



Challenges and opportunities for health finance in South Africa: a supply and regulatory perspective

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1. Executive summary

This report provides an overview of the regulatory structures and supply of pre-funded health financing products in South Africa. The intent of the document is to stimulate debate around the necessary conditions for a more inclusive and accessible product market that can contribute to improved health outcomes.

1.1. Background and context

The South African pre-funded health finance market is a complicated system that functions via fragmented risk pools under separate regulatory regimes for medical schemes and health insurance, respectively.

The market for pre-funded healthcare products is dominated by **medical schemes**. These products operate similarly to not-for-profit trust funds and service around 16% of the South African population (8.8 million people). Medical schemes are regulated by the Council for Medical Schemes (CMS) according to the Medical Schemes Act (MSA). The funds can either function as restricted membership funds that ring-fence membership to a particular employer/industry or as open funds that make membership available to all that can afford the premiums. The market is based on the principles of solidarity and community rating and provides members with a set of prescribed minimum benefits (PMBs).

The **health insurance** market constitutes a far smaller proportion of healthcare financing. Health insurance products are for-profit products that are regulated either under the short term or long term insurance acts depending on the insurer's licence and product structure. The products are regulated by the South African Financial Services Board (FSB). Health insurance products mainly operate in two market segments: either as top up insurance products for medical scheme members or as standalone offerings that are independent to medical scheme membership. The latter can further be defined as cash based products that pay lump sum cash benefits independent of the cost of care or care-based products that provide cover aimed at meeting the cost of care.

There are structural equity concerns between those covered by pre-funded products and uncovered lives, both in terms of financial flows and access to healthcare providers. Medical scheme cover is concentrated in the upper income deciles, with insurers providing less comprehensive but more affordable financing solutions, but still not reaching the bulk of South Africans. The majority of South Africans make use of the public sector and services are charged based according to means tested user fees. There is also a significant proportion of costs that are spent out of pocket for services not covered through government funding or pre-funded insurance vehicles.

Demand for health financing vehicles arises in relation to challenges regarding access and perceived quality of care in the public sector. The government has expressed a clear intention to implement National Health Insurance (NHI): a series of major health system reforms intended to address issues of equity and quality. If these reforms are successfully implemented the demand for private healthcare financing should dissipate naturally. Medical schemes are envisioned to have a substantially reduced role in the long term, providing only supplementary cover. A work stream has been established to clarify the role of medical schemes in an NHI environment. No mention is made in the proposed NHI legislation of the role, if any, of long-term and short-term health insurance products.

The regulatory pathway between the current and future roles of private healthcare financing vehicles has not yet been articulated. This means that in addition to the long-term uncertainty there is

considerable uncertainty about the role, functioning and regulation of these vehicles in the short to medium term. This includes uncertainty on the regulatory demarcation between types of funding vehicles and classes of products. This report is located against the backdrop of this uncertainty.

1.2. Historical development

Medical schemes emerged out of employer funds: consequently the market is still heavily influenced by employer involvement. They historically operated as friendly societies, with many of the social solidarity features seen in the current market. A period of deregulation in the 1990s precipitated the involvement of for-profit entities in the market (notably, third-party administrators and large insurers). These dynamics also favoured the development of open medical schemes, and the involvement of brokers in product distribution.

Whilst the health insurance market has roots in the 1980s, the market grew and developed in the 1990s during the period of medical scheme deregulation: it was during this period that large insurers developed an interest in healthcare as a potentially profitable market.

The Medical Schemes Act 131 of 1998 reintroduced social solidarity principles into the medical scheme market: open enrolment, community rating and a generous minimum benefit package. The Act was positioned within a Social Health Insurance policy framework which envisioned a staged extension of risk and income cross-subsidies, and eventual implementation of mandatory contributions for those earning above the income-tax threshold.

It was in this context that it became necessary to clearly demarcate between medical schemes and insurance products, which was done through an agreement between the long-term insurance industry (represented then by the Life Office Association) and the CMS and FSB in 2004. The key aim of the demarcation was to ensure that products sold on a for-profit, risk-rated basis did not undermine medical schemes by cherry picking the young and healthy. This original demarcation framework had a number of flaws: it did not explicitly consider the short-term insurance market, the definition of the business of a medical scheme was technically flawed and it did not have full legal standing, but operated as a guideline largely to the long-term insurance market.

These flaws led to a Supreme Court ruling that provided a legal standing for health insurance products that aimed to fund the cost of care. Subsequent to this ruling the market for health insurance grew rapidly and extended both in volume as well as the scope of the cover offered by these products.

Recently, a regulatory process aimed at amending the definition of a medical scheme has been promulgated, but the change will only be effective once the full extent of the health insurance market has been defined via the publication of an official demarcation regulation. The timeframe for this demarcation has been stalled and the expected date of release of this legislation was not clear at the time of writing. From a low income customer's perspective the differences between the regulatory environments are less significant than the cost of the premiums. But the differences have implications for the extent of cover, costs, risk cross-subsidies, employer involvement, long-term sustainability and financial soundness of different vehicles in the market.

1.3. Forces shaping the industry

The market for pre-funded healthcare financing products is strongly influenced by forces external to the funders themselves. Employers play a range of roles in the system: pre-funding occupational health; establishing restricted membership schemes; or providing care themselves. Employers enable

the provision of low-cost funding solutions by concentrating demand into defined groupings that could qualify for group discounts as well as subsidizing the cost of cover.

Third-party administrators and managed care organisations introduce a for-profit dynamic into the not-for-profit medical scheme market. They provide a sophisticated set of services to schemes. The market for these services has become increasingly concentrated over time, creating a number of powerful macro participants.

Large life insurers have acted as a catalyst for the medical scheme market. The health insurance market, in turn, has been driven largely by innovations and developments in the short term insurance market. This is due to the impact of the original demarcation agreement that dealt specifically with long-term insurers. Consequently, many of the large financial participants have been apprehensive to enter a market that is seen as a grey area in terms of regulation.

If defined product criteria and a clear regulatory structure can be agreed on it is likely that a number of large insurers and financial product providers would enter the market. Key to the success of pre-funded health finance solutions is distribution. The distribution channels and sales forces as well as cross selling opportunities for established financial market participants could significantly impact the health insurance market. If the regulations encouraged wider market participation this could signal the next wave of innovation.

The health financing market has also seen a narrowing of the relationships between funders and the providers of medical services. This has been precipitated by advances in monitoring and tracking of costs and outcomes partly in response to increasing cost trends. The result has been a more collaborative and balanced relationship with increases in the relevance of risk and cost sharing funding models like alternative reimbursement and capitation agreements. This has mostly taken place in the much larger and more sophisticated medical scheme market. But recently health insurers have also adopted many of these measures in a bid to curb costs and share risk.

1.4. Market overview

Due to the existence of pre-funding products in multiple environments, and the fact that they are subject to different regulatory regimes, there currently does not exist a single source of information on all healthcare financing products. This makes it challenging to form a single view of the market. The medical scheme industry is regulated at product level, with the CMS collecting and reporting information on individual benefit options. By contrast, the insurance industry is regulated at entity level. Consequently there is a far less detailed product-level view available.

This prompted the development of a Health Funding Register (HFR) as a central element of the research for this report. It provides a single view of the market by taking stock of all pre-funded healthcare financing products currently available in the local market and comparing and contrasting the features

The HFR formed the basis for a more detailed classification of the offerings on the market into four categories: medical schemes; top-up insurance cover; cash-based insurance products and care-based insurance products:

- The **medical scheme** market can be divided into 23 open and 60 restricted schemes. The product structures are complex with PMB's forming the basis for all but bargaining council schemes. Most products offer significantly more than the minimum PMB requirements and the market

exhibits a wide variation in benefit structures. The medical scheme market is further classified by a very high minimum cost of cover, making it unaffordable to the majority of South Africans.

- **Top-up cover** relates to insurance product offerings that provide ancillary cover above medical scheme membership. The products normally relate to gap cover, dental cover and defined shortfall covers. Most of the products require medical scheme membership as a prerequisite to take out the policy. The market is populated by nearly 100 products and has experienced escalating loss ratios and premiums in recent years.
- **Cash-based products** are normally structured as Hospital Cash Plan (HCP) products. This is an established health insurance market and cover mostly relates to a stated cash amount for each day spent in hospital. HCP products are mostly sold to the low income market that do not participate on medical schemes and premiums vary by age and chosen cover level. Currently the market is populated by at least 20 different products. This excludes offerings that are closed to new business and products that are mainly offered to higher income lives as rider covers to products like life insurance. The HCP market has noted increasing loss ratios with fraud being cited as a primary risk driver. A number of products have been closed to new business as a result and the risk of fraud-driven losses seems to have stifled innovation. The cash benefits imply that the products do not enable access to private hospitals and insurers have noted that there is little information available regarding the needs that these products meet in practice.
- **Care-based insurance products** can be defined as health insurance products offering (i) hospital only cover, (ii) primary care only cover, (iii) cover for primary care combined with limited hospitalisation cover, or (iv) primary care and hospital cover. The market has grown rapidly and primarily services the low income market. The products offer direct access, often to private doctors and hospitals for a range of specified events and needs. The market is populated by nearly 40 different offerings and most offer some form of network arrangement to enable access for policyholders.

The care-based insurance market has developed in response to a growing demand for affordable cover. The products are able to offer affordable access to low income earners via group discounts and employer subsidies. The market has started to experience increasing claims cost due to the impact of utilization increases. The key for this market is affordability and the ability of insurers to keep premiums as low as possible will determine the long term success of this market.

The HFR shows that care-based insurance products are the only affordable options for a family seeking cover if they earn below the tax threshold.

1.5. Key challenges

There are a number of factors that challenge the provision pre-funded healthcare solutions to the low-income market. This includes:

- **Affordability.** The cost of cover is the main factor for most low income earners. In the medical scheme market there have been two main policy initiatives aimed at structuring an affordable low cost product (the Low-Income Medical Scheme initiative of 2006 (LIMS) and the Low-Cost Benefit Option (LCBO) initiative in 2015) but to date neither have come to fruition. Currently medical schemes remain unaffordable to the majority of South Africans. The impact of income cross subsidies and employer funded contribution subsidies does improve the affordability considerations, but these factors only become truly effective with the advent

of the tax credit. Hence it only becomes relevant for those earning above the tax threshold. Under the current structures health insurance is able to offer a less comprehensive but more affordable product offering that is made all the more affordable via group contribution discounts and employer subsidies.

- *Market fragmentation.* The health funding market is fragmented to the extent that it impacts on the ability of the products to provide value, control costs and align incentives. This lack of integration leads to inefficiency that serves to increase costs for both health insurance and medical scheme products. This further constrains the low income market's ability to access cover.
- *Cost inflation.* Healthcare Cost Inflation (HCCI) in excess of inflation has long been prevalent in the medical scheme market and has recently become a feature of the health insurance landscape. This is driven by inflation related increases in tariffs as well as utilisation increases as consumers increase the amount of health services they use. Other factors that increase costs include non-healthcare costs, regulations as well as fraud. Many of these factors require parallel risk-management and cost-containment strategies that curb health costs, which can increase non-health costs.

1.6. Where to from here?

At the time of writing the market was awaiting new demarcation regulations that would limit health insurance products and outlaw care-based insurance cover. If these regulations are passed the insurance market will likely be confined to the cover of ancillary risks. The analysis shows that a change of this nature will leave many South Africans exposed and without the ability to afford some form of pre-funded health financed protection over and above public healthcare provision. The results of the HFR scenario analysis indicate that those earning below the tax threshold would be very unlikely to be able to afford a medical scheme product offering. There is thus a potential need for a defined product category aimed at low income individuals that would facilitate (full or partial) access to private facilities.

The medical scheme market has attempted to develop policy that would have allowed such products product, first via LIMS and then the LCBO, but these initiatives did not come to fruition. These failures have caused many to lose confidence in the ability of the medical scheme model to service the needs of low income earners. In the interim, insurance products have moved to fill the gap via a loosely regulated loophole avoided by many established insurance providers.

To overcome uncertainties and create a level playing field, this report suggests the establishment of a defined regulatory framework for the provision of care-based insurance cover for the low income market, situated within both the long and short term insurance acts. The products could be ring-fenced via income requirements and the market clearly defined in terms of key principles like insurance benefits, distribution, policyholder education and communication. Such a dispensation would require detailed reporting per product line.

It is expected that the establishment of a defined framework for insurance products aimed at the low income market will encourage large scale market participation from the insurance industry. This will enable insurers to compete for policyholders based on price and policy benefits which in turn should allow low income earners access to competitive premiums and more comprehensive cover options. Ring-fencing the care-based insurer market (potentially via income) would allow for a larger pool of

lives to access private coverage without eliciting a drain on the medical scheme population. This will enable a more inclusive market that services a larger proportion of South Africans.

2. Introduction

Pre-funded health finance mechanisms are generally expensive for low-income households, but provide the possibility of protection from a range of financial risks arising from health events. The objective of this report is to provide an overview of the regulatory and supply landscape for pre-funded health financing vehicles in South Africa. The report is aimed at providing key stakeholders, including regulators, policymakers and the providers of financing vehicles, with a detailed overview of the forces shaping the industry. This in turn will help to inform policy debate, both in South Africa and the SADC region.

The report is considered within a shifting regulatory and policy framework at a time of significant health system reform. The gaps, challenges and opportunities posed by these regulatory structures are presented. In considering the landscape, affordability and access are key considerations. It is hoped that the report can act as a catalyst for a more inclusive and accessible pre-funding market for healthcare costs, ultimately leading to improved health outcomes for South Africa.

The study entails a detailed review of the health financing mechanisms currently available in order to provide a market snapshot. Medical schemes dominate the pre-funding market. Consequently, market commentary frequently excludes other insurance-based products. The intention of this report is to provide a more complete view of the market by also considering insurance products like gap cover, top-up cover, dental cover, hospital cash plans and care-based insurance products¹.

Due to the existence of pre-funding products in multiple environments, and the fact that they are subject to different regulatory regimes, there currently does not exist a single source of information on all healthcare financing products. This makes it challenging to form a holistic view of the market. From a consumer perspective the differences between the regulatory environments is difficult to contextualise and they are largely unconcerned with which regulatory environment a product is located in. But the differences have implications for the extent of cover, costs, risk cross-subsidies, employer involvement, long-term sustainability and financial soundness. Building a full view of the pre-funded market is therefore necessary to be able to consider the opportunities and challenges for serving a broader target market. A holistic view is also necessary in order to fully consider the potential options from a regulatory standpoint. Regulators are struggling to reconcile the two environments, particularly given the broader policy uncertainty regarding the future role of private healthcare financing. Whilst the NHI vision of universal coverage may render many of these considerations moot, NHI implementation will take time and will face challenges. This report further considers what could be done, in the interim, for the market to provide options to lower-income customers.

The rest of the document will provide the reader with sufficient context to understand how the market snapshot presented here has arisen. The intention is not to single out individual providers or models, but to provide commentary on the implications of overall market dynamics.

¹ However, the report is limited to pre-funded healthcare financing mechanisms active in South Africa that aim to cover the direct cost of a medical event. This means that products like occupational health products, disability insurance, income-replacement and critical illness are not covered.

This report is informed by a series of consultations with market participants and stakeholders, extensive desktop research and the collation of available product information. The discussion presented is intentionally high level, given the wide range of potential issues to be considered. The report is not intended as a comprehensive analysis of each aspect of the market. It has been written in a narrative style in an attempt to convey the views expressed in the consultation process. Due to the complex nature of the environment and the range of stakeholders involved there are inevitable differences of opinion – the intention is to capture those differences and not to present the authors’ own views.

The report is structured as follows:

- *Setting the scene* provides the context for the report in terms of the overall health system, health financing flows and the history of market development and regulation. This helps readers to understand how the path that has been followed has shaped the products that are available in the market.
- *Forces shaping the industry*: this section considers current market dynamics by considering key stakeholders and the interactions between various market participants.
- *Market Overview* then discusses the current landscape for health financing products in South Africa, based on the product information collated for this project. It details the types of products on offer based on a collated database compiled by the authors. This database outlines the features of medical scheme and health insurance products on the market and is called the Health Funding Register (HFR). The available products are explicitly considered through an affordability lens for lower income individuals.
- The observed shortfalls in the market (particularly for the low-income market) are considered in more detail in *Market challenges*.
- The emergent themes are drawn together in the *Conclusion*. It highlights the regulatory implications and a potential regulatory pathway to a more inclusive healthcare funding system.

Setting the scene

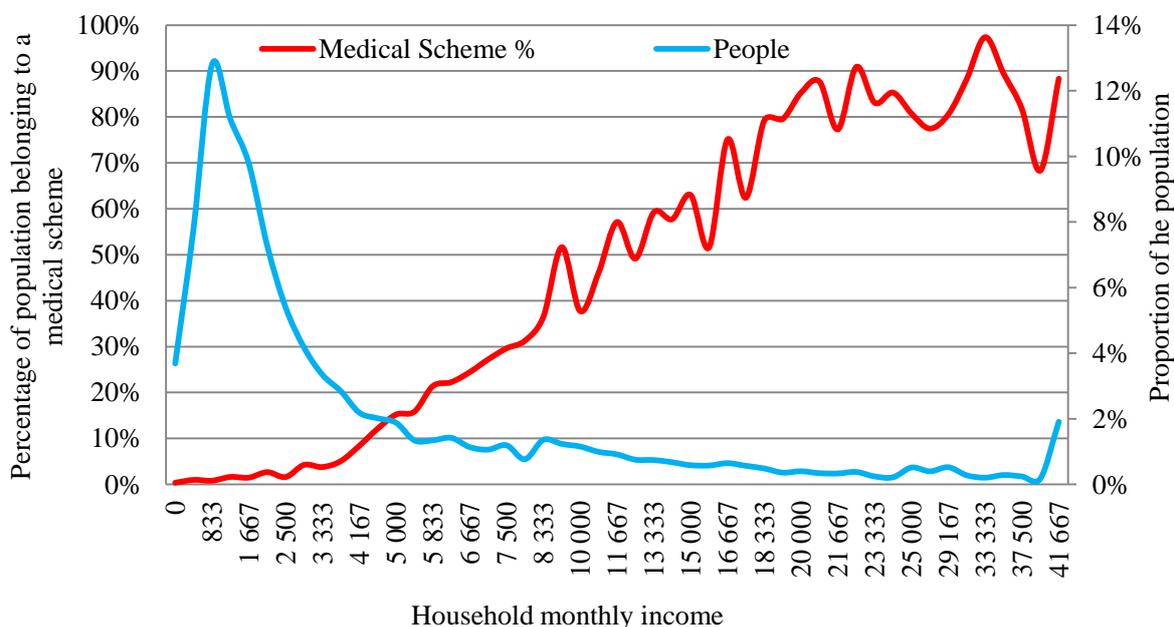
3. Background and context

The health funder market in South Africa is complicated and interrelated with a large number of market participants and stakeholders. The dominant healthcare financing vehicles in South Africa are medical schemes that function as not-for-profit vehicles that provide near-indemnity cover [2]². Whilst the majority of South Africans are reliant on publically-funded and – delivered care, medical schemes enable approximately 16% of the population to access privately delivered care [3].

There is evidence to suggest that while the majority of people who access private hospital care do so via medical schemes, up to 30% of the population make use of private general practitioners and pharmacies [1]. Those that do not have insurance cover for these benefits pay out-of-pocket. One potential explanation is that people that rely on state hospitals do not mind making use of a state facility as long as they are sure the diagnoses is correct.

The medical scheme market has struggled to expand into the lower income market, and coverage remains concentrated in the upper income deciles.

Figure 1: Medical scheme membership by household monthly income

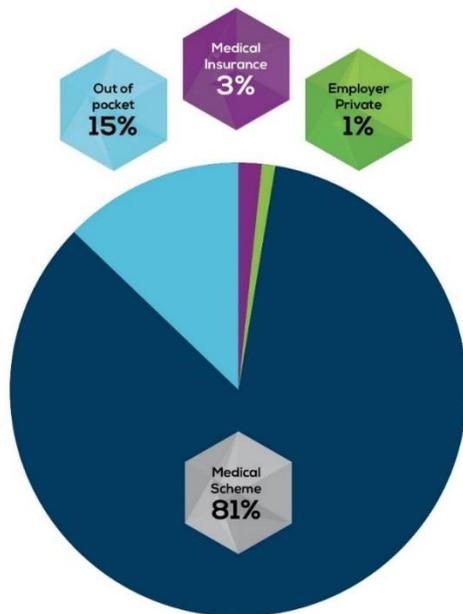


Source: Statistics South Africa.

