THE SOUTH AFRICAN MEDICAL ASSOCIATION SUBMISSION TO:

THE COMPETITION COMMISSION HEALTH MARKET INQUIRY

In respect of

Call for Submissions and Participation in Seminar
On the healthcare financing regulatory framework
(1 December 2017)

25 January 2018

CONTENTS

EXECUTIVE SUMMARY

The South African Medical Association (SAMA) thanks the Competition Commission Health Market Inquiry (HMI) for the opportunity to comment on the healthcare financing regulatory framework and the impact it has on competition in the private healthcare sector.

We encourage the HMI to utilise these comments, which we have collected from the medical practitioner community and the evidence available to us make recommendations for the improvement of the current healthcare financing regulatory framework.

Interventions required to address anti-selection, if it occurs so as to increase meaningful competition:

- *The schemes option plans need to be consolidated as schemes deliberately fragment risk pools in a form of benefit options to target low-risk, high-income populations. MSA makes provision for registration of sustainability of option plans. This needs to be implemented with immediate effect*
- *The non-health products are used to attract low risk populations. Often schemes argue that these interventions are used as health promotion intervention to reward healthy lifestyles.*
- *Number of medical schemes also needs to be consolidated*
- *Mandatory enrolment ought to be implemented, community-rating enforced and prescribed minimum benefit (PMB) expanded*

Improvement of risk pooling in the market so as to improve competition:

- *The risk pooling is not intended to improve competition in healthcare. Instead, its primary purpose is to improve efficiency and equity in healthcare. Unfortunately, it is the concept of health being a public good and the risk pooling arrangements that define the typical market failures in healthcare.*
- *The HMI needs not only to look at the competitive nature of the medical scheme market but also looks at its efficiencies and equity. Usually, there are trade-offs between equity, efficiency and competition*

How could changes to medical scheme benefit options improve competition in the market?

- *The schemes have fragmented benefit options to compete, however, this has introduced inefficiencies and inequities. We recommend that the HMI reanalyse the data to examine the extent of cross-subsidies and its effect on equity. We describe the method in page*
- *Pooling at scheme level by enforcement of Section 33 of Medical Schemes Act (102) of 1998, will address anti-selection to a huge extent.*
- *CMS must prescribe the efficient option plan size.*

INTRODUCTION

The South African Medical Association ("SAMA" or the "Association" in this document) welcomes the Competition Commission's discussion document on the need for and impact of selected interventions to address regulatory gaps in healthcare financing, with the aim of strengthening competition.

SAMA is a professional association for public and private sector medical practitioners and is registered as an independent, non-profit company.

SAMA membership is voluntary and stands at over 16 500 in 2017. This includes general and specialist medical practitioners, practising in both public and private health sectors in the country.

We believe that the current funding model in the private sector is marred by several failures of regulation, and of regulatory authorities.

SAMA believes that the complexity of the environment and the fact that the medical schemes and administrators are significantly better resourced than their regulators (financially and in terms of skills sets) has resulted in ineffectual regulation at a practical level and poor implementation of the requirements of the Medical Schemes Act.

The number of complaints to the Council has escalated over several years, and addressing these complaints is a long and cumbersome process. We are extremely concerned at what we perceive to be a lack of regulatory independence on the part of the Council for Medical Schemes.

One of the most important concepts in an insurance environment is that of risk pooling. We see that risk pooling at medical scheme option level has failed – with smaller, less sustainable pools being created over time.

This has also resulted in distributive injustices – with some scheme options, usually at the high and the low end of benefits, having to be subsidised by other middle-range schemes, which we believe perpetuates inequalities in healthcare provision and financial coverage. The purpose of risk pooling is to pool all finances together, to dilute risk pool and to provide equal healthcare at the time of need.

We have observed with concern that the CMS allows for registering of an increasing number of plan options – which contribute to risk pool fragmentation and facilitate cherry-picking of members to certain options and schemes.

