribution levels to bring about growth, they will have to pay a sizable contribution under an REF mechanism which would have to be loaded to their price.

Schemes that are able to negotiate the best rates with providers and structure their care delivery in the most efficient way will benefit most. These will tend to be larger schemes that can negotiate on volumes or schemes using large administrators where they can negotiate collectively on behalf of client schemes.

6) What impact will an introduction of a risk adjustment mechanism have both on medical schemes and the country as a whole as the country moves towards a NHI?

Response:

With the drive for improvement in member profile removed, schemes can focus their attention on optimizing the efficiency, quality and price of healthcare delivery. Schemes can invest in and promote innovative solutions to manage the health risk and costs for their highest risk members without the worry of the risk attached to attracting older / sicker members. This should lead to better health outcomes for the medical scheme population as a whole.

With the only competing factor effectively being the price for healthcare services, schemes may in fact begin to tailor their products and focus their marketing efforts to attract older/sicker members as this would increase their claims volumes and strengthen their negotiation power with providers.

The introduction of a risk adjustment mechanism may promote consolidation within the industry in the run-up to NHI. As schemes will be compensated for taking on high risk members, there will be less reluctance to amalgamate with such schemes to increase volumes and strengthen negotiation power.

The risk equalisation mechanism may also be useful as a precursor to:

- Developing a competency in managing a large fund
- Distributing money according to risk/need, typically required in a NHI system.

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4. Incomparability of benefit options

This section provides a response to the questions raised under the 'Incomparability of Benefit Options' section of the HMI document.

1) **Is the current level of competition between medical schemes on their benefit options effective, considering the information available and the complexity of the subject?**

   Response:

   In our opinion, medical scheme benefits are relatively complex and the level of competition between medical schemes on value could improve.

2) **What changes would allow members to compare the real value of medical scheme benefit options?**

   Response:

   Value has objective measures, as well as subjective. The importance of the objective measures would also differ from person to person, depending on their actual healthcare needs. The subjective measures would depend on a person's perception of value.

   In this context, simply standardising all benefit options into a single design (or only a few designs) may be considered a method to allow better comparisons. However;

   - Differing consumer needs and perceptions of value suggest a better approach may be to provide the consumers with a simple standardised benefit classification, applied across all benefit options in the market.
   - Without risk equalisation, schemes with higher claiming older members would appear expensive, although they may be very efficient. This would hasten the actuarial death spiral for such schemes, leading to consolidation of members towards the schemes with the healthiest/ youngest members, irrespective of their efficiency. At an industry level, this would result in a net loss of value.
   - Standardising the benefit options (such as the 'common benefits' proposed in CMS Circular 8 of 2006) will result in the cheaper benefit options becoming more expensive. The cheaper options also often have the lower income earners.

   Thus, a simple standardised classification system to help consumers is proposed. Such a standardised benefit classification system would classify benefit options based primarily on objectively measured benefit richness, rather than on other definitions that are less obvious. This is an approach used in other markets. An example is set out below.

Benefit Option Classification	**Benefit Richness and Description**
Hospital Plans	No day-to-day benefits other than PMBs and preventative tests
Low Benefit Plans	Benefit richness below 70%.
Medium Benefit Plans	Benefit richness 70% to 79%.
High Benefit Plans	Benefit richness 80% to 89%.
Comprehensive Benefit Plans	90% and above benefit richness.

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Benefit Richness definition = Proportion of healthcare claims submitted that will be paid, assuming managed care rules around designated service providers (DSPs), formularies, etc. are adhered too.

Ideally, the benefit richness is calculated and published as follows:

i. The benefit richness definition should be discussed at industry level and agreed.
ii. The benefit richness should be objectively calculated according to the agreed definition, for every benefit option in the open market.
iii. A comprehensive claims data set would be required to calculate the above.
iv. Perhaps the Council for Medical Schemes (CMS) takes ownership to deliver and publish this classification. Calculation could be outsourced, perhaps to the Actuarial Society of South Africa or another entity.

Other objective and simple classifications could also be introduced to complement this, preferably based on consumer survey outcomes. It will always still be a requirement for a consumer to consider the detail before purchasing medical scheme cover.

3) What is the contribution (if any) of medical savings accounts to the member and to the medical scheme?

Response:

Pre-funding for uncertain events is almost certainly preferential in most cases to paying costs as they arise. Savings benefits thus provide for a simple mechanism by which members can allocate funds towards future healthcare costs.