² Note on referencing convention followed in this report: in-text source references are numbered. The full reference for each numbered source is contained in the References list in Annexure 4.

There are a range of other healthcare financing vehicles that fall into both the long-term and short-term insurance product domains. Reports on healthcare financing have frequently disregarded these products as they historically made up a relatively small proportion of the market (Figure 2).

Figure 2: Split of private expenditure on health 2009/10 [1]



However, the range and reach of these products have increased in recent years. In part this was due to an initial demarcation agreement focussing mainly on the long-term insurance space – thereby creating a grey area for short-term products. This was further impacted by the Guardrisk court ruling (outlined in Section 4.3). More importantly, this market has developed in response to a lack of affordable solutions in the medical scheme space.

The financial importance of private healthcare funding in South Africa. Expenditure on medical schemes account for 41.8% of total healthcare expenditure [4]. This is high by international standards [4], particularly considering that cover is voluntary (although contributing to a medical scheme is frequently a condition of service imposed by employers [5]).

Due to the existence of pre-funding products in multiple environments, and the fact that they are subject to different regulatory regimes, there currently does not exist a single source of information on all healthcare financing products. This makes it challenging to form a single view of the market. From a consumer perspective the differences between the regulatory environments is difficult to contextualise. But the differences have implications for the extent of cover, costs, risk cross-subsidies, employer involvement, long-term sustainability and financial

The South African health system is characterised by high levels of inequality [6]; both in the quality of care provided and in the ability for different subsets of the population to access this care. Private healthcare financing vehicles largely purchase care from the private healthcare sector. Compared to the public health system, private healthcare in South Africa is generally perceived to offer higher and more consistent quality of care, albeit at a price [7, 8]. The private sector accounts for a substantial portion of national health expenditure but access is limited to those who can afford the contributions [9].

Despite comparably high healthcare expenditure for the country overall, these inequities result in relatively poor outcomes at a national level [5]. Of particular concern are poor and declining outcomes for maternal and child mortality. Health reforms in South Africa are aimed at reducing the extent of these inequalities, with strong emphasis on improving the quality of care in the public sector [10]. *The public sector is described as having “quality problems in the areas of staff attitudes, waiting times, cleanliness, drug stock outs, infection control and safety, and security of staff and patients” [10].*

There are also stark differences in the distribution of healthcare providers between the two sectors (Figure 3). For example, private hospital beds are concentrated in urban areas and the number of nurses, general practitioners and medical specialists per 1000 people is considerably higher in the private sector [11].

Figure 3: Healthcare providers in the public and private sectors (2010) [11]

	DOCTORS 	SPECIALISTS 	HOSPITALS 	BEDS 
PUBLIC	13 656	4 986	410	85 362
PRIVATE	8 119	7 588	357	36 200

Public healthcare is largely provided free of charge to individual users. User fees for accessing public sector care is currently means tested³ based on income, with some aspects of care (children under the age of six, pregnant and breastfeeding women, the elderly and disabled, and certain categories of the chronically ill) being provided free at the point of service [5]. However, revenue collection in the public sector is a very small proportion of total public-sector healthcare spend (less than 1%). The revenue collected is primarily from institutional funders (medical schemes, the Road Accident Fund), and not from individuals. Incomes are rarely verified and so most patients access care for free.

The public sector means test determines the fee schedules that will apply to patients that make use of public sector facilities. The schedule is based on income and patients are classified as H0 up to H3: the H0 patients being eligible for a 100% subsidy while H3 patients are liable for the full cost of services.

The demand for private healthcare financing products arises in relation to public healthcare that is largely free at the point of service. The extent of the demand for these products therefore points to concerns that consumers (and employers) have with both the quality and

³ The public sector means test determines the fee schedules that will apply to patients that make use of public sector facilities. The tariff schedule implemented by the public sector is called the Uniform Patient Fee Schedule (UPFS).

accessibility of publically-delivered care. The National Department of Health has expressed a clear intention to implement National Health Insurance (NHI): a series of major health system reforms intended to address issues of equity and quality [10]. If these reforms are successfully implemented the demand for private healthcare financing should dissipate naturally.

Consequently, the long-term role of private healthcare financing in South Africa is unclear. According to the White Paper on NHI [10] the role of medical schemes will be to provide supplementary cover to that provided by the NHI fund. However, the extent of cover to be provided by this fund has not been clearly defined as yet, and it is not clear how benefit packages will be demarcated. The notion that consumers should be able to duplicate cover (i.e. contribute to NHI and still continue to purchase private cover) is likely to be an area of contention. A work stream has been established to clarify the role of medical schemes in an NHI environment [12]. It is important to note that no mention is made in the White Paper of the role, if any, of long-term and short-term health insurance products [10].

The regulatory pathway between the current and future roles of private healthcare financing vehicles has not yet been articulated. This means that in addition to the long-term uncertainty there is also considerable uncertainty about the role, functioning and regulation of these vehicles in the short to medium term. This report is published against the backdrop of this uncertainty. Given that NHI is still some distance from full implementation, it is important to carefully consider the options and innovations available in the market to serve a broader base, and to clearly identify the regulatory issues.

4. Regulatory history and development

In this section we provide some historical context on the development of the medical scheme and health insurance regulatory domains. The historical development of the two domains is key to understanding how they relate to each other, as is the history of the demarcation between the domains. The particular history surrounding regulatory initiatives aimed at coverage for the low income market is also described.

4.1. Medical Scheme history

Medical schemes emerged out of employer funds: consequently the market is still heavily influenced by employer involvement. The funds originated⁴ as informal employer-based institutions that pooled money for the funding of healthcare for employees [13]. The market was first formalised with the drafting of the Friendly Societies Act (No 25 of 1956), which included many of the social solidarity features seen in the current market. The first Medical Schemes Act (No 72 of 1967) then aimed to introduce structures to the market that would ensure that the funds remained sustainable and offered value to members [13].

In 1993 the Medical Schemes Act of 1967 was amended, ushering in a period of partial deregulation which precipitated the involvement of for-profit entities in the market (notably, third-party administrators and large insurers). These dynamics also favoured the development of open schemes, and the involvement of brokers in product distribution. One of the changes introduced was the

⁴ 13. Van den Heever, A., *Review of competition in the South African health system*. 2012, Competition Commission: Pretoria. This document contains a fuller history of medical schemes for interested readers.

allowance of cover and premiums to be subject to risk-rating⁵. In many cases this led to the exclusion of older and sicker people from cover [2].

Much of this deregulation was reversed by the introduction of the new Medical Schemes Act (No 131 of 1998) which came into effect in 2000. The Medical Schemes Act of 1998 reintroduced social solidarity principles into the medical scheme market, including:

- **Open Enrolment.** Under the revised Act medical schemes cannot refuse access to any prospective member based on risk factors. This implies that no one can be excluded from cover if they are able to afford the premium.
- **Community rating for all members.** The Act stipulates that contributions can only be varied by option choice, income, and number of dependants and/or beneficiary type (i.e. whether the member is the principal member, an adult dependant or a child dependant); and
- An extensive **Prescribed Minimum Benefit (PMB)** package, to be paid in full on all medical scheme options.

Since the introduction of the Medical Schemes Act in 2000 there has been one material update to the regulation which added a list of chronic conditions to the list of PMBs.

Medical schemes operate as non-for profit trust funds. Each fund is managed by a dedicated Board of Trustees (BoT). It is the directive and responsibility of the BoT to ensure that the funds adhere to the requirements to the Medical Schemes Act (MSA). All medical scheme funds are regulated by a separate and independent regulating authority - the Council for Medical Schemes (CMS).

Medical Schemes are the only financial services providers in South Africa that are regulated by a separate independent regulating authority.

The latest version⁶ of the MSA defines the business of a medical scheme as:

“undertaking liability in return for a premium or contribution

- *to make provision for the obtaining of any relevant health service;*
- *to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and*
- *where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.”*

All medical schemes need to comply with the requirements of the Act, unless they have a specific exemption. There are a few low-income industry-based schemes (Bargaining Council schemes) that

⁵ Risk rating refers to the practice of varying cover and the cost of premiums by health status and other related factors such as age.

⁶ This definition has been slightly altered as per the Financial Services Laws General Amendment (FSLGA) Act, no. 45 of 2013 as gazetted on the 16th of January 2014. However, the implementation of the changes have not been enacted as at the time of writing.

are exempted from providing the PMB package. Bargaining council schemes need to continually prove that it would not be financially viable if they had to comply with the full set of regulations.

Schemes are currently required to hold solvency capital of 25% of gross contributions, and there are restrictions on the asset classes in which schemes can invest [14]. In late 2015 the CMS published a proposed solvency framework based on the principle of risk-based capital [15]. There have been numerous calls over the years to review the solvency framework [16-19].

4.2. Health insurance history

Health insurance benefits are usually stipulated as a cash sum that is either linked directly to the cost of treatment or related to a set scale. There are a wide range of potential product types encompassed under this definition: gap cover, shortfall cover, top-up cover, hospital cash cover, major medical cover, ancillary cover (e.g. dental cover), travel insurance etc. In practice products vary greatly internationally due to differences in regulation as well as in customer needs and demands. The level of care offered by the state also has an impact on the demand and scope for health insurance in a particular market.

Health Insurance products are relatively new in the South African market. The first products were developed by long-term insurers in the 1980s, having been influenced by products in the United States. The concept of cash-based health insurance offerings originated from Major Medical Cover that was first introduced in the USA in the 1950s. The market grew and developed in the 1990s during the period of medical scheme deregulation: it was during this period that large insurers developed an interest in healthcare as a potentially profitable market. During the early 1990's health insurance grew rapidly in the local market, and products were made popular via above-the-line marketing (radio and mail adverts).

Local insurers also proved innovative and pioneered Dread Disease (or Critical Illness) cover during the 1980's. Dread Disease cover provides lump sum cash benefits on the diagnosis of a specified illness. The products were originally sold with the aim of assisting HIV sufferers with the cost of the disease.

Insurance products are regulated under one of two acts, depending on whether the products are sold by long-term or short-term insurers:

- The Long Term Insurance Act (No 52 of 1998)
- The Short Term Insurance Act (No 52 of 1998)

The current forms of the Long Term Insurance Act and Short Term Insurance Act were drafted in tandem with the MSA of 1998 and also came into force in 2000.

The Short Term Insurance Act defines an accident and health policy as follows:

“Accident and health policy” means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a:

- *Disability event;*
- *Health event; or*
- *Death event.*

Contemplated in the contract as a risk, occurs, but excluding any contract:

in terms of which the contemplated policy benefits:

- *are something other than a stated sum of money;*
- *are to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and*
- *are to be provided to any provider of a health service in return for the provision of such service; or*

of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act No. 72 of 1967)

- *which relates to a particular member of the scheme or to the beneficiaries of such member; and*
- *which is entered into by the scheme to fund in whole or in part its liability to such member or beneficiaries in terms of its rules and includes a reinsurance policy in respect of such a policy.*

Under the Long Term Insurance Act a health insurance product would fall under the category of a health policy as defined by the Act:

“Health policy” means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event, but excluding any contract of which the contemplated policy benefits:

- *Are something other than a stated sum of money;*
- *Are to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and*
- *Are to be provided to any provider of a health service in return for the provision of such service; or:*

of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act No. 72 of 1967)

- *which relates to a particular member of the scheme or to the beneficiaries of such member; and*
- *which is entered into by the scheme to fund in whole or in part its liability to such member & or beneficiaries in terms of its rules and includes a reinsurance policy in respect of such a contract;*

The regulating body for health insurance products is the South African Financial Services Board (FSB). The Association for Savings and Investments in South Africa (ASISA) represent the interests of long term insurers while the South African Insurance Association (SAIA) represents short term insurers.

4.3. Evolution of demarcation

The Medical Schemes Act was located within a Social Health Insurance policy framework which envisioned gradual extension of risk and income cross-subsidies, and eventual implementation of mandatory contributions for those earning above the income-tax threshold [2]. It was in this context that it became necessary to clearly demarcate between medical scheme and insurance products.

An agreement was reached between the Life Office Association (LOA) (the industry representative body for long-term insurers at that time) and the CMS, setting out demarcation between medical schemes and health insurance products. This was formalised in 2004 when the CMS, FSB and the LOA, released a demarcation document to provide clarity to all stakeholders regarding the definition of the “business of a medical scheme” as defined in the MSA. The key aim of this demarcation, which was aimed at the long-term insurance market, was to ensure that products sold on a for-profit, risk-rated basis did not undermine medical schemes by cherry picking the young and healthy.

This original demarcation agreement did not have full legislative standing. But it did set out the proposed conditions under which the products would operate. By implication the demarcation between health insurance products and medical schemes was dependent on the interpretation of the MSA. When the Act was originally promulgated it was generally accepted that the MSA would be interpreted to mean that all products aimed at meeting the cost of healthcare would be deemed the business of a medical scheme. From interviews with stakeholders it is apparent that this view was generally accepted by the industry and care-based health insurance all but disappeared from the South African market post the implementation of the MSA.

It subsequently emerged that the demarcation framework had two key flaws: it did not explicitly consider the short-term insurance market, and the definition of the business of a medical scheme was technically flawed.

A conflict between a short term insurance provider (Guardrisk) that sold a gap-cover offering and the CMS acted as a catalyst for reviewing the demarcation agreement. The product in question provided benefits for the exact shortfall between medical scheme reimbursement for specialist in-hospital treatment, and what the provider actually charged. This insurance product therefore provided cover directly related to the actual cost of care. Consequently, the CMS considered this category of products to be in contravention of the definition of a medical scheme. The CMS was concerned that these types of products encouraged younger healthier medical scheme members to select cheaper medical scheme options in combination with insurance products. This dynamic arises because the insurance products were risk-rated and the medical scheme options were community-rated. The consequence is an undermining of the risk cross-subsidy between medical scheme members. In 2006 the CMS challenged the validity of these products in court.

This court case (Case No. 168, 2008) is referred to in this document as the Guardrisk case. Guardrisk countered the demarcation agreement by arguing that policyholders had to belong to a medical scheme in order to buy the gap cover product. They postulated that gap cover would in fact encourage medical scheme membership. They further argued that the benefits offered by gap cover products do not compete with the benefits of any existing medical scheme. As such the products cannot be viewed as conducting the business of a medical scheme.

In December 2006 the High Court ruled in favour of the CMS. Guardrisk appealed the judgement and the case was escalated to the Supreme Court. On the 28th of March 2008 the Supreme Court ruled in favour of Guardrisk and the company was able to resume operational activities.

The basis of the ruling was on the use of “and”/“or” in the three components of the definition of a medical scheme, and how this altered the interpretation of the Act. The ruling hinged on the fact that gap cover products did not meet all three definition bullets in the MSA and thus they could not be deemed medical scheme products and were not subject to the MSA. This implies that only those entities that meet all three definition bullets are deemed to be doing the business of a medical scheme.

The ruling led to a mix of outcomes. Some insurance companies closed their health insurance products to new business based on discussions with the CMS. But the ruling also led to a number of new health insurance offerings being launched in the market.

In the stakeholder interviews, a number of participants noted the Guardrisk ruling as a turning point in their operations. Many medical schemes also interpreted the court case as legitimising the idea of a dual product solution⁷. Over time, health insurance products in South Africa have adapted to be more flexible and to offer benefits more closely targeted at the cost of care. Products of this nature blur the lines between medical schemes and health insurance. Some insurers have even entered into direct arrangements with providers and offer policyholders access to a network of health professionals and private hospitals.

On the 2nd of March 2012 the National Department of Health (NDoH) in conjunction with the CMS and Financial Services Board (FSB) released a discussion document outlining a proposed revised demarcation agreement. A further revised version of the proposed demarcation regulations were gazetted on the 29th of April 2014.

The main proposed changes included:

- Amending the definition of what constitutes a medical scheme and including the requirement that health insurance products need to complement and support the business of a medical scheme;
- Additional regulatory authority afforded to the CMS and Medical Scheme Registrar regarding the regulation of health insurance products;
- The potential removal of risk based underwriting and reduction of broker commission for insurance based products;
- The inability of health insurance offerings to indemnify policyholders for health related expenses;
- All benefits would need to be clearly stated in Rand terms before a claim incident; and
- Preventing health insurers from offering a range of benefits or bundled offerings designed to mimic the benefit structures of medical schemes.

The proposed demarcation regulations made specific reference to the amendment of the definition of a medical scheme in the Financial Services Laws General Amendment (FSLGA) Act (no. 45 of 2013, as gazetted on the 16th of January 2014). It replaces the contentious “and” in the definition of the business of a medical scheme with “or”. This was a direct response to the Guardrisk case. The change is intended to remove the legal precedent that was established by the Guardrisk case. The proposed alternative definition implies that any product that performs any one of the three components will be deemed as conducting the business of a medical scheme. This legislation has been passed. However, it stipulates that the change will only be effective once the demarcation guidelines are finalised. There is no certainty as to when this will happen.

⁷ Dual product solutions relates to a combined offering made of in part of a medical scheme and in part from a top-up insurance offering.

This change will imply that a much broader category of products will fall under the ambit of the MSA. The explanatory memorandum to the second draft regulations reiterates that all such health insurance products would be prohibited unless explicitly exempted through the demarcation regulations.

4.4. Regulatory initiatives aimed at the low-income market

There have been two major regulatory initiatives aimed at extending medical scheme cover to the low-income market. The first was the “Consultative Investigation into Low Income Medical Schemes”, or LIMS process. A Ministerial Task Team (MTT) initiated the LIMS process in 2005, with significant industry involvement. The second, more recent initiative, was a proposed framework for schemes to become exempt from aspects of the MSA in order to provide Low Cost Benefit Options (LCBO).

The LIMS report found that the scope of benefits offered by schemes needed revision, since the PMBs create a high base cost of cover in addition to driving the price of medical scheme options upward [20]. The LIMS process stated that there exists a clear trade-off between the “comprehensiveness of cover offered by the PMBs in the current medical scheme market, and the affordability barrier that these PMBs create for low-income households” [20]. The LIMS process looked at a revised minimum benefit package that could be offered to low-income individuals [20]. The need for simplicity in the benefit design was emphasised [20].

The LIMS process conducted a nationwide household survey in order to identify the key characteristics of benefit design that low-income households favour. They found that low-income households place greater value on coverage for out-of-hospital benefits than for in-hospital benefits: “the relative value placed on comprehensive out of hospital care was approximately 50% higher than that placed on private hospital cover”. The LIMS process also suggested that a product for this low-income market should not have co-payments, levies or medical savings accounts.

Additional considerations emanating from the LIMS process included the implementation of income limits (to demarcate LIMS schemes from other medical schemes), as well as the encouragement of employer subsidies and government subsidies.

During 2015 the CMS engaged with the medical scheme industry on extending cover to the lower-income sector of the market [21, 22]. Drawing from these industry discussions, the proposed package to be covered by LCBOs was similar to that envisaged under LIMS: preventative and primary care with some cover for chronic conditions [23]. Key discussion points related to the solvency requirements of the LCBO’s, the level of non-healthcare costs associated with the offerings as well as the needs of the uncovered population.

In September 2015 the CMS released a circular outlining the format under which the LCBOs would function [23]. It is important to note that the LCBO framework was on an exemption basis (i.e. market participants would be exempt from particular requirements of the MSA in order to offer LCBOs) as opposed to requiring new legislation or amendments to the MSA to be passed. This is enabled by powers, granted to the CMS in the MSA, to exempt medical schemes from certain provisions of the act. The particular aspects of the regulation where exemption was envisaged were: open enrolment, PMBs and broker remuneration [23]. The exemption approach, whilst less rigorous, allows for more responsive regulation: an important consideration given the full legislative calendar of the NDoH.

In October 2015, the LCBO directive was retracted, and to date no update regarding the LCBOs has been issued [24]. The retraction was seemingly in response to criticisms, in part relating to the adequacy of the proposed benefit package [25]. From an ideological perspective, the LCBO approach runs counter to the proposed NHI which foresees a single benefit package for all South Africans (as opposed to benefit packages differentiated on the basis of affordability) as well as a reduced role for medical schemes [25].