We have also observed that options which are loss-making are permitted to reregister and continue for years on end – which is not permissible in terms of the Medical Schemes Act. New option plans are geared towards young and healthy and benefit designs are not inclusive. For example, electronic platform based plans that use a digital card and digital platforms for healthcare use exclude the elderly and those in areas with insufficient infrastructure for electronic platforms.

The fragmentation of scheme risk pool through multiple benefit options introduces information asymmetry between schemes and members as well as between doctors and schemes. Although our doctors are at the forefront of medical care, often there is no clarity on benefits. What is considered PMB in one option plan may not be a PMB in another option plan. This confuses both our doctors and patients and contributes to poor quality and inequitable care.

ADDRESSING ADVERSE SELECTION

It is important to recognize that adverse selection is a characteristic globally of privately insured markets, not just in South Africa.

The potential harms of adverse selection through inefficiencies have been known and understood for some time. In 1997, David Cutler from Harvard University discussed how 3 inefficiencies could result from adverse selection (1):

- Prices to participants will not reflect marginal costs, hence on a benefit-cost basis individuals will select the wrong plans
- Desirable risk-spreading is lost
- Health plans will manipulate their offerings to deter the sick and attract the healthy

The Harvard group also show evidence that rating methods that are redistributive and focussed on improving equity, such as community rating, exacerbate this problem (2).

Regulations, which can mitigate adverse selection include the **mandatory purchase** of coverage, **community ratin**g and **risk equalization** (3). On the distributive side, standardised package of care ensures those who need care get it when need arise. Introducing and expanding essential mandatory benefits ensures that medical schemes do not exclude high-risk populations through limited disease coverage and exclusions.

In 2009, Mcleod explored the potential impacts of phased implementation of mandatory insurance on the price of minimum benefits in South Africa. Although acknowledging that estimates are not available for the differences in disease burden of the currently covered and potentially covered population, which made estimation difficult, McLeod demonstrated that mandatory increases in cover should alter the mix of age and gender currently in the medical schemes environment, increase insurance coverage and overall reduce the cost of providing the PMB's (4).

RISK POOLING ACROSS SCHEMES

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

Medical schemes in South Africa represent a highly fragmented risk pooling system. Fragmentation of the pool –is the existence of too many small organizations involved in revenue collection, pooling and purchasing – damaged the performance of all three tasks, particularly pooling.

In South Africa, we are not only concerned about risk pool fragmentation at scheme level. Risk pools in South Africa are heterogeneous, besides the private/public sector divide other risk pools exists: Road Accident Fund, Compensation for Occupational Disease Fund, National Health Services and in some instances albeit few, municipal health services. Within the private sector, the scheme risk pools and health market products further fragment the private sector risk pools, into benefit plan options.

The concept of risk adjustment in South Africa was proposed around 2005 by Professor Macleod. Risk adjustment is a way of equalising the risk profiles of medical scheme members in order to avoid loading contributions on the insured to some pre-set extent. This will effectively enforce community rating across all medical schemes

so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join.

South Africa medical schemes use risk pool fragmentation to differentiate their products and compete. The risk pool fragmentation is generally inefficient as schemes target high-income earners and low-risk individuals. Furthermore, risk fragmentation increases administration costs.

While cherry-picking low risk groups may have particular benefits to schemes, it is not clear why schemes will enhance products to attract high-income earners in higher-premium plans while allowing these plans to run at a loss. We suspect there may be perverse incentive for this and it would be worthwhile for HMI to look into it.

A study on the recommendations on minimum risk pool size for different healthcare benefits was published by the actuarial and clinical consulting firm, Milliman USA in 1997. This recommended different risk pool sizes dependent on the type of risk to be covered (5).

Table 1: Minimum risk pool size for provider organizations for risk acceptance

Type of Risk	Minimum member lives
Primary care Physician	500 -1 000
All physician services	20 000 to 30 000
Hospital services	60 000 to 100 000
All risk	20 000+

In South Africa, the Council for Medical Schemes uses 30 000 beneficiaries as the definition of a large scheme. Most of the PMB's are hospicentric and thus if one considers the cut off of 20 000 + as proposed by Milliman as definition for adequate size for an All-Risk Pool, therefore only 47% of schemes have sufficient population to ensure for all risk (Table 1). It is, however, important to note that most of the schemes with below 20 000 people are restricted schemes.