In cases where a benefit shortfall occurs, savings are also a simple useful method whereby these shortfalls are paid by the medical scheme. This helps consumers and healthcare practitioners to interact with less administrative burden.

For employees that receive medical scheme subsidies as a percentage of the contribution (e.g. 60% subsidy), the savings contribution is then also subsidised by the employer.

Apart from the employer subsidy advantage, arguably savings benefits could simply be replicated in savings bank accounts. However, evidence suggests that the consumers generally prefer benefit options with savings rather than other designs. This is evidenced as follows:

- At a high level, from the CMS reports, benefit options with savings have been growing whilst benefit options with risk day-to-day benefits have been generally declining. Savings benefit options also have significantly more members and grow quicker than hospital plans.
- For closed medical schemes with multiple benefit options in the Medscheme environment, the savings benefit options have the most members and growing.

4) What is the effect of current medical savings accounts on moral hazard and how can the continued existence of these accounts in the medical schemes industry lower moral hazard, and improve competition between schemes?

Response:

Theoretically, savings benefits remove moral hazard in relation to day-to-day healthcare expenditure. This is because the accumulated savings belong to the member and the medical scheme in theory is not affected by wasteful claims. However, savings do impact on the medical scheme in the following manner:

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i. Typically, an annual savings benefit is provided upfront and the contributions collected monthly in arrears. Thus, members that have high claims in the beginning of the year and terminate membership early in the year, pose a bad debt risk to the scheme. This, however, is typically not a major risk to medical schemes.
ii. The concept underlying the savings account does not encourage best practice in terms of healthcare system design. Ideally, the primary caregiver (typically the General Practitioner) is the co-ordinator of care. Thus, specialist care should be accessed and co-ordinated via the primary care practitioner. Such an arrangement is difficult to setup and enforce if savings benefits are utilised rather than risk benefits. This is because savings accounts 'belong to the member' and they can utilise it as they desire (to pay for health related expenditure).
iii. Intentional co-payments have a role to play in managing moral hazard. Accumulated savings are often used to cover co-payment shortfalls, lessening the impact of such initiatives.
iv. Efficient use of healthcare resource initiatives, such as medicine reference pricing, formularies, protocols and networks, may be undermined when savings are simply used to cover the shortfall.

Some argue that day-to-day benefits are not insurable, since they are predictable, and thus savings benefits are the best designs for day-to-day cover. However, claims data evidence shows that day-to-day claims are volatile and uncertain. Thus, arguably, risk day-to-day benefits together with managed care efficiency rules better achieve the ideals and aims of day-to-day pre-funded cover, even if it does introduce some moral hazard. The efficiencies gained, such as reduced hospitalisation due to co-ordinated care, outweigh the cost of moral hazard.

Having said the above, in the current system without risk equalisation and income cross-subsidisation, open schemes would prefer to offer savings benefits. This is because healthier consumers prefer savings – at least unused benefits remain. And open schemes need to attract healthier members to be sustainable.

If savings were outlawed at an industry level in the current system, there is arguably a risk that the younger healthier lives may opt out. This is because they may see little value in paying for risk benefits only that they don't expect to utilise till much older.

5) **Will a simplification of benefit options improve transparency and accountability? To what extent will this incentivize medical schemes to compete on the merits – that is on value for money and innovative contracting where they can pass the benefits directly onto the members?**

Response:

Simplification is supported and should improve comparability for consumers.

However, without risk equalisation, it is unclear how transparency and accountability would be affected. This is because, without risk equalisation, schemes with higher claiming older members would appear expensive, although they may be very efficient. This would hasten the actuarial death spiral for such schemes, leading to consolidation of members towards the schemes with the healthiest/ youngest members, irrespective of their efficiency. At an industry level, this would result in a net loss of value, not linked to any improvement in transparency and accountability.

Arguably schemes would compete more by cherry-picking, as the profile of lives would have the biggest impact on claims and sustainability.

Schemes with a poor profile may be less able to open new competitive benefit options to try and attract healthier lives, required to remain sustainable.