The fact that both the LCBO framework and the demarcation process have stalled is unsurprising given the tensions and interdependencies between the two markets for pre-funded health finance, particularly relating to low-cost offerings. In the meantime, there has been increased activity relating to risk-rated health insurance products outside of the medical scheme environment. These products often mimic aspects of medical scheme coverage, but offer less comprehensive cover and are therefore substantially cheaper. It is likely that these products would fall outside of the envisaged demarcation regulations and would need to be either phased out or incorporated into the medical scheme environment. However, requiring these products to cover PMBs would raise the cost of cover substantially.

Forces shaping the industry

This part of the report looks at the major forces shaping the pre-funded healthcare financing industry. This involves considering the stakeholders that funders engage with, and their influence on the strategic direction taken by funders. Employers play a key role in driving the demand for healthcare financing solutions, as well as enabling affordability through subsidising the cost of cover. Third-party service providers, such as administrators and managed care organisations, have an important role to play. For open schemes in particular they introduce a profit (and growth) incentive into the not-for-profit medical scheme environment. Non-healthcare costs influence the total cost of cover, and hence the competitiveness of this market is relevant to the ability of the system to deliver low-cost product solutions. Large multi-product financial services firms have played an increasingly dominant role in the healthcare financing market. Furthermore, it is integral to consider distribution (and the integrated offerings and ancillary benefits that go hand in hand with distribution strategies), as distribution of products is key to their success. Lastly, the underlying market for medical goods and services, including purchasing functions, pricing and utilisation, also contributes to shaping the pre-funded health finance market.

5. Role of employers

Employers have a prominent role to play in the health financing market. Their role can be particularly effective in the low-income setting.

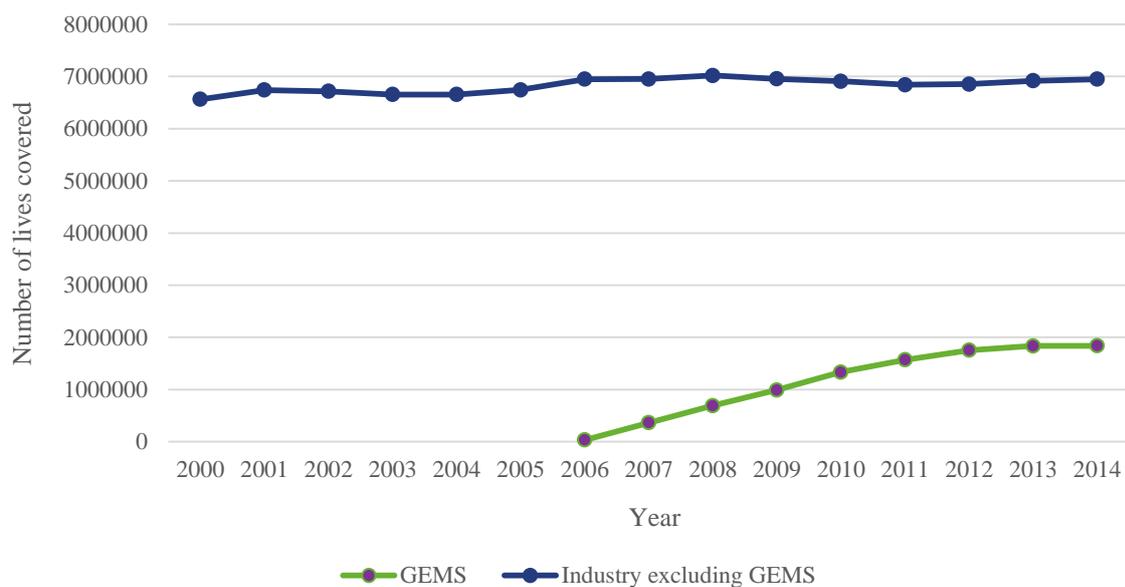
Employers have been one of the largest catalysts in the global health funding market [26]. Large employers are in a unique position to drive transformation within the healthcare market: they can act as large purchasers of healthcare services for their employees and they are adept in quality improvement and supplier management [26]. Whilst both healthcare providers and health funders may have competing objectives with the best interests of the individual, for example profit criteria, employers' interests are arguably more aligned with the individual [26]. As discussed in Section 3.2, the history of the medical scheme market is rooted in employer-based funds.

Condition of service based membership. In recent years, participation by the majority of employers has been limited to making medical scheme cover a condition of service (for those earning above a certain level), and selecting a scheme or panel of schemes for employees [27]. This limited role is largely attributable to the increased popularity of cost-to-company remuneration [2], a tax credit that is agnostic about whether the employer or employee funds medical scheme cover [28] and the changing nature of employment with fewer people staying with a single employer over their careers.

The 'medical scheme membership as a condition of service requirement' imposed by employers plays an important role in stabilising the medical scheme market. This effectively creates mandatory membership for a portion of the market, and thereby diminishes the impact of anti-selection at an industry level. According to Discovery Health a significant proportion of open scheme beneficiaries join through their employers as a condition of service [27].

Employer-subsidised membership. Employer-subsidised healthcare has proven to be very effective for increasing health cover take-up and affordability. The best local example of this is the Government Employee Medical Scheme (GEMS) where a subsidy offered by the state to employees of qualifying entities via their employers is seen as one of the only avenues of "real" new growth in the medical scheme market.

Figure 4: GEMS impact on industry growth 2000 - 2014



Source: consolidated CMS annual reports

There has been consistent downward pressure on employer subsidies over time [2, 29, 30]. Financial support for post-retirement health cover has also declined over time, in part due to changes in accounting rules [30]. This has led to many companies reconsidering both their pre-retirement and post-retirement subsidy structures with an eye to reducing this liability over time [30]. This contributes to affordability pressure. The provision of subsidies also varies considerably by industry and by income [31].

Restricted membership funds. Some employers choose to set up their own in-house fund to provide for the healthcare needs of employees. Doing so allows the employer greater influence over benefit design and the cost of cover. However, this model is only practically feasible for large employers [13] or well-organised industries. These restricted funds are characterised by generous benefit structures and contribution tables that allow for effective cross subsidies between income bands [2]. The latter make the products much more affordable to the low-income employees. However, with the exception of GEMS, the popularity of employer-based restricted medical schemes has reduced over time in favour of open schemes and a higher level of choice. The number of restricted schemes has reduced from 115 in 2000 to 59 in 2005 (Figure 7).

Health insurance products offered at group discount rate. Health insurance products can be made available to blue collar employers at a significant group discount. Whilst medical schemes are not able to differentiate the price of cover between individual members and members of employer groups, insurers are able to do so. Health insurance providers are able to offer significant discounts to employer groups of sufficient size. If the latter is combined with even a modest subsidy from the employer a health insurance product that would normally be unaffordable can be offered at such a level that the insured employee can purchase cover for himself and a number of family members.

Own healthcare facilities. There are a number of examples of employers, particularly within the mining sector, that are actively investing in healthcare facilities. For example, Sasol, which provides medical benefits to its higher-income employees through the restricted medical scheme Sasolmed, has

opened a number of healthcare centres as part of its strategy to make tangible differences to the communities in which they operate [32] [33].

Prefunded occupational healthcare. Occupational health in South Africa is a complex area influenced by a wide range of legislation [31], and falls outside of the scope of this report. In addition to direct provision employers are also able to pre-fund care. Occupational health financing products facilitated by worksite facilities can be effective in preventing the poverty cycle. Employers are able to pre-fund care for employees under an occupational health framework (with tax benefits). These products typically offer benefits such as primary-care consultations and minor treatment as well as certain medications via on-site facilities or a network of providers⁸. While the care under this arrangement does not extend to the family of the policyholder it can be an effective and affordable model to keep the breadwinner of the family healthy. There is no data on the extent of coverage provided by these vehicles, although there is some evidence to suggest that the reach is fairly limited [31].

6. Third-party service providers

The core functions of a medical scheme, as outlined by the MSA, relate to governance and decision making. However, a successful scheme needs to engage in a host of activities on a daily basis, many of which are outsourced to third-party service providers. Whilst medical schemes are not-for-profit entities overseen by boards of trustees, with no outside contributors of capital, they are surrounded by (and often confused by the public with) a number of for-profit entities that provide a range of services such as administration⁹, marketing, managed care¹⁰, consulting and advisory services.

The relationship between fund and third-party service provider presents an intricate balance between the for-profit incentives of administrators and the non-for profit ethos of the medical scheme industry.

Too offset this, the MSA mandates an arms-length relationship between funds and service providers. The CMS has endeavoured to strengthen governance in the medical scheme industry, with a number of high-profile examples of schemes being placed under curatorship [34-37]. The regulator has also focused on monitoring non-healthcare costs as a means of limiting the extraction of profits from schemes, particularly following an exposé of the use of reinsurance in such a manner [38]. Van den Heever (2012) usefully distinguishes between strong schemes and weak schemes based on whether schemes require service providers to bid for business or whether relationships are entrenched [13]. GEMS is a good example of a strong scheme: the scheme puts all outsourced services out to tender on a three-year cycle, and administration and managed care services are split between different service providers.

A good example of the tension between open schemes and their service providers relates to the issue of scheme growth. Solvency requirements for schemes are defined as a proportion of gross contributions. Consequently scheme growth puts pressure on solvency margins and may therefore be resisted by scheme trustees. However, membership growth directly translates to increases in revenue

⁸ See <http://www.universal.co.za/Downloads/OccupationalHealth.pdf> as an example

⁹ Medical scheme administrators provide services such as collecting contributions, paying claims and interfacing with members.

¹⁰ Managed care organisations (MCOs) undertake much of the purchasing function on behalf of schemes by rationing benefits and engaging with healthcare providers. Examples of managed care programmes include benefit pre-authorisation, disease management, high-risk member management and the establishment of clinical protocols.

and profit for third-party administrators. This is because fees are normally based on a set amount per beneficiary or per member.

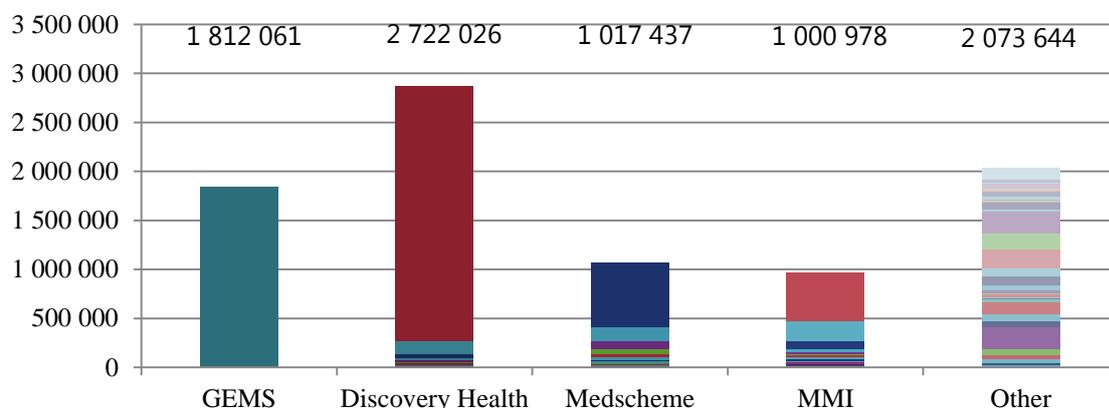
The average administration and managed care costs in the open scheme market amounted to R 183 per beneficiary per month in 2014. In 2014 these costs ranged from R 82 per beneficiary per month to nearly R 400 per beneficiary per month. This is particularly relevant to the low-income market. These non-healthcare costs were one of the key areas of concern during both the LIMS and LCBO processes. Even if the average administration and managed care costs were halved, under an LCBO framework these costs would constitute a significant portion of the total cost of cover.

Both administrators and managed care organisations provide sophisticated services including real-time processing of claims and business-to-business capability (between funders and healthcare providers). *These service providers house much of the intellectual capital, systems, clinical protocols and purchasing capability in the South African private health system. As insurers venture into providing indemnity cover, the question arises regarding the need for these capabilities to support insurers.*

The third-party service provider market has become increasingly concentrated. The top three administrators held 49.3% of market share in 2002 [2], this had increased to 80% by 2014. In part, this has been driven by amalgamations between medical schemes. However, there have also been market withdrawals and amalgamations between service providers (for example, Metropolitan and Momentum merged resulting in two service providers being part of the same entity MMI Holdings). In addition, because medical schemes are governed via boards of trustees, it is possible after following proper processes for schemes to choose to switch services providers. This highlights some of the risks present in third party administration and managed care. The concern would be that changes in competitive dynamics would influence the cost of administration and managed care services.

The market is dominated by Discovery Pty Ltd, Medscheme and MMI Holdings (Figure 5). A number of other smaller players co-exist in the market, including Primecure, Universal healthcare, Agility and Eternity. As the underlying medical scheme market consolidates further, more stakeholders are expected to drop out.

Figure 5: Third party service provider market share (by lives administered) 2014



Source: Council for Medical Schemes Annual Report 2013/14 [39] Note: GEMS is illustrated separately because it splits administration and managed care services across Medscheme and MMI.

Some schemes (open and restricted) choose to retain these costs internally and are termed self-administered. For self-administered funds, costs like staff and systems are paid directly by the scheme. This model has some advantages, but the non-profit environment means a lack of incentives for growth and innovation. In addition, there are reduced opportunities for economies of scale. Consequently, the majority of funds choose to outsource these functions and the proportion of self-administered schemes has declined over time (11.9% of the market in 2002 [2] down to 6% of the market in 2014).

6.1. The role of large multi-product financial services firms

Many of the market participants in the pre-funded healthcare financing market originated from the life insurance industry. Medscheme, which specializes in third-party administration and managed care, is the largest exception of an independent niche market player.

Prior to the period of deregulation in the 1990s medical schemes were largely considered a cottage industry. Being not-for-profit meant that capital and innovation were not attracted to the market, and competitive forces were weak. But the relaxation of medical scheme regulation in the 1990s led to greater commercial opportunities. This led to large financial institutions entering the market while applying life-insurance-style underwriting and distribution models [13].

Over time a large number of insurers have established (for-profit) administration and managed care businesses, and either established new schemes or taken over the administration of existing schemes. Examples include Fedsure, Norwich Life, Old Mutual, Sanlam, Southern Life, Liberty, Momentum, Metropolitan and Discovery. The various players have had varying degrees of success, struggling with the risk profiles of the schemes they are associated with and with growth. The market has seen large players exit and then subsequently re-enter: Old Mutual, Sanlam and Liberty are all good examples.

Box 1: The evolution of the participation of the large financial services firms

Discovery Health was initially part of the Momentum group (which is now part of MMI Holdings). They have a different history to the other large financial services firms in that they started out as a healthcare focused business, and have subsequently expanded into life insurance and other financial services offerings. Their affiliated scheme (Discovery Health Medical Scheme) being the largest open scheme in the market.

The financial services company with the second most substantial administration and managed care business is MMI Holdings. MMI Holdings was formed out of a merger between Momentum and Metropolitan, both of which had healthcare businesses, albeit with very different target markets and strategies.

Momentum administers a Momentum-branded medical scheme. The Momentum medical scheme has survived and thrived in a tough operating environment, maintaining a good risk profile and steady but slow growth. Metropolitan Life started a health division through buying out administration capability from the Bankmed medical scheme. They went on to specialize in administration and managed care for restricted medical schemes, particularly parastatal schemes. For some time they were one of the largest administrators and managed care firms, providing administration to a range of schemes, large and small. But in 2015 they lost market share via two large contracts that moved to competitors: Bankmed to Discovery Health and Polmed to Medscheme.

On the back of a very successful health insurance product (Medical Lifestyle), Liberty Life entered the medical scheme administration market with an open scheme called ProVia. By that stage Discovery Health was already growing rapidly and Liberty wanted to compete directly with them. ProVia grew slowly over the late 1990s and early 2000s but did not reach critical mass. In 2002 Liberty sold their administration business to Medscheme. Liberty subsequently re-entered the medical scheme administration and managed care business with an open scheme called the Liberty Medical Scheme (LMS).

Medical Lifestyle was a long-term insurance product that offered stated cash benefits per medical event. The benefits were linked to the severity of the incident and aimed to cover the cost of care. The products was closed to new business with the introduction of the MSA and accompanying demarcation agreement in 2000.

For a time, Old Mutual also offered an open scheme as part of their offering (Caremed, later rebranded as Oxygen). Oxygen medical scheme survived for some time, but could not maintain critical mass and a good risk profile. The fund amalgamated in 2008 and Old Mutual exited¹¹ healthcare, selling some of their administration capability to Medscheme.

Sanlam has entered and exited the healthcare administration and managed care market a number of times over the last two decades. Currently it has formed an equity relationship with Medscheme in order to pursue potential synergies. The parties are seeking to exploit their relative strengths, with Sanlam's distribution and loyalty program capability, and Medscheme's administration and managed care capability.

Distribution is a key requirement to the success of any financial product offering. Hence, from a scheme perspective, stronger relationships with large insurers are desirable in order to more effectively market their offerings and benefit from the established distribution networks of large insurers. In most cases this takes the form of the scheme using the financial services firm as the scheme's administrator.

The market for insurance is progressing naturally toward an integrated model with most financial services firms acting as generalists. This has led to many large insurers seeking to offer health coverage or secure a partner in the medical scheme market. Some of the larger open schemes are linked to brands that offer integrated solutions (for example, loyalty and wellness programmes and gap cover integrated with medical scheme cover). Some funds that have employed an effective strategy of this nature experience "lapse/churn" rates of just 4% [27].

*It is important to note that consumers are not always aware of the legal distinction between schemes and their service providers, particularly in examples where the names of the entities are similar*¹². This brand confusion is particularly associated with large multi-product financial services entities.

It is likely that an attractive offering in the lower income and uncovered market segment will signal the next wave of competition and innovation amongst large financial services firms, whether in the medical scheme or health insurance arenas. The potential of health financing has clearly held allure for large financial services firms, and is part of providing a full suite of products. But relatively few have been able to achieve longevity. The next frontier in this market is the lower-income market as there exists a substantial market with unmet needs.

¹¹ Old Mutual still maintains a limited book of short term health insurance products.

¹² See www.momentum.co.za and <https://www.momentum.co.za/for/you/products/health>. Similarly, www.discovery.co.za and <https://www.discovery.co.za/portal/individual/medical-aid>. Also, <http://www.libertyhealth.co.za/> and <http://www.libertymedicalscheme.co.za/>

To date many of these large firms have been apprehensive to enter the health insurance market due to the uncertainty surrounding demarcation regulation. But this sentiment is changing as the inability of the medical scheme market to service the needs of these consumers is becoming evident. It is likely that this apprehension will continue for the immediate future, *but if a legitimate framework can be devised the large financial services firms with their product distribution capability could be one of the key market participants in providing products for the lower income market.*

7. Integration, distribution and sales

Effective distribution has been a major factor in influencing the growth of open schemes. Strategies employed have included extensive marketing campaigns, dedicated sales forces, and offering ancillary product offerings to increase the commission potential for agents. Most of the large open schemes employ a range of strategies and carry extensive marketing budgets (including some costs which are embedded into administration fees).

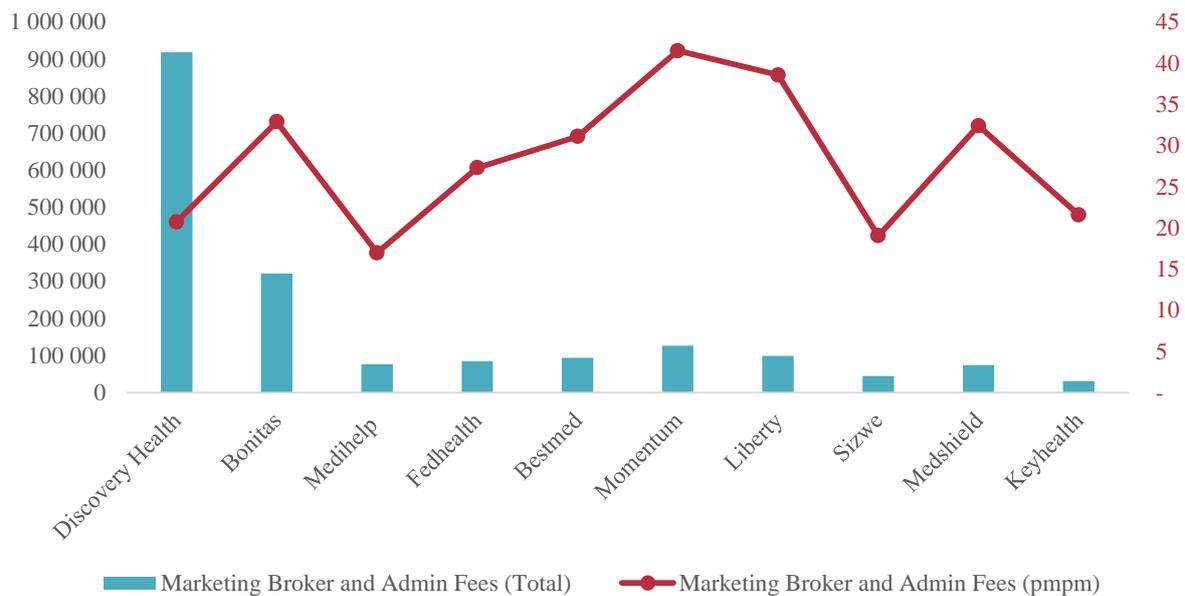
Complex products like healthcare products are normally “sold” as the buyer is often unaware of the need, product or the cover details. The South African market is no different with many of the covered medical scheme population viewing the products as overly complex. Normally complex product offerings are sold via an agency model that offers support and information to the end user regarding the details of the offering.