Table 2: Size of Medical Scheme options December 2016 (Annual CMS Report 2016/2017)

Medical Scheme Size		
	Restricted	Open
Less than 2500	3	0
2500 to under 5000	7	1
5000 to under 10 000	12	0
10 000 to under 20 000	18	2
20 000 to under 30 000	6	4
30 000 to under 50 000	4	2
50 000 to under 100 000	8	2
100 000 to under 200 000	1	5
200 000 to under 500 000	2	2
500 000 to 1 000 000	0	1
1 000 000 to 1 500 000	1	0

If one examines the sizes of the individual options plans in the medical scheme environment, it is apparent that the majority of option plans are not of sufficient size to accept sufficient risk for all risk cover. 80% of restricted scheme options and 75% of Open scheme options fall below recommended thresholds for all risk cover. (Figure 1)

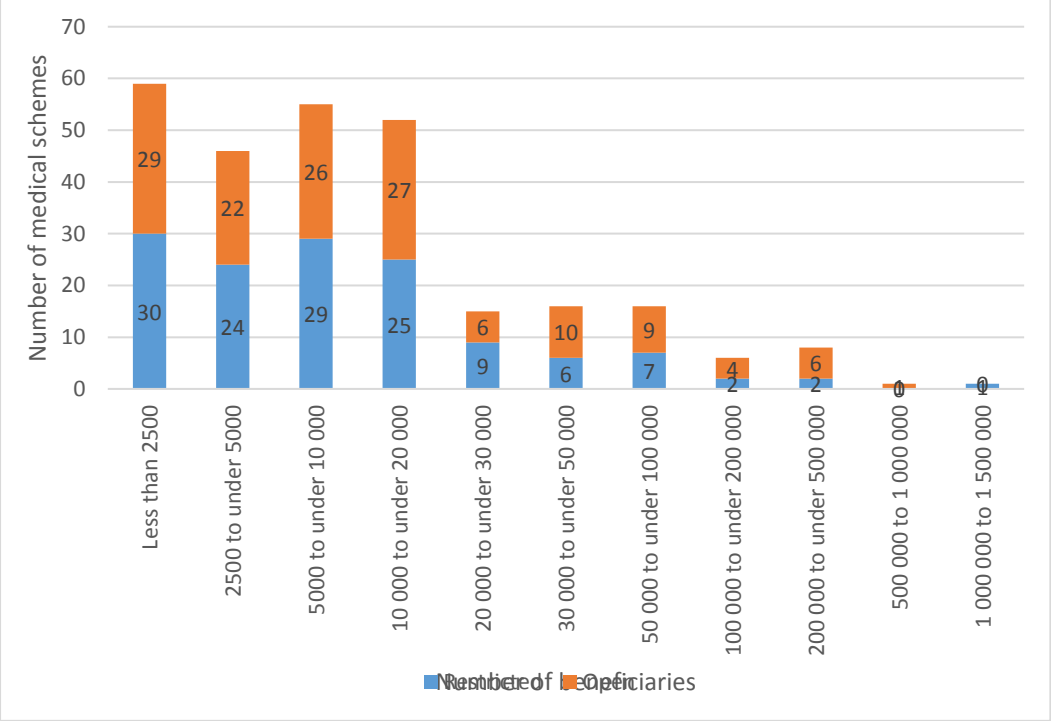

Figure 1: Number of option plans by scheme size

Whereas there had been a decrease in the number of scheme options between 2000 and 2008, this number had tended to creep upwards again, with schemes introducing ever new options in an attempt to cherry-pick members.

The high number of options not only fragments risk pools, but also makes comparisons between schemes and options difficult for members and doctors.

Why are benefit options that are in fiscal deficit for consecutive years, allowed to exist?