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6) **How can benefit options be simplified to allow meaningful comparisons and increased competition? In this regard these are some possible options, but the HMI welcomes others:**

a) **CMS's recommendations in Circular 8 of 2006 of an establishment of common benefits across a scheme with a single contribution table (scheme benefits) with buy-up supplementary benefits. In this example, medical schemes will provide common benefits with a single price to the entire membership and members can purchase additional benefits on a voluntary basis. This would result in a single risk pool for each medical scheme for common benefits and distinct risk pools for supplementary benefits. This would require risk equalisation for the pricing of PMBs only.**

Response:

This approach would align well with PMBs and a single set of common benefits. However:

i. PMBs are not simply defined and as a common benefit it is not ideal.
ii. Setting up a common package across all lives will result in the contributions being more expensive than the existing lower cost benefit options within the scheme. This is because the current cheaper benefit options have healthier lives. In a common package, the healthier lives cross-subsidise the sick more. Many of the younger, healthier lives may also be lower income.
iii. Risk equalisation will increase the claims costs for schemes that currently have healthier profiles of lives. Many of these are closed schemes with lower income earners. Thus, risk equalisation would critically require income cross-subsidisation too. Otherwise the risk of loss of lower income healthier lives is high – this would increase contributions overall if these lives left the system.

As per the response to question 2, we rather propose a simple standardised classification system to help consumers better compare benefit options and value.

b) **Simplify and standardise a mandatory benefit package that all medical schemes must offer. Medical schemes can then sell (a limited number of) complimentary (top-up) benefit options.**

Response:

This proposal is similar to the above approach, except that risk equalization is removed and the common benefit package is likely wider than just PMBs. Our comments are:

i. The package must be simply defined.
ii. The larger the package, the more expensive it will be. This poses a problem for lower income families, especially those that don't require the full package or can't afford all of it.
iii. Without risk equalisation, schemes with higher claiming older members would appear more obviously expensive, although they may be very efficient. This would hasten the actuarial death spiral for such schemes, leading to consolidation of members towards the schemes with the healthiest/ youngest members, irrespective of their efficiency. At an industry level, this would result in a net loss of value.

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c) **Each medical scheme must offer a standardized package but can then offer a limited number of other benefit options of their own design, but that meet the requirement of the MSA.**

Response:

Without risk equalisation, the standard package option may appear cheap or expensive due to the profile of lives rather than efficiency. Schemes are likely to particularly cherry-pick lives into these standardised options through marketing means to appear competitive. Or run them at a loss to similarly appear competitive and efficient.

It is unclear if these issues would outweigh the benefit to consumers of having at least one simple standardised benefit option in the market across all schemes.

d) **Limit the number of benefit options each scheme can offer, and ensure that each meet the requirements of the MSA.**

Response:

Effectively this is what the CMS is currently doing on an ad hoc basis. However, such an approach would at least help set a consistent standard across the industry. However, the number of benefit options should not be too low – typically closure of benefit options result in increased claims in the lower options as these higher claiming members buy-down.

e) **No new restrictions on benefit options, but medical schemes must clearly classify each option so that the consumer knows which CMS benefit category it falls in. This will allow the consumer to know and be able to compare options within a particular group such as comprehensive, for example. The CMS will need to review the broad options categories into narrower groupings.**

Response:

This is in line with our proposal as described under question 2. We would recommend a simple benefit richness based classification system.

7) **What prevented the implementation of the revised benefit design structure proposed in Circular 8 of 2006?**

Response:

We suggest the CMS is consulted on this. However, there was significant concern regarding the likely negative impact on lower income lives. Such a restructure would have increased contributions for lives on the cheaper benefit options, which are typically lower income and healthy. The risk of losing both of these segments would not be ideal.

8) **What are the disadvantages of simplifying the benefit options?**

Response:

With changing benefit option designs, there will be winners and losers. Consolidating options also typically results in an increased claims experience in the lower options i.e. effectively higher claimers opt

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for a cheaper plan without a commensurate reduction in claims. This dynamic increases the contributions on the lower benefit options.

9) What other mechanisms must also be implemented for any simplification of benefit options to result in increased competition?

Response:

Our proposal is a simple objective classification system to help consumers better compare benefit options and value. This should be based on benefit richness, and perhaps some other simple classifications.

However, value is distorted by the profile of lives in a benefit option. To remove this distortion, risk equalization is required. However, risk equalization will increase the cost of cheaper benefit options and schemes and thus cannot be implemented without income cross-subsidisation.

Mandatory cover (perhaps via compulsory income based contributions) would also ensure a more stable and sustainable system on the road towards NHI, and protect against the risk of losing healthier lower income lives should a significant benefit package restructure be undertaken.

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