Commission for medical scheme products is capped and limited to a maximum of R 80 (excluding Vat) per member per month [40]. This amounts to approximately 2.7% of the average open scheme premium [39]. As a monetary incentive this is not very appealing given the complexity of the product offering and the likely time and effort required to research and understand the products. In order to sell medical scheme products or advise members, intermediaries also need to be licensed financial service providers in terms of the FAIS Act. Being able to secure an additional source of commission for brokers via an ancillary product offering is therefore a key drawcard for sales.

This has resulted in the marketing of open medical schemes becoming more complex. An integrated strategy or a close tie to a large brokerage brings to the fore a number of governance questions given the incentive to extract profits from medical schemes. The open scheme market also applies direct marketing to a certain extent, this is funded from member contributions.

The figure below illustrates the marketing and brokerage costs of the 10 largest open funds in the industry during 2014 – in total and per member per month.

Figure 6: Marketing and Broker Fees – 10 Largest Open Schemes in 2014



Source: 2013/2014 CMS Annual Report [39]

Large schemes tend to have the most effective distribution channels (particularly for schemes that have grown organically, a causal relationship can be surmised). As outlined above large schemes spend a significant amount on marketing and intermediary fees. It is interesting to note that there is a general upward slope in the per member per month marketing costs as scheme size decreases. This relates to the high cost in absolute terms of direct marketing campaigns via television, radio or sponsorship. Larger schemes therefore benefit directly from their scale in that they are able to engage in more comprehensive marketing campaigns for a lower proportional per member cost.

Scheme growth is based both on acquiring new members and on retaining the current membership base of the fund. Considering retention shifts the focus in the market from a short-term sales-driven focus to a longer-term holistic value proposition. The latter implies a more active relationship between the fund and its membership base. Consequently there has been an increase in the role of loyalty and wellness programmes in the market. The products also provide increased commission potential for the sales agent: these programmes often offer a greater commission payment than the scheme itself (as a consequence of not being subject to the medical scheme regulatory cap). The inability of self-administered schemes to provide loyalty programmes places these schemes at a competitive disadvantage.

Due to the success of market-leader Discovery Vitality (part of the same holding group as the administrator and managed care organisation Discovery Health) these programmes are perceived as a must-have in order to compete, particularly for other large financial services firms who see these programmes as a means of enabling cross-selling of different product lines (such as life insurance). However no programme has managed to effectively compete with Vitality at scale. In part this is due to the changes in the regulatory environment as well as the constant innovation of the product.

Both schemes and large financial services firms have realised the value in incentivising healthier behaviour in scheme members. For schemes doing so may help improve the scheme’s risk profile (both through selection effects and behaviour change). For financial services firms there may be

additional benefits for their life insurance risk pool. Loyalty programmes have consequently undergone a gradual shift towards providing rewards based on health-related behaviour such as exercise and diet, aimed at incentivising a healthier lifestyle. This ability to interact with a client and influence their health status has further highlighted the partnership potential between schemes and large insurers. This dynamic does not serve the lower-income segment of the market particularly well: particularly since loyalty programmes add to the cost of cover.

The vast majority of restricted schemes, in contrast, have no need to employ a dedicated marketing strategy or to fund broker commissions. However, many restricted schemes have partnered with short-term insurance providers that sell products like gap cover and premium waiver insurance on a group basis into the restricted scheme base. This implies that while the brokerage model does not apply directly to the restricted scheme market, the membership base would still be exposed to indirect broker fees via a 3rd party agreement.

As compared to schemes, health insurance is normally either sold direct¹³ or distributed via a network of agents. The strategy is also dependant on the target market and whether the offerings are sold to groups or individuals. Niche health insurance is often sold via worksite marketing in close collaboration with the employer.

A number of health insurance companies have increasingly employed direct advertising via radio, television or SMS campaigns. These campaigns often outline the simplicity of the products and benefits as key drawcards. In consultation with insurers these seem to be effective strategies as many of the participants noted significant sales numbers (although they also note concerns with high lapse rates).

The levels of commission for health insurance offerings generally amount to 20% of gross premium. While this is a much higher percentage it is often comparable in nominal terms to most medical schemes commission levels. One of the proposed changes in the demarcation agreement that generated a significant amount of reaction was the proposed cap on commission for these products. This could decrease the incentive for brokers to sell health insurance products.

R 80 commission would equate to a commission level of 20% on a gross premium of R 400.

Integration, brand awareness and loyalty are emerging as the key concepts for the future. Successful marketing is a necessary component for nearly all health product offerings with the exception of restricted medical schemes.

8. The underlying market for medical goods and services

Particularly in the case of indemnity health insurance products, there is a strong relationship between healthcare financing vehicles and the underlying market for healthcare goods and services. To the extent that the underlying market does not function well there is a direct impact on the affordability of

¹³ Direct sales refer to sales facilitated by headline marketing that prompt the potential client to contact the insurer directly without the need to buy the offering via a broker.

pre-funded health cover. In this section we consider the purchasing function performed by medical schemes as well as some of the challenges affecting the underlying cost of private healthcare.

8.1. The purchasing function

In addition to a revenue collection and risk pooling function, healthcare funders can also play a purchasing role in the healthcare system. This means that funders (or their third party service providers) make decisions on what medical goods and services to purchase (i.e. they play a role in rationing care), they negotiate with healthcare providers and they develop business-to-business relationships with providers.

Effective purchasing requires a number of building blocks including clinical coding, statistical groupers, quality measurement, sophisticated systems and relationships with healthcare providers. The medical scheme environment has many of the capabilities required for active purchasing. However, there are a number of constraints on this capability being effectively used to reduce the cost of cover (for example, competitive pressure not to limit the choices members have of which providers to use).

The purchasing function introduces complex agency relationships into the healthcare financing market. Decisions regarding the care provided to a patient are influenced by providers, patients and managed care organisations. Consequently there is frequently tension between managed care organisations and providers over clinical matters.

The purchasing function has historically been stronger for medical schemes than for health insurance products. However, in recent times we have seen the emergence of short-term health insurance products that are based on networks of healthcare providers. This indicates the willingness of healthcare providers to partner with funders outside of the traditional medical scheme space and raises interesting questions regarding tariff negotiations.

8.2. Price and utilisation

The ability to offer affordable healthcare financing cover is determined to a large extent by the underlying cost of healthcare. At the time of writing, the Competition Commission was undertaking a review of the private health market, which raised a number of questions relating to market dynamics¹⁴. A full discussion of these issues falls outside of the scope of this report but importantly the underlying cost of care will be affected by the prices of goods and services and the extent to which care is utilised.

It is worth noting that the South African private market lacks price control mechanisms, as well as mechanisms to facilitate price negotiations between funders and provider (such as a bargaining chamber of sorts) [41-43]. The Health Professions Council of South Africa also provides no guidance to practitioners regarding the prices charged (although there are poorly enforced requirements for informed consent from patients), and providers are able to balance-bill patients (i.e. to bill the patient directly for amounts in excess of the tariff reimbursed by the funder). There are also questions relating to market concentration of providers (such as private hospitals, radiology and pathology services), market power of providers (for example, where there are shortages of certain medical specialities) and regulatory constraints on innovation in the delivery of care (for example, Health Professions Council

¹⁴ <http://www.compcom.co.za/healthcare-inquiry/>

of South Africa - HPCSA rules prohibiting the employment of doctors and inadequate m-health regulation).

Prior to 2004, fee-for-service tariffs were negotiated centrally between medical schemes (represented by the Representative Association of Medical Schemes, and later the Board of Healthcare Funders) and representative bodies of providers. These tariff schedules applied to a wide range of medical disciplines, including general practitioners, medical specialists and dental practitioners.

The central negotiation of tariffs was deemed anti-competitive by the Competition Commission in favour of individual negotiations between schemes and providers. This created a logistically unfeasible situation where each medical scheme was theoretically required to negotiate with each medical practitioner [43] – at the time there were more than 12 000 doctors operating in the private sector [44] and 131 medical schemes [45]. From 2004 the Council for Medical Schemes (CMS) published a reference tariff schedule, the National Health Reference Price List (NHRPL) as a guide for both schemes, in determining reimbursement levels, and providers, in price setting [46]. The Department of Health (DoH) took over responsibility for the NHRPL from the CMS from 2007. The NHRPL became referred to as the Reference Price List (RPL). The 2009 price list was subsequently declared as illegal on procedural grounds in a 2010 ruling by the Northern Gauteng High Court and therefore set aside.

Until November 2008, the HPCSA also published a price list (referred to as the HPCSA ethical tariff). These tariffs were meant to be used to determine whether a practitioner was overcharging, and as such represented a price ceiling [47]. Historically the ethical tariff has been roughly three times higher than the NHRPL [48]. The market is currently characterised by the absence of both a reference price list and an ethical tariff.

In addition, schemes are required to cover the PMBs at cost. They are therefore not allowed to impose a maximum tariff, unless that tariff has been negotiated with the provider concerned. This means that unless a scheme has a contract with a provider, the scheme will have to reimburse the provider at the price charged. The existence of PMBs, and the proportion of benefits that are PMBs, thus impacts on the prices encountered by medical schemes.

The utilisation of healthcare goods and services also impacts on the cost of cover. Increases in utilisation can be divided into demand-side effects (largely relating to the demographic profile of the risk pool) and supply-side effects. Supply-side effects largely relate to supplier-induced demand: the notion that due to information asymmetries, third-party payer effects and imperfect agency relationships, healthcare providers are able to drive up the demand for medical goods and services. There are also issues relating to the way in which care is organised: care in the private sector is fragmented and lacks co-ordination.

Schemes have increasingly made use of alternative reimbursement arrangements (such as capitation fees, fixed for hospital procedures and per-diem fees for hospital care) to reduce the misalignment of incentives between themselves and providers. As the market develops these models could also potentially be adopted for the health insurance market.

Market overview

This part of the report provides an overview of the various types of health funding products offered in the South African market. This is contextualised by the results of the Health Funding Register (HFR) as well as a number of scenarios regarding the affordability of the various products for different income levels. Please refer to Annexure 1 for details of this analysis. A review of the methodology used to create the HFR is also included.

9. Health funding products

As discussed, there are two main types of health funding products active in the South African market. Medical schemes operate as not-for profit trust funds while insurance offerings operate as for profit products. Three broad categories of health insurance offerings are discussed: top up insurance, cash-based insurance and cost-based insurance.

9.1. Medical schemes

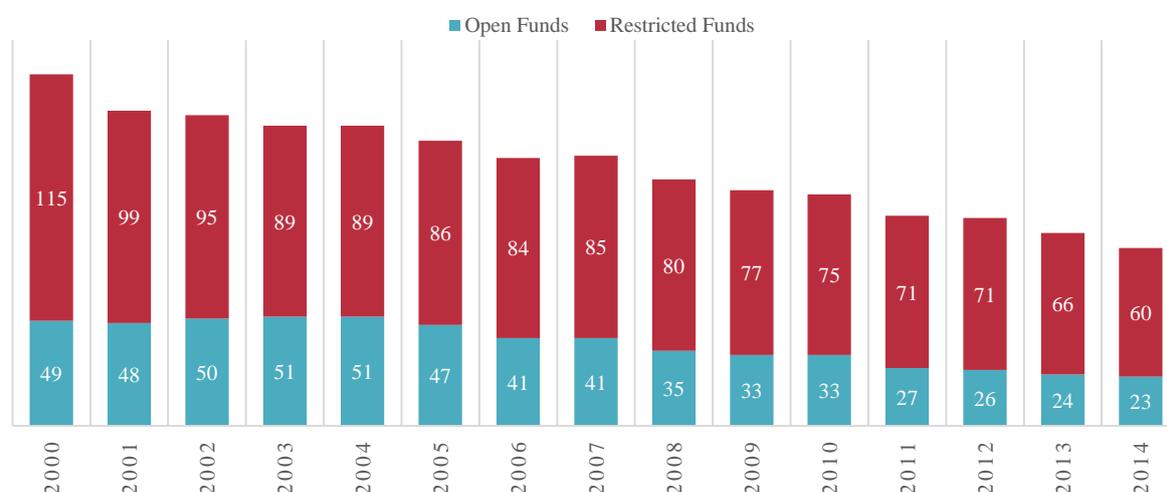
9.1.1. Open and restricted membership schemes

There are two main forms of medical schemes in the South African market: open and restricted. Together they provide cover to 8.8 million lives (16% of the South African population). The interplay and balance between open and restricted schemes is an important feature of the market and has also changed over time. Both types of schemes are permitted to offer multiple products referred to as benefit options [3]. Community rating is required for all products and occurs at the level of each benefit option.

The medical scheme market has consolidated over time. Often this is facilitated via smaller schemes being absorbed into larger funds as well as restricted schemes being absorbed by open schemes. In the case of the latter the restricted funds often have marginally worse risk profiles, but less anti selection risk than open schemes.

The figure below illustrates the number of medical schemes by year since 2000.

Figure 7: Number of medical schemes over time.



Restricted schemes cover approximately 3.9 million lives and are permitted to limit membership on the basis of:

- Employment in a particular profession, trade or industry;
- Membership of a particular employer or profession; and
- Membership of a particular professional association or union [5].

Open schemes cover approximately 4.9 million lives and are not able to set eligibility criteria and need to offer open access to anyone that can afford the premiums. Most open funds can be purchased directly online or via a brokerage/agency.

Eligibility is thus related to scheme type, member affiliation or status as well as the member's ability to fund the required premiums.

Medical schemes are the most comprehensive health funding products in the market and offer members a wide-ranging benefit package that at a minimum will constitute the full suite of PMB benefits. Costs routinely increase by more than CPI and the main cost drivers relate to the costs of benefits. These increases are related to both the rate of utilisation of medical services as well as cost increases for the services themselves. Other factors include the costs of reaching and maintaining solvency, administration and managed care fees. Open schemes also need to pay for non-health costs like brokerage services and marketing. The broker model is a primary distribution strategy for many open schemes along with headline and online marketing.

Provider engagements are often facilitated via contracts and service provider networks (Designated Service Providers – DSPs). In the case of the latter the provider is paid a set fee/tariff that is pre-determined contractually. Alternatively the service provider is paid at cost (non-network PMB claims) or at the pre-determined scheme rate.

A small subset of the restricted scheme market relates to so called bargaining council schemes. These schemes represent industry based restricted funds or options. The products offer limited benefits that do not need to comply with the full requirements of the MSA.

Eligibility is related to membership of a qualifying industry or employer. The funds have been able to attract a limited number of new lives into the market, but the strict eligibility requirements imply that the products are not applicable to the mass market.

9.2. Top Up insurance

Top up insurance cover represents insurance based offerings that fund shortfalls in medical scheme benefits. Typical benefits include the difference between a specialist's account and the amount a scheme typically pays for a procedure performed in hospital. Benefits are normally limited to a capital amount or multiple of the equivalent medical scheme tariff (this is capped at 500% for most products).

The product costs in isolation are low, but the offerings are only available to medical scheme members. Administration and managed care is fairly limited for these products and the main cost drivers are the cost of claims. Recently there has been a significant increase in the cost of claims. This

has been directly related to members becoming more aware of the product offerings as well as medical service providers targeting the benefits.

Contributions are normally deducted via debit order and claims are paid directly to the policyholder. The product offerings have recently started expanding to cover a range of other non-major shortfalls like scans, dental benefits and other specified outpatient procedures.

The market remains comparably small and was estimated to amount to 450 000 policies in 2014 (SAIA estimate). Sales were initially almost exclusively targeted at employer groups. Over the last couple of years the individual market has grown due to the impact of brokers as well as medical scheme members becoming more aware of the products themselves. The latter has also served to increase claims.

A concern related to these product offerings is that they will entice more and more medical scheme members to purchase cheaper scheme options and “top up” with insurance offerings. This is termed a buy-down risk and if it were to happen en-masse in the medical scheme market many funds would become unsustainable. To date there has not been practical evidence of top-up covers incentivising buy-downs.

9.3. Cash based insurance products

Cash based insurance products offer cash sums that are triggered by a health event. The most common form of cash based insurance in South Africa are Hospital Cash Plan (HCP) products. HCPs offer cover that is based on the length of a hospital admission.

Cash based insurance products are non-specific benefit products. The policyholder can use the benefits for anything and many insurers noted that they do not have information on what policyholders use the benefits for¹⁵. *This implies that HCP insurers do not have a needs based understanding of their policyholder base and also do not know what the primary drivers are for taking up cover.*

It also implies that the market for these products is less precise and benefits are often supplemented by additional lump sum riders to make the products more attractive from a general cover perspective. These riders usually offer increased pay-outs in the case of emergencies, public transport accidents as well as cash benefits for illness, funeral and other health related events.

The premium levels for cash based products range widely in terms of costs and are related to the chosen cover level and individual rating factors such as age in many cases. Most insurers also apply some form of claims stage underwriting.

¹⁵ Research on the demand for hospital cash plans that FinMark Trust commissioned showed that “HCPs are primarily used to replace income that is lost due to hospitalisation as well as to cater for all the additional nonmedical expenses that consumers incur when hospitalised.” *The money is seen as a windfall gain that can even be used for other expenses such as paying school fees. So while it may be used for some ancillary medical expenses, such as medicines, it is generally not used to cover the cost of care, as most respondents used public facilities.*” (Haf, C., 2013. A demand-side perspective on hospital cash plans in South Africa. Report commissioned by FinMark Trust. Available at: www.finmark.org.za).

This market is prone to fraud and many insurers note this as a primary risk and cost driver. Institutionalised fraud, driven via medical scheme members being admitted at KZN hospitals are nearly universally mentioned as the primary proponents of fraud. Preventing and combating institutionalised fraud of this nature is challenging. In the instance of cash based insurance it is further hampered by the fact that most insurers aim to limit costs with minimal claims review and clinical resources.

Contributions are collected via a range of methods. The majority of members fund policies via direct payments or debit order. Products are usually sold directly to the public and the target market is low and noted to be below R 6 000 income per member per month.

9.4. Cost based insurance products

Cost based insurance products represent insurance products that aim to cover the direct cost of medical treatment. Benefits can range from limited out of hospital cover to relatively¹⁶ high levels of cover for both major medical and day to day claims.

Cost based insurance products are currently not clearly regulated by a defined mandate. Some in the medical scheme market consider these offerings a threat given the potential for these products to apply insurance based principles like risk rating while offering benefits that resemble medical scheme products.

Benefit levels are related to the product benefit schedule and cover levels. The product offerings vary in terms of benefits and often include a range of rider product offerings like life, disability and dread disease covers. Primary benefits are usually stated cash amounts per claim event or overall claim category, like “R X for hospitalisation”.

These products have traditionally been sold and developed by niche short term insurers that specialise in health cover with the support of a reinsurer or other experienced risk partner. Some long term insurers have also started to re-enter the market recently.

Insurance based products are normally cheaper than medical scheme offerings owing to the risk rating principles that can be applied to the former. Contributions can be collected by debit order, direct payment or a range of other methods including money transfer or employer arrangements for group contracts. Like the cash based product offerings, the impact of ancillary expenses are minimal and the main cost drivers relate to claims costs.