This is simply the result of failed regulation. The number of unstainable options has increased by 10 percent over a 5 year period (fig 2). Allowing registration of unsustainable of option plans has not improved efficiency, instead we have seen increased reduction in both PMB and discretionary benefits offered by the schemes in most option plans except higher plans.

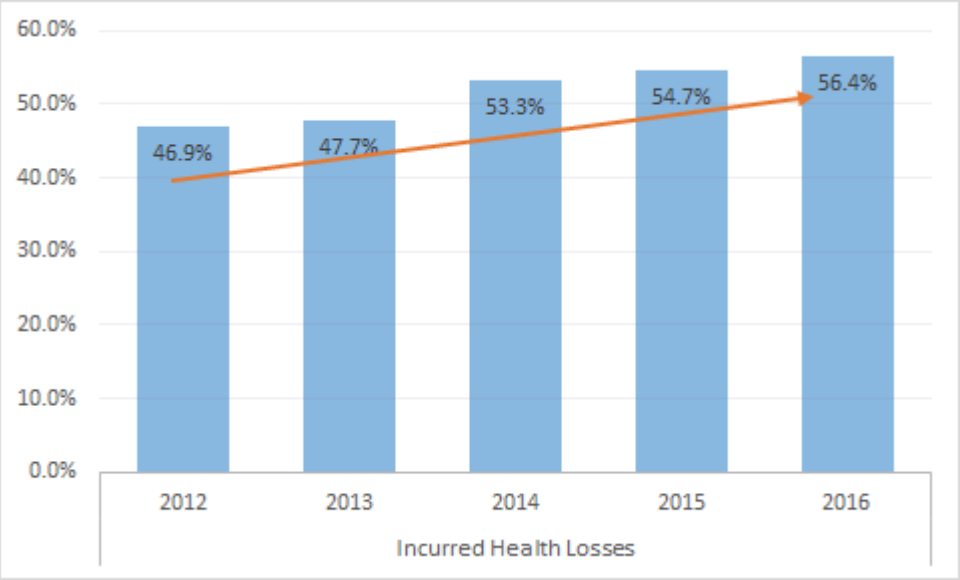

Figure 2: Incurred health losses 2012-2016

Section 33 of the Medical Schemes Act (101 of 1998) outlines requirements for registration of benefit options: The Registrar may not register benefit options unless the Council is satisfied that the benefit option

a) Includes PMB's
b) Shall be self-sustaining in terms of membership and financial performance
c) Is financially sound
d) Will not jeopardise financial soundness of any existing benefit options.

CMS has over the years allowed registration of the benefits options that do not include PMB's that are not self-sustaining and may jeopardise financial soundness of other plans. There have been injustices in the distribution of resources, for example, it is not uncommon for schemes to request a member from a self-sustaining pool to upgrade to a loss-making option to access the benefits. Risk pooling's intention is to improve equity in distribution of resources. The tendency to require members to buy up from a self-sustaining pool when needs erodes equity and efficiency principles underlying risk pooling of health resources and introduces anti-selection. In essence schemes are very comfortable in providing for health care needs based on ability to pay.

Arguments have been advanced that the cross-subsidised options serve the high-risk groups however we suspect that this may not be true. It has been argued that sick people tend to buy high option plans, however, we know that income correlates with health, that is, in a selected population burden of disease is more likely to be high amongst the poor.

Particularly in higher plans, one would see that these plans include essential and posh non-essential services (private ward, non-generic medicines, top of the range appliances, unlimited cover, and access to treatment overseas). The moral hazards are likely to exist in high option plans due to availability of unlimited benefits.

In lower plans the picture is mixed, these plans tends to attract the elderly, the youth and low-income groups. These plans also tend to consider income to determine the contribution. Therefore, there is some form of income cross-subsidy. The lower plans have restricted benefits and moral hazard is less likely. We thus speculate that lower plans are subsided because the groups have high health needs. We suspect that high benefit options get more Rand subsidy per capita vs. low option plans.

Recommendation: As we do not have access to data, we recommend that Health Market Inquiry interrogate the extent of cross-subsidisation between the option plans with a view of assessing equity. The analysis should adjust for age and health need and determine the subsidy amount per Capita in Rands before and after adjusting for health needs and age.