10. Health Funding Register

10.1. What is the HFR?

The Health Funding Register (HFR) aims to collate and document all of the individual health funding products available in the South African market. The results can then be used to compare different product types and conclude on relevance for and challenges to serving the low-income market. The

¹⁶ In the context of insurance products, high cover levels would relate to offerings with high monetary limits. Generally comprehensive insurance products still have lower benefit levels than low cover medical scheme products.

results are based on information collected via desktop research, stakeholder interviews, data requests and discussions with regulators and industry bodies¹⁷.

A number of health insurance products are sold via white-labelling or an underwriting management agent (UMA) structures and this represent the potential for double counting. In order to avoid this products have been cross referenced with information requested from insurers to confirm the status of the product.

Another challenge relates to the fact that there is no central data depository for health insurance products in particular, thus there is no reference that can be used to vet and check that all market participants have been included. The authors have gone to great lengths to include all the products that operate in South Africa at the time of writing.

The following product offerings have been excluded from the HFR:

- Products closed to new business or in the process of closing,
- White branded offerings that have already been included under the primary insurer,
- Products that fall outside of the scope of the report like pure dread disease products, critical illness covers and other similar offerings.
- International health insurance products that offer “expat” cover for other nationalities that live in South Africa or for South Africans that live abroad.
- Employer funded benefits or products that would be classified as occupational health insurance.

The HFR includes a classification of each product type. This has been used to stratify the various funding models into distinct categories depending on the overall design and product benefits. This includes a review of the structural factors for each product provider as well as detailed consideration of the individual product offered as well as benefits by major benefit type. The product offerings are classified into product classifications based on their structure, benefit levels and individual benefit offerings.

The HFR further considers the cost ranges of the product offerings. This is contextualised in the scenario analysis as illustrated in Annexure 1. The aim of this analysis is to illustrate the practical affordability constraints as faced by the low income market. The results are illustrated at the hand of three scenarios that takes the reader through the practical barriers and enablers of low income health financing.

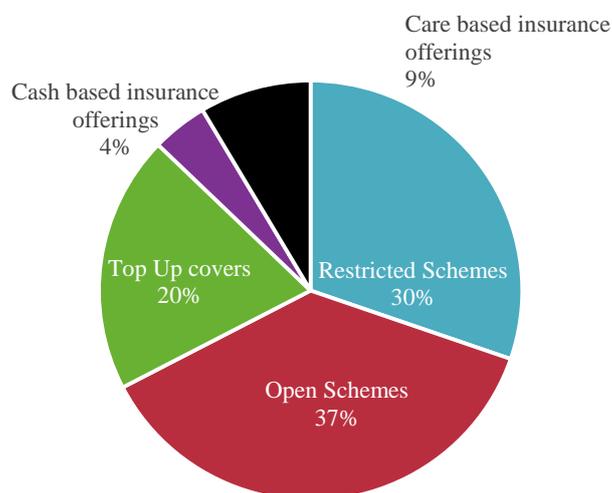
10.2. HFR market landscape

The HFR includes nearly 470 unique products that offer health related benefits in South Africa. Many of these products are further stratified via product combinations, optional rider benefits, risk/age based underwriting as well as income based variances in cost.

¹⁷ The results are captured in a detailed Excel tool. This report provides an overview of the findings across individual products for each product type and for the market as a whole.

The health funding market is thus a large and complicated feature of the local financial sector. The figure below illustrates the proportional distribution of the products per category as outlined in Section 9.

Figure 8: Health funding landscape by product type



Source: HFR

87% of all products active in the market are medical scheme products or insurance products that are normally only available to medical scheme members. This ties in with the results of Figure 2 that indicated that the majority of privately bought cover is purchased by the medical scheme market.

The small scale of the health insurance market indicates that these offerings serve a potentially much smaller portion of the population. Detailed statistics regarding the number of health insurance policyholders per product type is not available. However, the market for health insurance is growing and many of the new entrants to the market are noted to be low income individuals that cannot afford medical scheme cover.

The table below illustrates the number of insurers active in each market segment by product type:

Table 1: Distribution of insurers and health insurance products

Product Type	Number of Insurers	Number of Products
Top Up Cover	25	93
Cash-based insurance: HCP*	6	21
Cost-based insurance: Hospital Cover	3	5
Cost-based insurance: Day to Day Cover	4	10
Cost-based insurance: Day to Day and Limited Hospitalisation	3	5
Cost-based insurance: Day to day and Hospitalisation	6	20

*Excludes life policy rider products and products that are closed to new business.

Many of the participants in the health insurance market are niche players and most of the large established and diversified insurers in South Africa have not entered the market. This is in spite of the market potential for non-medical scheme products. 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.

The lack of activity in the insurance market segment from established insurers is a result of the regulatory uncertainty. Most large life or general insurers in South Africa do not offer care-based health insurance products due to the implications of the original demarcation agreement and the potential risk of entering the market in such uncertain regulatory circumstances.

Potentially another 8 million to 10 million South Africans would be able and willing to purchase a care-based insurance offering for under R 300 per family.

10.2.1. Medical scheme offerings

The medical scheme market is populated by 83 funds, 23 of which are open funds and 60 of which are restricted funds. All of the options are non-profit entities that do not collect any risk profits from members. In total there are approximately 316 options active in the market. As noted above the number of funds has been gradually declining as the market has consolidated. The individual options can further be categorised as:

- Low cost network options,
- Hospital options,
- Traditional risk cover only options,
- Savings options, and
- Comprehensive cover options. Normally these products are either traditional or savings based products but offer very high cover levels and additional benefits once certain benefits have been exhausted.

The 23 open funds offer 142 product options. Open funds are generally larger and more expensive than their restricted scheme counterparts. The average open fund services approximately 93 000 beneficiaries compared to nearly 27 000 for the average restricted fund.

Open funds also need to compete directly with one another, this is mainly based on option price and product innovation (within the confines of the MSA). The latter as well as the smaller average size of restricted funds imply that open funds generally offer a wider range of options. In 2014 open funds offered three times the number of options (7.5 per fund) compared to restricted funds (2.3 per fund) on average.

All options for both open and restricted funds need to offer the full suite of PMB benefits as a minimum benefit package. Most options offer benefits in excess of this requirement. Costs are managed via provider agreements and network arrangements.

The cost ranges for medical scheme products vary widely based on income, fund type and benefits offered as well as the profile of the option. The average open scheme contribution amounted to R 1 410 per person per month during 2014 compared to R 1 230 per person per month for restricted schemes (2014/2015 CMS annual report). Contributions are normally collected via debit order or a salary deduction (in terms of restricted funds).

The restricted scheme market generally applies income cross subsidies across all options within the confines of an employer group. In the restricted scheme market subsidies can be structured more appropriately given integration with salary levels, payroll and via structured employer subsidies.

Some open funds offer low cover, income rated options aimed at the lower income market. Currently there are approximately 17 open fund options that offer options with income rated contributions. But according to the MSA each option needs to be self-sustaining and as such the discounted premiums for one income band need to be recouped by the premiums from higher income bands. This requirement, in tandem with the lack of protection against anti-selection in this market, implies that the discounts offered for lower income bands are not as substantial as required for a truly affordable solution.

In fact the contribution structures for income rated options can be seen as regressive. Lower income earners generally need to contribute a higher proportion of their income than higher income earners for membership to an open scheme income rated option.

The medical scheme model has limited ability to expand cover to the low and uncovered section of the market. The medical scheme model has been unable to reach the majority of South Africans and national membership has stagnated at around 16% of the population; the product offerings are simply too expensive for mass take up.

The scenario analysis as outlined in Annexure 1 illustrates three scenarios of the proportion of income that low-cost medical scheme options would on average comprise: for low income earners that earn R 3 500, R 6 200 and R 6 300 per month, respectively. The last two scenarios were selected to fall just below and just above the tax threshold, at which point a tax credit for medical scheme membership will kick in. The scenario analysis indicates that medical scheme membership will on average require a significant proportion of income for those earning below the tax threshold of R 75 000 per annum. The figure below illustrates a summary of the proportions of income on average that need to be contributed for medical scheme membership under each scenario. Please see Annexure 1 for more details regarding the calculations.

Figure 9: Proportion of income spent per scenario and affordability consideration for low cost medical scheme options.

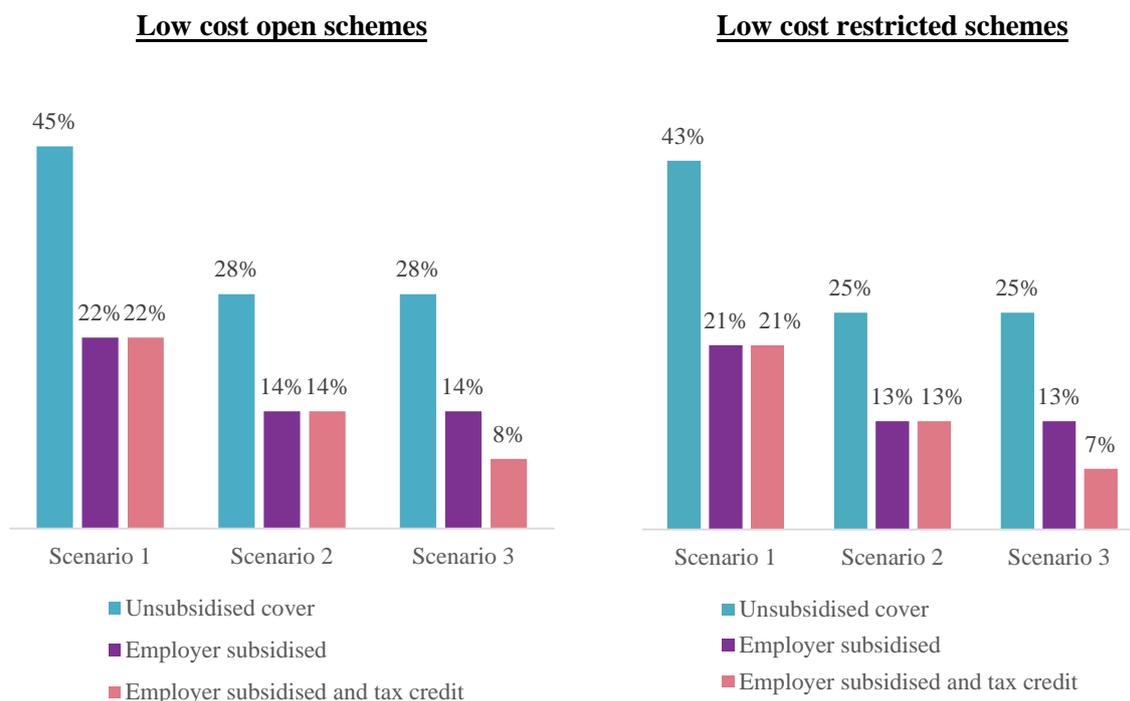


Figure 9 indicates that without an employer subsidy, low cost medical scheme coverage would imply that a low income family would need to spend 25% to 45% of their income for family based coverage. An employer subsidy would reduce the cost but coverage would still likely remain unaffordable. The only scenario that would be financially feasible would be one where the membership has access to a subsidy as well as the benefit of the tax credit.

The results indicate that even the least expensive medical scheme options only become affordable at income levels of R 6 300 per month or more, with the advent of an employer subsidy and a tax credit. Households earning less than this would likely not be able to afford a medical scheme for the whole family, even if contributions are partially subsidised.

10.2.2. Top-up insurance products

Top-up insurance products are insurance based health finance products that are confined to the medical scheme market. The products offer complementary cover to medical scheme benefits and most require medical scheme membership as a prerequisite for taking out cover.

There are currently approximately 25 primary insurers that offer 93 product options. The product offerings can be further classified as:

Gap cover products

Benefits are normally confined to shortfalls on specialist charges for procedures performed in hospital. Cover has lately been extended to other gaps like co-payments and limits for a range of procedures and services including outpatient procedures like CT scans and X-rays. Cover is available independently of any particular medical scheme option.

There are currently approximately 78 individual gap cover products in the market. The products are normally priced on an inclusive per-family rate and the average cost per policy is R 250 – R 300 per family per month. Benefits are limited by an overall annual limit and paid directly to the insured policyholder following a valid claim. There is thus currently no relationship between the provider and insurer in this market.

Medical scheme shortfall products

Medical scheme shortfall products are derivatives of the gap cover market and offer more targeted benefits for individual shortfalls. This is sometimes defined at a per option level and as such the products are more refined to the individual benefit shortfalls. The products can also be refined to provide a more targeted solution for restricted schemes or employer groups.

There are currently approximately five targeted shortfall products that are sold in the market with an average premium of nearly R 200 per family per month. Similar to gap cover, the products do not currently have any direct links to healthcare providers in the market.

Both Gap cover and shortfall product offerings are often sold on a group basis that can reduce the stated premium levels above by up to 40% or 50%.

Both gap cover and medical scheme shortfall products can also offer a range of optional ancillary product offerings like medical scheme premium waiver, oncology benefits as well as trauma and accident covers. These products require an additional premium.

Dental cover products

Dental insurance products are a fairly new product in the South African market but are common in countries that have a national health insurance system like the UK or Canada. Locally there are ten products sold by four insurers. The cover levels range from simple to advanced dentistry.

Some of the dental insurance products are offered on a capitated base with a risk sharing/ceding arrangement between the dentist and the insurer. This is a common feature of the international dental insurance model and likely reflects a migration of an international product to South Africa. Costs range widely from R 24 to R 392 and are directly related to the funding model and level of benefits.

Shortfall insurance products have limited to no value to the low income or uncovered market due to the requirement of having to belong to a medical scheme or benefits being confined to a single particular benefit category like dentistry.

10.2.3. Cash based insurance products

The majority of cash based insurance products represent HCP products. The exact number of active insurers and policies in the market is uncertain. During the review it became apparent that a number of insurers have recently closed their existing HCP book or have indicated that they are planning to exit the market. For practical purposes these offerings as well as HCP rider products that were primarily sold in tandem to other products like life policies were excluded from the HFR.

Cash based insurance product offerings provide a defined cash payment following a hospital event. This is most often based on the number of days for which the insured party was hospitalised. Most offerings require a minimum period of hospitalisation of three days for the benefits to become applicable after which the cover is backdated to the first day of hospitalisation. The level of cover is

defined in Rand terms per day and is selected at the outset by the policyholder from a range of options. Cover ranges generally vary from R 250 to R 5000 per day in hospital.

The premium levels vary by cover level and policyholder age. The level of premium per individual product selection is not publicly available. A detailed study into this market in 2012 indicated that the premium levels ranged from R 96 to R 850 per policy per month depending on cover level (R 250 – R 5 000 per day) as well as policyholder age (18 – 65 years at entry).

Some insurers noted that policyholders frequently request cover based on a pre-selected premium level rather than a certain cover level. This is indicative of the low income membership base of these products and the significant role affordability plays in the low income market.

Cash based insurance benefits are paid directly to the insured party and as such there is no interaction or relationship between the medical service provider and insurers. As noted above the product benefit utilisation is uncertain and insurers often include a range of rider benefits that are embedded into the product offering. This normally includes:

- Additional cover (50%) for days spent in high care and ICU.
- Dread disease lump sum benefits.
- Public transport accident benefits.
- Accidental death and disability benefits.
- Medical and legal advice services.

These benefits are normally included in the standard offering and some insurers noted that they reflect the uncertainty regarding what needs cash based insurance meet in practice.

Cash based insurance products are able to offer low income earners some recourse regarding medical costs. But the products only pay out in the case of hospitalisation. Without a significant cash deposit it would not be possible to gain access to a private hospital as an uncovered patient, such cash based insurance products would not be able to facilitate access to a private hospital.

Cash based insurance covers would thus only be effective in the direct defrayment of major medical costs if public facilities are utilised. The lump sum nature of the pay-outs would also enable the insured party to utilise the benefits for a wide range of non-health related costs associated with a major medical event like rehabilitation and loss of income. This correlates to the findings of the 2012 study that found HCP's were both affordable and effective in meeting the direct and related costs of a major medical event if a state facility is used.

As noted, the cash based nature of the products has also made them a prone target for fraud. This has become a systemic problem in the market and seems to have decreased the range of products available as well as tempered product innovation.

10.2.4. Cost based insurance products

Cost based insurance products offer insurance benefits aimed at meeting the direct cost of medical treatment. These products have been an area of growth, but this market sector has been plagued by

regulatory uncertainty. Consequently some established insurers have been apprehensive to enter the market.

Currently there are approximately 40 products that operate in this market that are offered by six primary insurers. The majority of these insurers are niche players that mainly operate only in this market. Some of the participants focus on certain sub-sectors of the low income market by area or employment type. Some product offerings also limit eligibility to certain target groups on a product level like students. Interestingly, there are also products that cater only for the elderly (ages 55 and up). In consultation with some of the insurers it was indicated that these targeted offerings are not performing as well as expected from a take up perspective. It should be noted that the products aimed at the elderly were perhaps a response to the market criticism that health insurance primarily caters for the young and healthy. *Even so, the ability to launch a targeted offering aimed at a traditionally undesirable demographic illustrates the flexibility of health insurance as a funding model.*

Cost based insurance product benefits are aimed to offer the insured policyholder access to medical treatment on a full or partial indemnity basis. Many of the products offer access to private facilities and doctors. The products thus aim to mimic medical scheme benefits as far as possible under an insurance banner. The extent to which this is possible is determined by the benefits of the individual products as well as provider arrangements in place.

Products that mimic medical scheme benefits under an insurance banner are one of the main concerns from the medical scheme market. One of the primary drivers for the introduction of the demarcation agreement is to protect medical schemes from potential “cherry picking” by health insurers.

Based on benefit structure the cost based insurance products in the market can be categorised as follows:

Insured Hospital Benefits

Currently there are five products that offer specific cost based hospital only insurance. The products are not income rated and benefits for hospitalisation are defined as per a set monetary schedule of limits. This is related to the clinical reason for hospitalisation (illness or accident) as well as the period of hospitalisation for illness cover and a lump sum cover for accident cover. The products often include a dread disease rider benefit as well as cover for maternity and emergency services.

The products do not cover treatment for any chronic conditions but do offer cover for ancillary benefits like lump sum payments for death, disability and dread disease cover.

Costs range widely and vary from R106 per month for a single person (R160 for a PAC¹⁸ family) to R499 per person (R 1 037 for a PAC family). This is significantly cheaper than a medical scheme offering and the product cost could be further reduced under a group arrangement. However, it should be noted that the benefits of a hospital insurance product are far lower than a basic medical scheme product.

¹⁸ PAC – Principal, Adult and Child

Day to Day (Primary Care) cover

These products have been an area of focus and growth for the health insurance market. Currently there are ten primary care insurance products available in the market that are supplied by four insurers.

Day to day insurance products normally offer benefits via a network of providers and benefits typically include:

- GP visits and linked prescribed medication. This is available without a co-payment from the policyholder and services are obtained only via a network of providers and pharmacies.
- Basic dentistry (consultations, cleaning, pain control, fillings and extractions) via network providers.
- Optometry cover for eye tests and basic frames and lenses.
- Radiology (x-rays only). Benefits require referral from a network provider for a set list of conditions.
- Basic pathology on referral from a network provider.
- Maternity benefits including scans (usually limited to two per pregnancy) on request and when performed by a network doctor. The cover also includes a range of standard check-ups, medications and tests.
- Some products offer cover for specialist visits. This is normally in the format of a monetary amount per policy/family member and will likely also require a referral from a network GP.
- Some of the products also include cover for a range of day to day procedures if performed in doctor's rooms.
- The product offerings do not normally include rider benefits like dread disease and death lump sums.

The benefits are limited for out of hospital treatments and the cover is often provided via a network of consulting health providers that is then marketed as “unlimited”. In reality over-utilisation of the services will imply restrictions like pre-authorisation or potentially termination of the policy benefits. This is a prime example of how insurance based products can protect themselves against anti-selection and abuse in a manner not available to medical schemes. Premiums are relatively low and amount to about R 300 – R 400 per person per month. On a group basis the product could be discounted by up to 50%.

Interestingly, the benefits and price points offered by these products are very similar to what was deemed as the ideal package for low income earners during the LIMS and LCBO considerations. In a way the health insurance market has moved to fill the cover-gap that was identified by the medical scheme industry during the LIMS and LCBO processes.

Day to Day and Limited Hospital Cover

A close variant to the primary care insurance category as outlined above, these products relate to a combined primary care product with the addition of limited hospitalisation benefits. The offerings are frequently sold as step up products from the standard primary care products.

The primary care component is essentially the same as the primary care only covers as outlined above with the addition of a range of hospital benefits. The latter includes similar hospital services to those outlined under the hospital only insurance covers, but at lower levels of cover thus offering a limited level of protection. Many of the products also include additional rider benefits at reduced cover levels.

There are currently five products that offer day to day covers with limited hospitalisation benefits. The average individual premium equals R 400 to R 500 per person and would again likely be subject to a discount if sold on a group basis.

Day to Day and Hospital Cover

The most comprehensive form of health insurance relates to products that offer *day to day cover and hospital cover*. This market consists of 20 products offered by six different insurers and is the largest health insurance component to the market outside of top-up cover. The products are not income rated but there are a number of offerings that are only available for certain age groups like students or the elderly.

The offerings represent a combination of the hospital only and primary care only products as outlined above. Indeed many of these comprehensive insurance products are directly marketed as a combination of a day to day and hospital only plan. As per the day to day only offerings all of the product have some form of health care provider arrangement in place.

From an individual price point the products are positioned very similar to low cost medical schemes with the average individual policy contribution costing nearly R 700 (approximately R 1530 per PAC family). As noted above the products can be significantly discounted if sold on a group basis.

Low income market focus

In terms of cover and range of benefits, cost based insurance offerings would likely be the closest match to a medical scheme for someone who could not afford the premiums of the latter. To date these products seem to have been the most successful in penetrating the low income uncovered market.

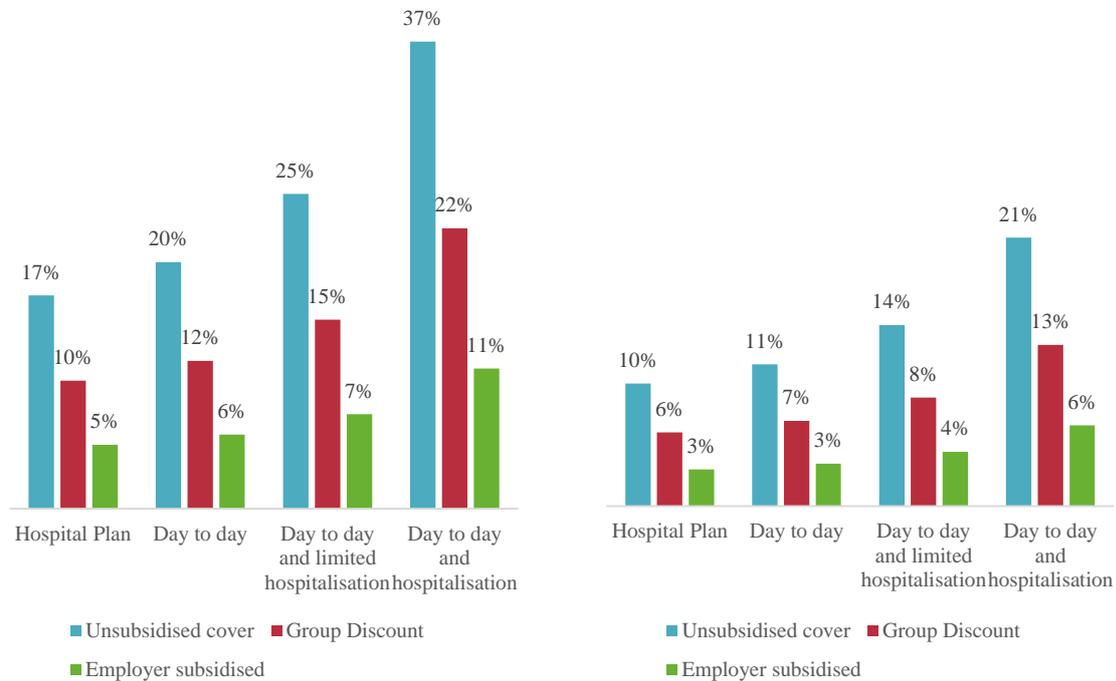
Many of the offerings offer access to private doctors. Some of the insurers have also entered into contractual agreements with private hospitals that will allow insured policyholders to access a private hospital without a co-payment or additional costs in certain circumstances.

From the scenario analysis in Annexure 1 it is clear that cost based health insurance offerings are significantly more affordable than medical scheme products. The results indicate that the advent of group discounts and employer subsidies improve the level of affordability by multiples. The figure below illustrates a summary of the affordability results from the scenario analysis.

Figure 10: Scenario results of proportion of income spent per product type and affordability consideration for cost based insurance products

Scenario 1 – Income of R 3 500 per month

Scenario 2 - Income of R 6 200 per month



The results indicate that for those earning below the tax threshold, cost based health insurance would likely be the only affordable option. The advent of group discounts and employer subsidies greatly increases the affordability of the products compared to medical scheme membership that will require a much larger proportion of income for family membership.

From the results above it is clear that while the benefits offered are far lower than medical schemes, many of these offerings offer a fairly wide range of cover as well as access to private facilities and doctors.

Health insurers that are able to offer access to private hospitals is a relatively new development in South Africa. In consultation with hospital groups it was indicated that as long as payment is guaranteed they would not oppose any particular funding model. Being able to access a private hospital, even just for limited procedures like childbirth, can be of immense value to a non-medical scheme member.

The market for cost based insurance has been relatively successful in penetrating the low income market owing to the lower costs of these products. But the principles of increasing costs for the old and sick via risk rating as well as a for-profit insurance model are some of the main reasons why many in the medical scheme market have opposed this model as a solution for the low income market.

However, there are a number of concerns related to an insurance based model for the uncovered population. The products are not actively regulated on a product level and as such could exploit low income policyholders. There are also concerns regarding the ethos of the wealthy being able to

access non-profit funding models while the lower income majority mainly have to rely on for profit offerings. Nevertheless, these health insurance products are currently the only affordable option for many, as the regulatory restrictions in the market prevent an affordable alternative via a medical scheme funding model.

Ultimately the appropriateness of the products and regulatory structures cannot be considered in theoretic isolation. In practice the cost and the ability to afford a product is likely the main consideration for the low income market. Health insurance products are able to offer more affordable cover than medical scheme membership but at lower benefit levels.

10.2.5. HFR results summary

The table below summarises the findings from the HFR for each category of products as outlined above:

Product	Classification	Number of funders	Number of products	Number of covered lives	Major medical benefits	Day to day benefits	Ancillary offerings	Network arrangements	Low income potential
Restricted medical schemes	Medical schemes regulated under MSA by CMS	60	137	3.9 million	Comprehensive on all options via PMB benefits	Related to option choice. Usually high for options that offer D2D cover.	Normally limited to International travel cover.	Extensive use of networks and DSP's especially in low cost market.	Low due to cost of PMB package.
Open medical schemes		23	174	4.9 million					
Top up cover	Insurance products regulated under LTIA and STIA by FSB	25	93	Approximately 550 000 – 600 000	Related to set schedule of benefits and tariff levels	Low. Product specific and related to individual benefit categories.	Range of ancillary products and offerings available at additional cost.	Networks used for dental offerings but not for gap and shortfall cover.	Low due to requirement of medical scheme membership for most products.
Cash based cover		6	21	Approximately 2.5 million	Related to period of hospitalisation and selected cover level	No benefit.	Range of covers for dread disease, accident, funeral and death benefits included as rider products.	Not applicable. Benefits are paid directly to policyholder.	Limited to major medical events in a public facility and ancillary costs.
Hospital only cover		3	5	No information available	Medium cover levels. Related to type of hospitalisation (illness or accident). Limited to amount per day or lump sum respectively.	No benefit.		A number of products offer network arrangements for private service providers.	High, products are the most affordable form of cost based insurance. Lack of day to day cover might not meet low target markets primary needs.
Primary care cover		4	10		No benefit.	Limited to no benefits	Very high. Benefits and price range fit within the parameters found to be ideal during both LIMS and LCBO considerations.		
Primary care and limited hospitalisation		3	5		Low cover levels. Related to type of hospitalisation (illness or accident). Limited to amount per day or lump sum respectively.	Cover normally via a network or providers for consultations, medication, as well as limited dentistry, radiology and optometry.	Range of covers for dread disease, accident, funeral and death benefits included as rider products. Cover normally low.	Extensive use of networks and provider arrangements.	High. Benefits in line with findings from both LIMS and LCBO considerations. Additional cost of hospital cover increases cost pressure for low income market.
Primary care and hospital cover		6	20		Medium cover levels. Related to type of hospitalisation (illness or accident). Limited to amount per day or lump sum respectively.				

Market challenges for low-cost products

The document so far has provided an overview of the players, regulatory context, product features and driving forces of the pre-funding health finance market in South Africa.

What prevents the current market landscape from serving the bulk of the South African population?

This part of the analysis draws together the threads from the previous sections to outline the primary market challenges from the perspective of the lower-income segment.

The key challenges discussed are:

- The (un)affordability of medical scheme products;
- Market fragmentation, including the impact of insufficient risk pooling; and
- Cost drivers.

11.(Un)affordability of medical scheme products

Medical schemes have frequently been criticised for not being affordable [9, 49]. Medical scheme cover is concentrated in the top two income quintiles. The vast majority of the South African population earn below R 6 000 per month per household, whereas medical scheme membership only becomes significantly prevalent at income levels above R 15 000 per month. The affordability concerns around medical schemes are reflected in the relatively high proportion of the country's healthcare expenditure that flows through medical schemes (47%) relative to the proportion of the population covered (16%).

Given the strong relationship between income levels and coverage, it is important to consider the role of affordability as a constraint to increasing access to medical scheme cover. Affordability is also an important concern for the market in light of the stagnation and aging of the medical scheme risk pool and the mounting pressure for some form of cover.

There are a number of regulatory issues which act as cost drivers for medical schemes and contribute to the inability of the market to expand coverage. The main factors impacting on the affordability constraints for the medical scheme market include:

- the cost of anti-selection;
- the impact of the tax threshold;
- the degree to which income cross subsidies can be leveraged to increase access for low income earners;
- the higher cost of the open scheme model; and
- the high minimum cost base of the required PMB cost package.

Each of these factors are outlined in detail in Annexure 2.

Since 2000, consideration of the premium cost information as per the CMS annual report and inflation data from Statistics South Africa indicate that year on year contribution increases in the open medical

scheme market have outstripped CPI by approximately 2.7% per annum. Over the same period medical scheme membership has shown minimal growth. Contribution increases in excess of CPI imply that the affordability constraints in the market will increase in future.

Increasing affordability pressure can also translate into option buy-downs and reductions in the average number of dependants per principal member (i.e. an increase in the proportion of partially-covered households [2, 9]). The average dependant ratio (dependants to principal members) has declined from 1.6 in 2005 to 1.3 in 2014 [39]. The latter is also a form of anti-selection. However, somewhat paradoxically, there is research to suggest the price elasticity of demand for medical schemes is relatively low [5]. This is presumably because cover is concentrated amongst a relatively high-income population that is able to bear the increasing costs. Buying down to a cheaper option and reducing the number of household members covered are also alternative mechanisms for retaining some level of coverage for a household. Affordability constraints can thus act as a catalyst for anti-selection and this will in turn increase costs further.

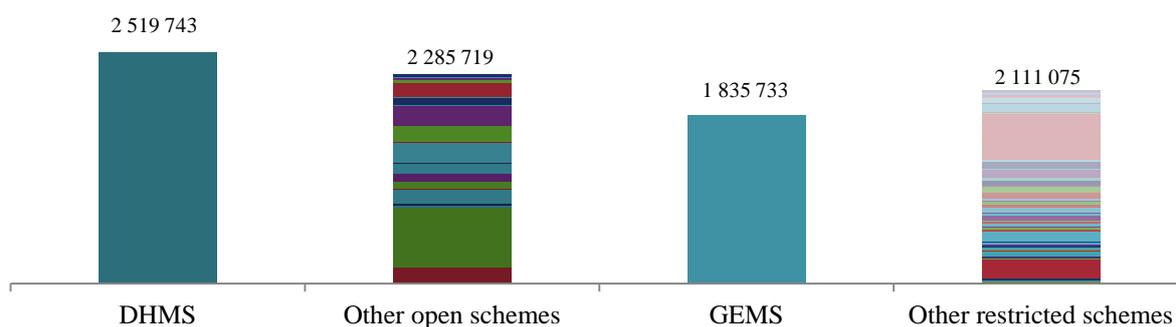
Low income lives are more at risk and will be impacted the most as costs increase. Some insurance products have been able to keep their contributions level between some years as the benefits are defined as per a set schedule of monetary amounts, and the latter was also not increased over the period. This has been cited as part of the reason why some employers prefer insurance based solutions for their blue collar workers.

12. Market fragmentation

The market for health financing products in South Africa is fragmented by industry as well as internally for the individual product structures. Health insurance products offer very limited social solidarity. The products are normally risk rated based on the expected levels of claims. But as indicated this has allowed these product offerings to operate at a lower cost level. Consequently the market as a whole seems to have grown substantially in recent years. While this cannot be confirmed by industry numbers as the latter is not collated at a sector level, the assumptions are supported by the increase in the number of insurance products on offer.

Medical schemes, on the other hand, have experienced a stagnant market with isolated pockets of growth. Around half the growth in the market has been driven by Keycare (Discovery Health's "lower income" option suite) and GEMS. Both the open and restricted scheme markets are highly skewed, with few large schemes and a long tail of smaller schemes. Consolidation has been a long term trend with far fewer schemes today that there were 30 years ago. This is illustrated in the figure below that outlines the distribution of members by scheme type.

Figure 11: Member Distribution by Scheme Type¹⁹



Source: CMS Annual Reports

Despite the market concentration in both the open and restricted scheme markets, there is currently a high level of fragmentation in medical schemes due to a large number of sub-pools. This fragmentation drives inefficiency, and implies that many schemes lack leverage over private providers (which has implications for both prices and utilisation).

The self-sustaining requirement for options as outlined in Section 10 is not consistently implemented. Theoretically, pooling is meant to occur at the level of each benefit option but some cross-subsidy between options is permitted. Generally medium range options financially support both the low cost and high cost options.

Whilst there is scope for redistribution within medical schemes, redistribution across the system is needed. Even if pooling were to occur at the level of medical scheme the market would still be highly fragmented with a large number of relatively small schemes that would have little ability to benefit from scale. System based redistribution is likely not achievable in the short term.

The large number of small schemes can be explained by structural features of the market. Restricted funds offer a specified and targeted health funding solution to a particular employer base. Each fund is thus limited in terms of the potential scope for growth by the size of the employer group it services. Restricted schemes offer a range of benefits over open schemes but they do present the issue of risk pool fragmentation.

The second feature of the market that encourages small schemes is the current solvency framework. The current framework acts as a significant barrier to scheme growth. This is because it is very difficult to grow the accumulated funds at the necessary rate – this is particularly problematic given the limited sources of capital available to schemes. A similar disincentive to amalgamate arises because of the linear relationship between gross contributions and solvency capital.

The disincentive for schemes to increase risk pool size is concerning from a health systems perspective:

- Larger risk pools are more stable from a purely statistical point of view;
- Larger risk pools also allow for a stronger purchasing function in the health system;

¹⁹ DHMS – Discovery Health Medical Scheme

- The current medical scheme market is fragmented – hence an incentive to amalgamate is desirable; and
- The medical scheme industry has failed to grow substantially and to increase access.

Despite the disincentives for schemes to amalgamate and for schemes to actively increase risk pool size, the number of schemes has decreased over time as illustrated in Figure 7. But this has often been the result of weakening in a particular scheme’s financial position that in turn is the direct result of the impact of a fragmented market.

Health insurance offerings are also fragmented in the sense that each insurer needs to maintain a profitable portfolio of products in isolation. There is greater scope for cross subsidies within an individual insurer, but the market remains fundamentally fragmented at an industry level. This is a fundamental part of the for-profit model and the remainder of the discussion on fragmentation will focus on the medical scheme market.

Pooling at a national level with a single payer and purchaser of services is central to the NHI proposal. But, as indicated, it will likely take a long time before the NHI fund is able to fulfil the role of private healthcare funding in South Africa. As such this report considered the current market structures and the related challenges.

A less fragmented private funding market will enable a more effective bargaining function as well as other economies of scale. This will translate into cost savings that could theoretically be used to increase access for the low income segment of the market.

There are a range of ways to reduce fragmentation in the medical scheme market:

- Explicitly reducing the number of funds (for example, by increasing the minimum scheme size or legislating a maximum number of funds);
- The establishment of a virtual single pool (using risk adjustment/equalisation); and
- Building bridges between funds (by, for example, using a unified payment system or standardising benefit packages).

There are arguments in favour of fewer risk pools: it could potentially be more efficient; it could potentially deliver lower administration costs; and it could pose improved possibilities for income and risk cross-subsidies. However, it is possible for risk pool integration to be bad for equity. This can arise if there are differential utilisation rates and barriers to access between different pools of lives. Technical work of risk equalisation and Circular 8 (please refer to Section **Error! Reference source not found.**) indicated that this would likely be the case in South Africa.

In other countries “risk adjustment” (referred to as risk equalisation in South Africa - please refer to Section **Error! Reference source not found.** for more details) has been used to create a virtual pool by enabling risk cross-subsidies) as an interim step to creating a single pool. This option balances consumer choice (as consumers can still select a medical scheme) with solidarity.

Other mechanisms could be used in conjunction with this approach to reduce the number of pools, and to gradually strengthen the purchasing function across the system. If this approach is utilised then benefit design becomes a critical part of the pathway.

12.1. Fragmentation in the risk pool

The medical scheme regulatory environment incentivises competition on the basis of risk profile, as opposed to competing on the basis of efficiency. This is because medical schemes operate under partial social solidarity, and risk pools are highly fragmented. Each medical scheme benefit option is community rated, and there is no risk pooling mechanism across the industry. The price of each option is therefore heavily influenced by the risk profile of beneficiaries on that option. If pricing was less dependent on risk profile, schemes would need to compete on the basis of being able to purchase health care more efficiently.

Ideally, markets that are based on social solidarity principles should also have protective mechanisms in place. This could include risk-sharing mechanisms between funds (referred to as the Risk Equalisation Fund or REF in South Africa), mandatory contributions (to reduce anti-selection), and clear demarcation guidelines to prevent cherry-picking of members [9].

There have been various proposals to improve the extent of risk pooling. The REF proposal was aimed at improving risk pooling between schemes. There were also proposals put forward by the CMS to improve risk pooling across benefit options within schemes (referred to as the Circular 8 reforms).

The REF would have served as a mechanism to limit the impact of differences in risk profile between schemes. A REF would have served as an industry-level fund that pooled resources to cover the cost of PMBs. Contributions to and from the REF would have been based on the risk profile of the scheme – with younger and healthier schemes paying into the fund and older and sicker schemes drawing down from the fund. Aging and anti-selection would thus have been funded on an industry basis and not at scheme level. But this did imply that younger funds would be net contributors to REF while older funds would be net claimants.

In 2006 a new government subsidised fund for government employees (GEMS) was launched. GEMS has been very successful in its ability to attract formerly uncovered lives to the market. Mainly this is related to the subsidy offered as well as cost savings based on the scale and volume of the fund. Given the profile of the GEMS membership base, the fund would be one of the largest contributors to the Risk

While the REF would have added stability to the industry in the long run it would have implied a direct cost increase in the short run for a number of schemes. In particular funds with a younger and healthier membership base than the industry average would have been the main funders of REF. These proposals would effectively result in a cross subsidy from low-income groups to high-income groups (because the low-income subpopulation tend to be younger and healthier, and the high-income subpopulation is older and sicker). The inter-relationship between income, age and race²⁰ in the medical scheme population makes improved risk cross-subsidies politically unpalatable without concomitant income cross-subsidies. To date REF has not been implemented.

Market fragmentation will likely remain a feature of the market for some time. A fragmented pooling function poses a significant risk to the health financing market both at a medical scheme industry and national private funding level.

²⁰ Due to South Africa's Apartheid history there is a strong relationship between race and income.