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

The lack of medical scheme risk equalisation has resulted in schemes learning to differentiate the risk groups. Scheme use non-health related products or accessory products to attract low-risk populations. These products include cash rebates, gym membership, health products, running shoes, electronic-based health plans etc.

We have seen that the behaviour of risk pools differ depending on whether they are high or low option plans. High option plans typically tend to deplete their budgets, therefore affecting scheme wide premiums, especially if there is moral hazard. Strict rationing is applied to lower plans. This may be a barrier to essential care access. Generally, schemes do not comply with reimbursement of PMB's in the lower plans. Members of the lower plans are generally susceptible to large premium increases, therefore schemes tend to keep premiums affordable for this plans.

If there is a need for a risk equalisation mechanism:

There is a need for some of risk equalisation mechanism. The perfect risk equalising mechanism is through universal coverage, however this may not always be feasible and practical. In SA it is likely that NHI will take time to implement. Thus any method of risk pooling needs not to undermine public policy. Where insurance is voluntary, and the rich are allowed to opt-out of contributing to NHI and take private insurance in its place, the financial viability and political support for NHI maybe threatened.

In the meantime, one could consider two options:

i. **Integrated common risk pool**, where all members, through their medical schemes, contribute per capita amount to the common pool. The money collected will then be used equitably for PMB's. Such a risk pool will allow SA to expand coverage without increasing costs. It should however be noted that as the pool size increase efficiency maybe lost
ii. **Risk transfers between schemes**, where schemes that attract low risk members transfer money to schemes that attract high risk members. This mechanism is administratively burdensome and will require a strong regulatory

framework and central coordination. This approach may threaten equity as schemes retain most of purchasing role and rationing**.** .

We do not foresee implementation of unconsidered risk equalisation improving competition. However, we believe that consolidating risk pools will improve equity in healthcare. Consolidation can happen between schemes immediately reducing the number of schemes by 53% by simply implementing.

What are the various mechanisms that can be introduced?

- Consolidate number of schemes and benefit options by determining efficient scheme and option plan size
- Mandatory participation bearing in minding the proposed National Health Insurance.
- Enforcement of community rating already in place- some schemes tend to delay registration of members with perceived high risk. This is a minor issue and can be easily monitored and enforced by CMS.
- Expand and enforce PMB's in order to maximise equitable distribution of pooled resources.
- Considering a common integrated risk pool, for PMB's allowing schemes to compete on supplementary cover. Inter-scheme transfers may also be considered however this arrangement may threaten desired equity. In an integrated pool all members will pay in accordance with ability and claim when needs arise.

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

- **Timing**

Consolidation of schemes can be done in around 3 years. It will be difficult to implement mandatory participation in view of NHI policy. Mandatory participation in medical schemes environment can be a stepping stone towards universal coverag**e.**

- **Effect on competition:**

Unfortunately, equity and efficiency interventions tend to undermine competition in health insurance. The Medical Schemes Act was introduced in the late 1990's to address a competitive insurance market fraught with risk-rating, adverse selection, insufficient coverage and dumping to the state. The MSA prescribed interventions that addressed risk-rating and defined a PMB, however, failure to implement mandatory enrolment and regulate size and feasibility of option plans resulted in adverse selection. Unfortunately, as PMB's are both catastrophic in nature and less common, devolving cross-subsidies at an adoption level was a mistake. For catastrophic rare events, pooling needs to be done at a higher level (scheme level or integrated common risk pool) to ensure that expenditure variation can be managed.

- **Variance in premium**

Unfortunately, effective risk pooling requires that the covered population receive equal care when needs arise. If the risk pools are to receive equal benefits then premiums for common benefits need to be similar and only differentiated by income. This is particularly important in South Africa and present opportunity for distributive/restorative justice.

- **Suppliers:**

Schemes use volume numbers to negotiate prices. At the moment the small schemes are price-takers. Consolidation of risk pools will offer the schemes a muscle to negotiate. As doctors we are concerned about the scheme market dominance and hope HMI recommends implementation of tariff determination where power would be balanced.

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

Risk adjustment mechanism is likely to benefit those in need if disease coverage is sufficient. The rich, who have enjoyed cross-subsidised benefits will suffer.

What costs will be involved to introduce these mechanisms?

A risk pooling mechanisms can include the transfer of costs or setting up of an integrated risk pool from which minimum benefits are paid.

An important consideration is the cost of managing a risk pool. In a voluntary competitive insurance market arrangement, a huge chunk of resources needs to be allocated to information flow and monitoring. There will be demands to manage transfers or pool resources and pay hospitals and health professionals depending on the mechanism chosen. If a risk pool adjustment mechanism whereby there is transfers between the schemes there is a requirement for a strong central coordination role. This is particularly important if there are huge income variations. Purchasing roles may still be devolved to scheme level although this arrangement may threaten equity.

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

It depends on the chosen method of risk adjustment. Risk adjustment through single pool for PMB can be a good stepping-stone for NHI. Actually, risk adjustment methods may enable NHI process provided the role of schemes is well defined

As discussed above, if medical scheme members are allowed to opt out of national insurance, the survival of NHI and political support would be threatened**.**

INCOMPARABILITY OF BENEFIT OPTIONS

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

There is some form of INEFFECTIVE competition a schemes persistently introduce new option plans to compete, HOWEVER the market remain stagnant and costs too high. The number of benefit plans makes it difficult to compare benefits.

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

- Schemes ought to be clear on what they offer upfront, and especially for common conditions. Members can thus use product offerings to compare. The language needs to be simple.

- The number of option plans should be reduced to at least 5 plans per scheme and number of medical schemes needs to be reduced both to improve efficiency and equity through risk pools.

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

- Autonomy in healthcare arguments have been introduced for reduction in moral hazards, however, there are some form of moral hazards if the beneficiary tends to claim towards end of the year for non-essential healthcare. This tends to increase premiums for the entire risk pool, as schemes do not differentiate between essential and non-essential healthcare. Moreover, expenditure from MSA is not closely monitored, and unnecessary healthcare can be purchased for example, Gucci Frames. Although schemes are not allowed to pay from PMMB's from MSA, most schemes still pay for PMB's from MSA as well. Unlimited MSA for higher groups also include an element of inequity, considering that these option plans are heavily subsidised.

What is the effect of current medical savings accounts on moral hazard (16) and how can the continued existence of these accounts in the medical schemes industry lower moral hazard, and improve competition between schemes? See above

- **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?

  Yes, tell people what their entitlements are, doctors also need to be aware what the entitlements are. At the moment we cannot tell you what the members entitlements are and this affects the quality of care that doctors can offer.
- 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:
  - 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.

This could work provided distributive justice is considered and PMB package reviewed to address population needs COMPREHENSIVELY

- 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.

  We are concerned about failures to review PMB package and the procedure followed by CMS in reviewing package. We are concerned that a PHC approach may be taken at the expense of comprehensive health cover. It has been demonstrated that large risk pools can cover comprehensive health needs equitably.

- Each medical scheme must offer a standardised package but can then offer a limited number of other benefit options of their own design, but that meet the requirement of the MSA.
  Only if PMB package is revised and expanded. Otherwise the public will be harmed by inadequate and fragmented care offered in current PMB package.
- Limit the number of benefit options each scheme can offer, and ensure that each meet the requirements of the MSA.
- 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. **CMS must definitely restrict number of benefit options and enforce Section 33 of MSA provisions.**

- **What prevented the implementation of the revised benefit design structure proposed in Circular 8 of 2006?**
  Regulatory interference by schemes and lack of regulatory independence.

CONCLUSION

SAMA is pleased to be in the position to contribute to the very important process of the Health Market Inquiry, for the benefit of private healthcare in South Africa.

Many of the conflicting policy objectives will not be easily solved and we hope that this submission and others received can shed light on and provide direction for potential regulatory amendments and other initiatives.

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