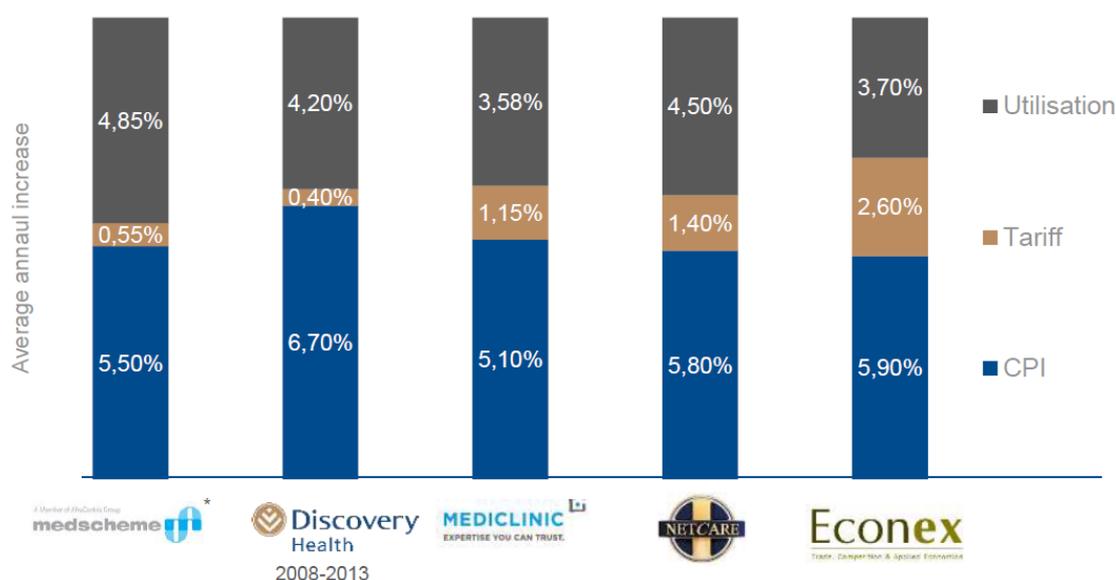
13. Cost drivers

As discussed in Section 11, the cost of pre-funded cover in South Africa has escalated at rates above CPI. This has impacted the cost of medical schemes for some time as well as health insurance products more recently. The increases have largely been the effect of escalating claims costs also referred to as Healthcare Cost Inflation (HCCI). The aim of this report is not to interrogate cost drivers in detail, but rather to consider the structural features of the market that contribute to rising costs over time.

HCCI is normally higher than CPI due to tariff increases as well as the specialised nature of the services, new technologies, salary increases that outstrip CPI and other service related factors. There is also a general increase in the rate at which consumers use healthcare services. This is termed utilisation and has been a significant cost driver in both the medical scheme and health insurance markets.

There have been a number of studies that have investigated the underlying cost drivers in the medical scheme industry. The figure below illustrates the primary cost drivers identified.

Figure 12: Medical Scheme Industry Cost Drivers



Source: Summary of data received by the Commission
 Note: * Figures from Medscheme were estimated assuming the residual impact was split 50:50 between tariff and utilisation

Source: Competition Commission Private Healthcare Market Enquiry.

The figure above indicates that HCCI in the medical scheme market far outstrips CPI inflation, but the difference is largely due to utilisation increases and not due to tariff inflation. The increased usage of medical services is thus the main driver of costs. During many of the stakeholder interviews it was noted that this is not unique to the medical scheme market and that health insurance products were bearing witness to the same trends.

Increased utilisation is not unique to the South African private market and is a global trend. It is thus likely that HCCI will remain well in excess of CPI even if tariff costs could be minimalised. This

poses a significant risk to the low income market as claims inflation is generally passed on to consumers either in the form of higher contributions or lower benefits.

There are also a number of non-health related factors that have increased the cost of pre-funded health finance offerings. In the medical scheme market many of these factors are related to regulations that govern factors like solvency requirements, anti-selection and medical service providers exploiting the PMB requirements. These factors have been discussed elsewhere in the report²¹ but it should be noted that they further serve to increase the cost of pre-funding health finance products.

Another important non-health cost item is the cost of administration and managed care. These factors impose an additional cost burden on medical schemes that need to implement sophisticated and costly claims and administration platforms. The health insurance market is able to apply a less onerous administration and managed care system at lower costs. But lately there has been an increase in the need for more effective processing and management also in the health insurance market, due to the increasing HCCI as well as increasing prevalence of fraud. The latter is a significant factor in the health insurance market and has been noted as a primary cost driver.

Increasing product costs are likely the single biggest threat to the low income pre-funding healthcare market. The key to the low income market relates to affordability. Increasing costs for health product providers will serve to increase the cost of the products to consumers. As illustrated, higher income earners normally absorb these increases with little impact regarding persistency. But the low income market is unlikely to be able to bear cost increase above CPI for long. The additive impact of year on year increases compounds the impact and further burdens the low income market in terms of their ability to afford cover.

²¹ See Annexure 2

Discussion of results

1. Findings

The market for low income pre-funded health finance products is precariously situated in a regulatory grey area.

Medical schemes have been unable to extend cover en-masse to the lower income market due to regulatory restrictions. Currently the market is struggling to expand and is exhibiting low growth rates. Initiatives to amend the regulatory requirements to allow more affordable products have all stalled.

The onerous regulatory requirements of the medical scheme industry present members with a dichotomy; the same regulations that ensure some of the highest levels of protection in the financial industry also drive costs to the extent that the majority of South Africans are excluded from cover. The requirements of the regulations also imply that the market is unable to respond to members on a pure needs basis to provide different or shifting benefit structures as needs change or vary by income.

In the same sense the insurance market has also not been able to fulfil this role fully due to regulatory uncertainty. The constraints on medical schemes has caused the innovations in the pre-funding health financing space for low income earners to emanate from the insurance market. This is especially prevalent in the rise of primary care insurance products that are structured very similarly to the proposed LCBO initiatives. The market for insurance products that offer a range of hospital and day to day cover has also grown. But insurance products that offer affordable cover to low income earners need to rely on a regulatory loophole that is constantly under threat of being removed. Consequently many of the large and established insurance market participants have not entered the market leading to lower levels of competition.

Insurance products are also becoming more integrated in the health provider side of the market and more insurance products are able to offer network access to private doctors and hospitals. These network products are very popular among blue collar employer groups and unions that use these products to offer affordable access to private medical services to their employees and members. A number of participants noted that the growth points of the insurance market is situated within organised labour. Removing these products would thus leave many of these groups without an alternative affordable offering. Given the rate of growth that these products have experienced in recent years the market has potentially already reached a tipping point of being “too big to stop” without a significant public outcry and potential strike action.

However, the growth of insurance based solutions requires consideration of the sustainability and equity of such a dual system solution.

Firstly the equity of a for-profit solution for the poor and a non-for-profit trust fund based solution for the wealthy seem intuitively inequitable. The current market structures have created a defined trade-off between solidarity and affordability. *For the low income market affordability is the most pressing factor.*

Secondly the loosely regulated structures that currently apply to the insurance based market imply that policyholders could be exploited more easily. Without a clear and defined regulatory framework the

low income market will be the most at risk due to the general lack of awareness and financial understanding.

Thirdly, the health insurance market has increasingly been subjected to significant claims inflation. This has manifested in a very similar fashion to the cost increases normally associated with the medical scheme market. The majority of medical scheme members are able to absorb increasing premiums, but the low income market is much more sensitive to price and cost inflation. *Sustained cost and premium increases above CPI could imply that the affordability benefits of insurance products are short lived.*

Regardless of the funding vehicle, the lack of affordable access and the ever growing need for an affordable low cost initiative is becoming an area of focus and a flashpoint of inequality. This is exacerbated by the widely noted concerns regarding the quality of care in the public sector. The proposed NHI system is envisaged to provide cover to all. Once implemented the need for low income solutions would dissipate and the policyholder base would rely on the NHI fund to pay for their medical needs. But the NHI fund is a long term initiative and will not present comparable services for a number of years. *Without a short or medium term private solution many South Africans will be exposed to increasing and unnecessary health risks.*

The market is thus in need of a unified and defined framework for the provision of products that meet the needs of low income earners. This needs to be considered in terms of cover necessities, affordability constraints and a clear regulatory dispensation. In consultations, many industry participants that were opposed to the idea of an insurance based funding solution a few years ago, now concede that this may be the most practical short term solution.

The regulatory authorities have proposed demarcation initiatives that would outlaw care-based insurance solutions aimed at low income earners. These demarcation regulations were drafted with the backdrop of the LCBO initiatives that were put forward during the same period. The latter never came to fruition and the implementation of a demarcation framework that would prevent care-based insurance offerings for low income earners without a credible alternative would be unpalatable. A change of this nature is also likely to elicit a legal challenge from the insurance market as noted by a number of industry stakeholders.

2. The way forward

The market is thus in need of a clear and appropriate regulatory framework for the low income market. Practically this can be structured as an affordable medical scheme model or as an insurance product offering.

A number of attempts have been made to draft a low cost framework under the medical schemes act. None of these initiatives have been successful. The impact of abandoning first LIMS and then LCBOs left many sceptical regarding a medical scheme based solution. The longevity of this framework, changes to the MSA as well as the required political will to effect such a change seem to be the main hurdles. Consequently grass roots level support for this type of initiative has waned.

A more practical solution for the short to medium term seems to be an insurance based solution. The market is already established and would only need to be extended or formalised for greater insurer and policyholder participation. An insurance solution can also apply a number of levers like group discounts and benefit adaptations to ensure the products meet the needs of policyholders at an affordable level.

The most important requirement for this market would be a clear regulatory dispensation for care-based low cost products. Currently there is no such framework. It has been proposed that this could be fulfilled via a product based exemption from the medical schemes act. The current legislative framework allows for such an exemption, but we argue that an exemption framework would not be ideal.

An exemption framework would act as another barrier to entry for the insurance market. To function optimally the insurance market requires competition with minimum barriers to entry. The easy entry and exit from a market are essential for the functioning of the insurance cycle²². The latter serve to reduce premiums and force insurance providers to compete on a number of fronts. Most importantly for the low income market it will drive price based competition. *Insurance based solutions in a well-functioning market is expected to be cheaper than those offered under an exemption framework.*

If the exemption framework is applied only for insurers currently active in the market it could “freeze” the current market. There are also questions regarding the granting of the exemptions. Currently there are a number of products that note an exemption, but there is no clear process as to how these exemptions were granted. Extending the exemption framework would significantly increase the administrative burden. The basis of an exemption would also likely be temporary or at the least only apply for a very narrow product definition. Any changes or product adaptations affecting the offering would require a review of the exemption. The longevity of the product offering would thus be a concern for policyholders, employers and unions.

A more suitable approach would be a defined regulatory dispensation for low cost insurance products that aim to offer care-based cover. This should be defined under principally similar terms for both the LTIA and STIA. The products could be ring-fenced from the medical scheme market via income based requirements to minimise buy-down risk.

The regulations should be clearly defined and provide clarity to the market regarding, underwriting, product definitions, benefit categories, provider engagements and reimbursement models, benefit payments, policyholder rights and communication, dispute resolution, marketing, and distribution. Care should also be taken to ensure the requirements are not overly prescriptive to the point of stifling innovation.

The regulations should require that all insurers submit detailed information on the offerings annually. The information should be submitted separately per product line and should outline the necessary financial, demographic and insurance results for each offering. The process and information requirements imposed by the CMS on the medical schemes market could be used as a guide in this regard.

The market is in need of a legitimate framework for the provision of cover to those that cannot afford medical scheme products. *This framework should entice participation from the bulk of the insurance industry to ensure that low income earners are able to benefit from a competitive and well diversified range of products.*

²² The insurance cycle refers to the process where initially entrants to a new market are able to charge a slightly higher premium due to the lack of competition. The positive results from this segment then attracts more market participants and increases competition. This in turn drives down premiums and less efficient market participants are forced to exit the market. Competition in the market then decreases and the cycle starts again.

Conclusion

The vast majority of South Africans cannot afford standard medical scheme coverage without a significant subsidy. The medical scheme market is thus not able to meet the growing need for low cost cover. This is due to the strict regulatory requirements of this market, initiatives aimed at meeting these requirements to allow more affordable medical scheme products have all failed.

In the absence of a medical scheme solution the insurance market has responded with care-based products aimed at low income earners. The offerings can be group depending on their benefit structures and offer a range of benefit options from primary care only products to a combined primary care and hospital product offering.

The principle concern for the low income market is affordability. The affordability of care-based insurance solutions is aided by group discounts and employer subsidies. The combination of these factors imply that insurance based offerings are significantly more affordable than medical scheme solutions at low income levels.

Insurance products are the only affordable option for those earning below the tax threshold. The benefit of the tax credit for those earning enough to receive it imply that wealthier South Africans can access medical scheme cover at lower total costs than the poor majority. The tax credit thus acts as a natural demarcation between insurance based products and low cost medical schemes. But these insurance products are not well regulated and currently operate via a regulatory loophole.

There is a need for a clearly defined regulatory dispensation for care-based low cost insurance products. These regulations should be applicable to both long term and short term products and clearly define the cornerstones of the market. Further, the regulations should encourage large scale participation from the insurance market and enable effective price and product based competition between insurance providers.

3. Annexure 1: HFR scenario analysis

Low income households are constrained primarily by their ability to afford premium levels both on an initial and ongoing basis. With this factor in mind we consider three scenarios to illustrate the average cost of health insurance product offerings available in the market per main product category.

The aim of this section is to illustrate what the differences in contributions amount to in practical terms and also how group discounts, employer subsidies and the tax credit for medical scheme products can assist low income households. The following three scenarios are considered:

- Scenario 1 considers a family with a combined income of R 3 500 per month via formal employment.
- Scenario 2 considers a family with a combined income of R 6 200 per month via formal employment.
- Scenario 3 considers a family with a combined income of R 6 300 per month via formal employment.

The results of each scenario are illustrated as a percentage of the household income that would need to be allocated to a health funding product. The values are weighted according to 13 different permutations relating to family size. 10% of income is often noted as a barrier for health spending internationally, at costs above this level it is assumed a household would prefer to seek alternative cheaper cover or lapse their policy. This is not an evidence based measure and the actual threshold would depend on the circumstances of the individual family, but it can be used as a rough guide for what would constitute an affordable product offering.

The results are further illustrated at the hand of the following affordability enablers:

- Group discounts for insurance based products. One aspect of the insurance market that assists the affordability of the products is the advent of group discounts. Insurers are able to offer lower premiums to groups as members that join as an employer/affinity group usually have lower claims due to reduced anti-selection and fraud. *For the purposes of this analysis it was assumed that if a group discount would be applicable it would amount to 40% of the total premium.*
- A 50% employer subsidy for both insurance and medical scheme products. As noted in Section **Error! Reference source not found.**, employers have historically played a pivotal role in health financing. A subsidy is a prime example of how an employer can ease the affordability constraints for the low income market. *For the purposes of this analysis it was assumed that if a subsidy is offered it would amount to 50% of the total contribution after taking account of any group discounts for insurance premiums and regardless of the family size.*
- Tax credit for qualifying medical scheme members. Members that earn enough to become eligible for tax are able to access a tax credit if they belong to a medical scheme. The current

tax threshold income is R 75 000 per annum (R 6 250 per month)²³ and the tax credit amounts are illustrated in the table below.

Table 2: 2016 Tax Credit Amounts²⁴

Member Type	Monthly Tax Credit Amount
Principal	R 286
Adult dependant	R 286
Child dependant	R 192

The medical scheme product offerings considered in the scenarios represent low cost options that are mostly income rated. The analysis considered the cheapest options in the market and given the income band requirements for each scenario related to approximately 6.5% - 7.5% off all options being considered for comparison. The results were further based on the assumption that the tax credit would be combined with an employer subsidy under Scenario 3.

The results of the scenario analysis is illustrated below.

3.1. Scenario 1

Scenario 1 represents a family that earns R 3 500 per month. The income in this scenario is below the tax threshold level and the household would not be eligible for the tax credit for a medical scheme.

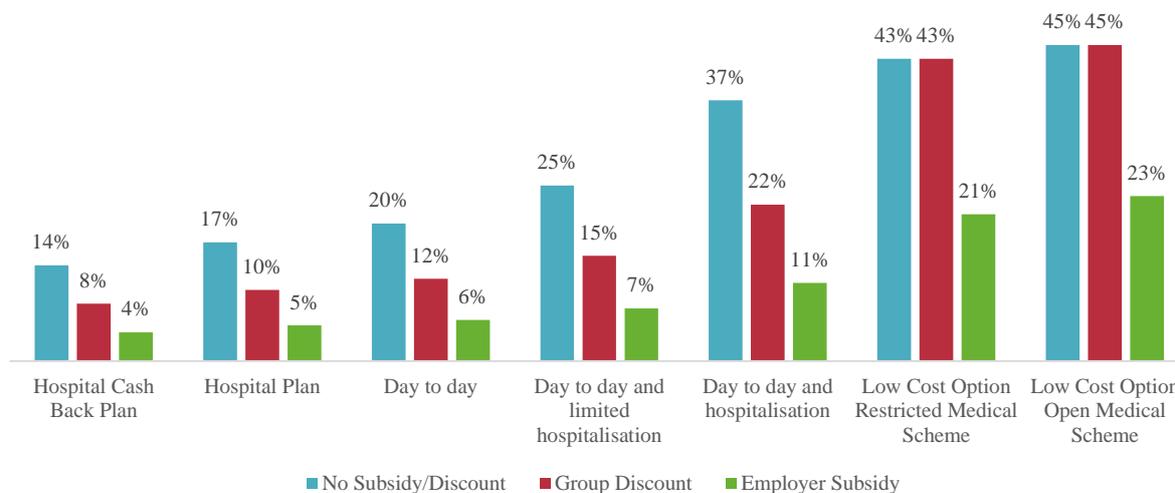
This family would qualify for the lowest income band on nearly all options. Exceptions to this relate to some open scheme funds that offer an income band for those earning below R 1 000 in some instances. An income band at this level is normally targeted at students and is intended to improve the demographic profile of the option rather than increase the affordability for those earning at such low income rates.

The figure below illustrates the affordability results per product category for Scenario 1.

²³ <http://www.sars.gov.za/TaxTypes/PIT/Pages/default.aspx>

²⁴ <http://www.sars.gov.za/TaxTypes/PIT/Pages/Medical-Credits.aspx>

Figure 13: Weighted average cost of cover, as a proportion of income for a household earning R 3 500 per month, per product type.



From Figure 13 it is clear that without some form of subsidy or discount a family earning R 3 500 per month or less would be unlikely to be able to afford any care-based health funding products. The results above for HCP products should be interpreted with caution as the rates above are reflective of average industry rates across ages and cover levels. It is thus likely that a young and healthy family would be able to access a HCP product at an affordable level.

The results indicate that the product costs increase uniformly as cover levels increase. Without the advent of a discount or a subsidy it is likely that only affordable offering would be a HCP product. Medical scheme membership in particular would most certainly be completely unaffordable in this instance as the costs would amount to nearly 50% of total income on average.

A group discount should allow the family to consider both HCP and a Hospital insurance policy as an option. Potentially a primary care product could also be considered depending on the needs of the family. But even with a discount the majority of the products would remain unaffordable on a family basis. Medical scheme products cannot be offered at a discounted premium and as such the premium costs remains unchanged.

People earning R 3 500 or less would have no alternative but health insurance from an affordability standpoint. The affordability of the products increase significantly with the advent of an employer subsidy. For insurance products it was assumed that an employer subsidy would only be applicable to group contracts and as such the group would also be eligible for a group discount.

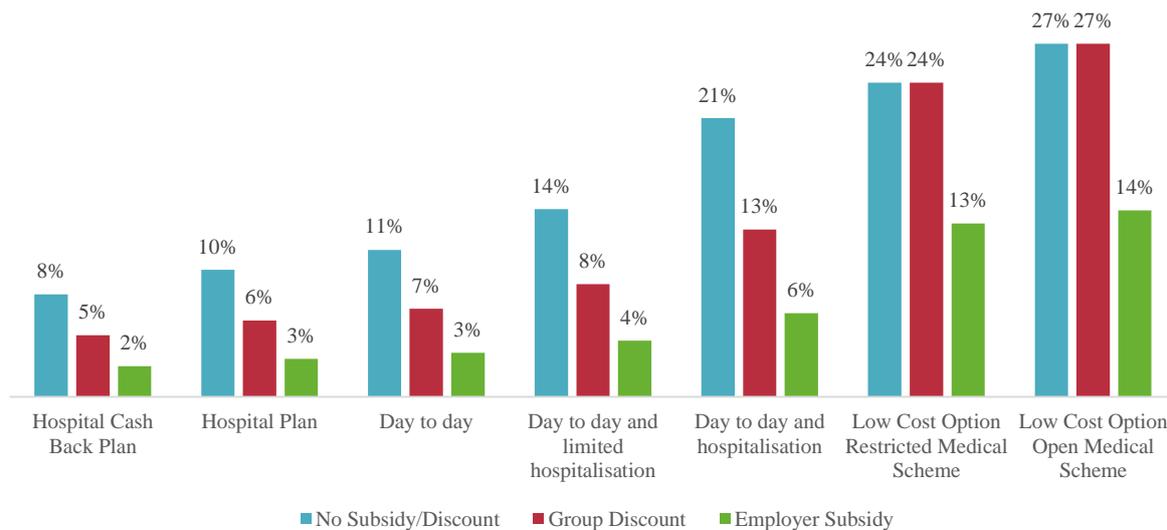
The results indicate that if a group discount and employer subsidy is included, all the insurance based offerings should be affordable given the 10% income threshold guide. The medical scheme product offerings improve significantly in terms of affordability with the advent of an employer subsidy, but would most likely still be out of reach for people in this income band as they would still need to contribute nearly a quarter of their income toward contributions.

3.2. Scenario 2

Scenario 2 represents a family that earns R 6 200 per month. The income for this family is nearly double that of Scenario 1 but is still below the tax threshold level. This household would thus also not be eligible for the tax credit for medical scheme contributions.

The figure below illustrates the affordability results per product category for Scenario 2.

Figure 14: Weighted average cost of cover, as a proportion of income for a household earning R 6 200 per month, per product type.



With an income just below the tax threshold, a HCP, hospital insurance as well as primary care insurance products should all be affordable without a discount or subsidy. Figure 14 indicates that the increase in income increases the health funding product affordability levels significantly. *This illustrates the extent to which affordability impacts on the ability to access cover.* Insurance products offering a combination of day to day and hospital cover as well as any medical scheme products would likely still not be affordable to families in this income bracket without support in the form of a discount or subsidy.

The results regarding HCP products should again be treated with caution and in the context that the actual premiums will depend on the policyholder's age and chosen cover level. A medical scheme offering would be significantly more affordable, but would still require nearly a quarter of household income for the family to access cover.

A group discount would allow the family to afford nearly all insurance based products. With a group discount, day to day and combined hospital cover would amount to 13% of the income on average for membership. Given the variance in premiums between insurers and the potential for larger group discounts than that assumed in the analysis, it is likely that an affordable product in this category would be available to this income bracket. As noted above medical scheme products cannot be offered at a discounted premium and as such will decrease in attractiveness with the advent of a group discount.

The affordability considerations change notably for this family with the advent of an employer subsidy. Medical scheme contributions decrease to 13% and 14% on average for low cost open and

restricted schemes and would be borderline affordable. But health insurance also decreases proportionally and a combined insurance offering would amount to approximately 6% of household income. The choice of product would then depend on if the employer offers employees the option to choose between products, the employees' understanding of the benefits and their health needs as well as how sensitive they are to price fluctuations.

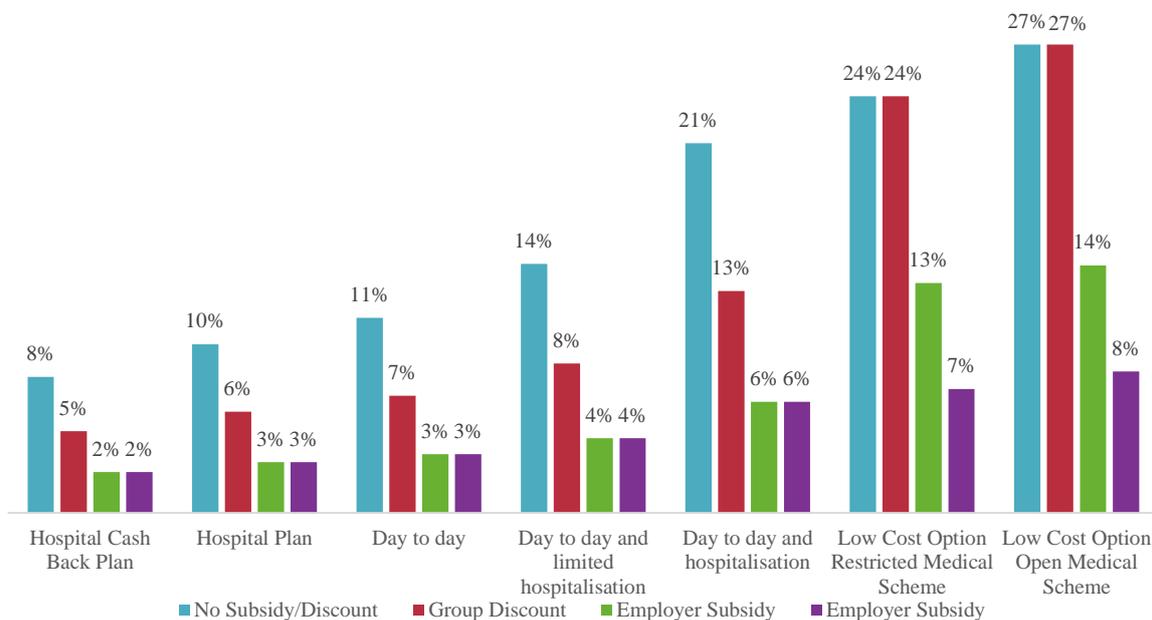
In reality the outcomes of Scenario 2 when considering the combined impact of a group discount and an employer subsidy will be based on decisions made at an employer level rather than an individual's own preferences. *For this scenario medical schemes will only be an affordable option if they are supported and partially funded by the employer.*

3.3. Scenario 3

Scenario 3 represents a family that earns R 6 300 per month. From a statistical income scenario this is nearly identical to Scenario 2. But this level of income is above the tax threshold level and consequently the household would be eligible for the tax credit for a medical scheme.

The figure below illustrates the affordability results per product category as well as the impact of the tax rebate for medical scheme contributions.

Figure 15: Weighted average cost of cover, as a proportion of income for a household earning R 6 300 per month, per product type.



The results for Scenario 3 are nearly identical to Scenario 2 when considering the affordability of the various product categories on a standalone, discounted and subsidised basis. But the affordability of medical schemes increases dramatically with the advent of the tax credit.

For income levels below the tax threshold medical scheme membership would not be affordable without putting significant financial strain on the member. But once income levels increase to a level that the employee would qualify for the tax credit the costs of a combined insurance based offering that is subsidised and discounted is very similar to a subsidised low cost medical scheme option.

The tax threshold and tax credit system potentially acts as a natural demarcation between health insurance and medical scheme membership. Subsidised low cost medical scheme products offer low income earners that qualify for the tax rebate superior cover at similar cost levels when compared to insurance based products. It is thus unlikely that an informed person that is able to access a subsidy for either product would elect to opt out of medical scheme membership.

4. Annexure 2: Factors impacting the (un)affordability of medical schemes

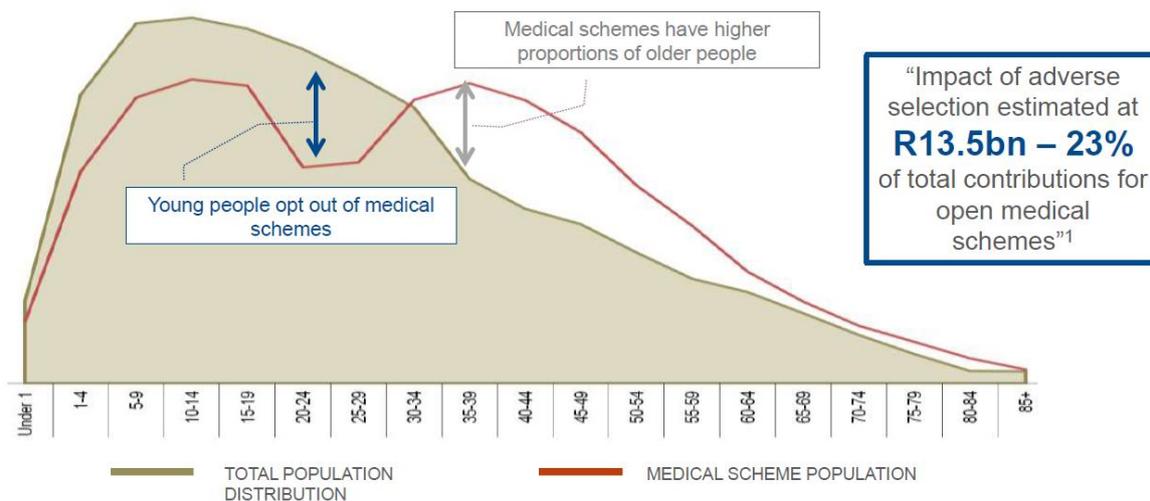
The key drivers that impact on the affordability of the medical scheme model are outlined below.

4.1. The cost of anti-selection

Medical schemes have limited means of protecting themselves against anti-selection and this increases costs in the industry. Anti-selection refers to consumer behaviour like only the least healthy seeking membership, members adding only those dependants that are likely to require care, or the healthy withdrawing from cover. *The sustainability of a community-rated environment rests on there being sufficient healthy lives to cross-subsidise those that are ill.*

The extent of anti-selection can be estimated by considering the differences in age profile between covered and uncovered lives (Figure 16). It is important to 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.

Figure 16: Age distribution of total population as compared to medical scheme population

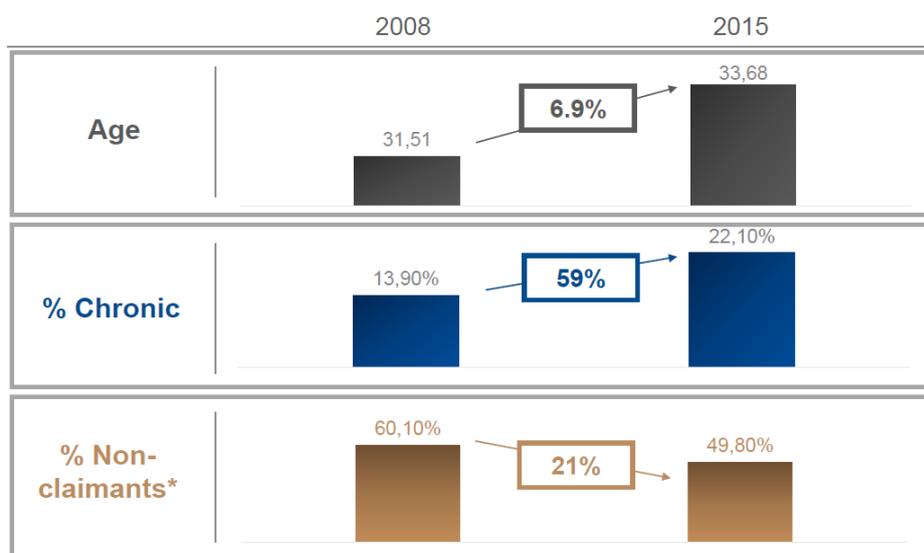


Source: Discovery Health (2016) [50] and 1: Childs

The results indicate that medical schemes have a significantly older profile than that of the general population. There is a clear absence of young lives, noting the dip in membership between the ages of 19 years to 35 years. Industry based information for the health insurance market is not available for comparison.

Discovery Health [50] argue that anti-selection is not a once-off effect but rather an ongoing cost driver in the medical scheme market. They illustrate this by considering age profile, the prevalence of chronic disease and the proportion of lives that did not utilise benefits over the period 2008 to 2015. This is illustrated in the figure below.

Figure 17: Evidence of anti-selection in Discovery Health Medical Scheme (2008 to 2015)



From Risk Benefits; If Savings Accounts included, then non-claimants drop from 27.9% in 2008 to 20.7% in 2015

Source: Discovery Health (2016) [50]

The anti-selective trends are clear in the results. The membership base is 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 of the industry.

Mandatory membership of a medical scheme is a key mechanism for reducing the impact of anti-selection. There have been a variety of estimates of the reduction in average contributions that would result from implementing a mandate (depending on what income level is used as a cut-off) [51]. Mandatory membership has not been introduced to date due to the cost impact and the lack of other mechanisms to reduce risks in the industry.

4.2. The tax treatment of medical scheme contributions

To some extent income cross-subsidies have been improved due to changes in the tax treatment of medical scheme contributions. Medical scheme contributions were previously tax deductible but now medical scheme members receive a tax credit. This translates to a more progressive result because previously those in higher income brackets would have effectively received a larger tax credit. The tax credit effectively caps the tax subsidy and is more equitable between those purchasing less extensive packages and those purchasing top-end packages. There is also improved equity between the medical scheme tax subsidy and the cost per capita in the public sector. The extent of the tax subsidy (in 2014) was R15.9 billion which equates to 12% of gross contributions.

There has been some discussion about the possibility of removing the tax subsidy for medical scheme cover, and redirecting the funds towards the funding of NHI. However, no firm proposals in this regard have been put forward.

It is important to note that there remains a disjoint between those medical scheme members earning just above the tax threshold and those earning just below the threshold: medical scheme cover is subsidised for those earning above the threshold and not for those earning below the threshold. This is

illustrated in the results of the scenario analysis in Annexure 1. The impact of the tax credit reduces the average costs of a subsidised low cost medical scheme option to 7% - 8% for those earning just above the threshold level compared to 13% - 14% for those earning just below the threshold. Medical scheme membership is therefore far more likely for those earning above the tax threshold.

Health insurance products receive no preferential tax treatment.

4.3. Income cross-subsidies

Medical schemes are permitted to use income-rating (i.e. to utilise income cross-subsidies within a benefit option). Income bands are used far more extensively by restricted membership schemes than open schemes, and the use of income bands by open schemes has reduced dramatically over time. In an analysis of 118 open scheme benefit options in 2014, Kaplan (2015) found that only 11% of options made use of income bands [52]. He also found that the most affordable options on the market were far more likely to make use of income bands than their competitors [52]. Health insurance products generally do not apply income rating principles.

Open medical schemes are exposed to anti-selection risk when using income bands. This is because there are two groups of low-income lives: pre-retirement and post-retirement²⁵. Schemes are therefore exposed to the financial risk of charging lower premiums for high-risk post-retirement lives. There are also practical issues associated with income verification particularly in the individual (as opposed to group business) market. Income rating is typically on the basis of the principal member's income. In reality affordability is more closely linked to household income. In the individual market there is scope for anti-selection (i.e. the principal member is the person with the lowest income in the household).

4.4. The lower cost base of defined risk groups like restricted schemes

There are a number of reasons that restricted membership schemes should theoretically be able to deliver more affordable medical scheme cover. The key reason is that they are less subject to anti-selection (although they may not be able to limit the selective registration of dependants). Restricted schemes are also under less competitive pressure to offer a wide range of benefit options. Offering a large number of benefit options reduces risk pooling and the extent of risk cross-subsidies. Restricted schemes are also more easily able to engineer income cross-subsidies (because they are protected from anti-selection). The cost of non-healthcare costs for this model is also lower, in part due to lower marketing and distribution costs.

Anti-selection in open schemes manifests as a worsening demographic profile. The figure below illustrates the average age comparison between open and restricted schemes over the past 10 years. The trend has been exacerbated by a shift of members from open schemes to GEMS over the period. However, the trends regarding ageing also hold when GEMS is removed. Currently restricted schemes have an average beneficiary age that is nearly 3.5 years younger than the open scheme average.

²⁵ There is also a student market and many income rated options offer a first income band with income levels as low as 0 to R 500 a month to attract these members.

Figure 18: Average age of open and restricted schemes (2005 – 2014)

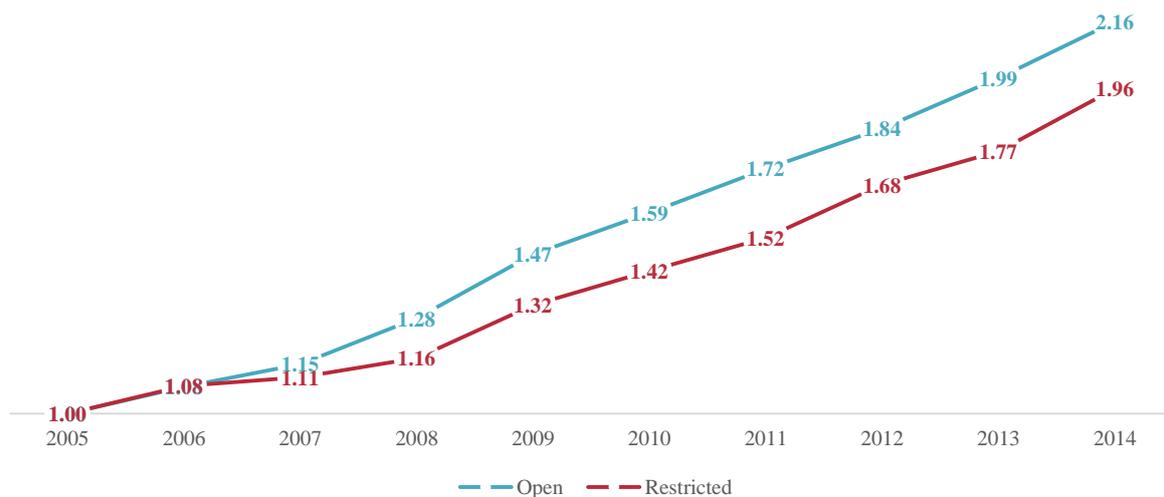


Source: CMS Annual Reports

When we consider the healthcare costs of open and restricted schemes it appears that these theoretical reasons for lower costs translate into actual cost differentials. The latest CMS report indicates that in 2014 the average restricted scheme contribution was R 180 less expensive per beneficiary per month [39].

The figure below illustrates indexed health care costs over the past 10 years for both open and restricted schemes.

Figure 19: Indexed healthcare costs for open and restricted schemes (2005 – 2014)



Source: CMS Annual Reports

Over the past 10 years health care costs for open schemes have increased by approximately 20% more than restricted schemes. This has also been coupled by lower levels of non-healthcare costs for

restricted schemes (R 100 per beneficiary per month for restricted schemes vs. R 183 for open schemes) [39].

A full comparison of the value delivered by open and restricted schemes would need to take into account benefit richness and the quality of care purchased. Analyses of benefit design have indicated that restricted schemes tend to offer more generous benefits than open schemes [2, 53]. *These factors all combine to imply that restricted schemes are in general a more cost-effective means of providing medical scheme cover than open schemes.*

4.5. PMBs create a high minimum cost of cover

The Prescribed Minimum Benefits (PMB) package creates a high minimum cost of cover. According to the latest industry based estimates as shared at the CMS LCBO indaba during March 2015 the average cost of the PMB package amounts to approximately R 805 per life per month. In addition, the ability for providers to claim in full for PMBs creates a disincentive for providers to enter into contracts with schemes. This in turn weakens the purchasing function of medical schemes and creates further upward pressure on costs.

Whilst the PMB package plays an important role in protecting the benefit entitlement of medical scheme members and equity between members, the package has driven an expensive, curative and hospital-centric medical scheme market. The basic cost of just the PMB benefit package without the additional non-health related costs normally associated with a medical scheme would be unaffordable to the majority of South Africans. *The existence of the PMBs thus limits the extent to which medical schemes can make benefit package trade-offs to enhance affordability and increase the membership base of the industry.*

A primary care only product that is exempt from the PMB requirements could be offered for approximately R 280 – R 380 per month. But as noted the regulatory requirements have prevented medical schemes from fulfilling this market gap. Regardless, though, the need for cover remains and this is reflected in the increased activity in the insurance space relating to primary-care focussed products that have adopted the suggested benefit packages and price levels.

5. Annexure 3: Interview participants

The following stakeholders took part in the research via face to face or telephonic interviews:

- Anna Rosenberg – ASISA
- Paresh Prema – CMS
- Richard Blackman – Day 1 Health Insurance
- Emil Stipp – Discovery Health
- Jonathan Broomberg – Discovery Health Pty. Ltd
- Mike Smit – Essential Health
- Mark Blecher - Treasury
- Reshma Sheoraj – Treasury
- Roly Buys – Mediclinic
- Michael Otten – OnePlan Medical Insurance
- Sven Laurenick - OnePlan Medical Insurance
- Mike Settas – Xelus

6. Annexure 4: Standard disclaimer

- In compiling this report Insight have relied upon the accuracy and completeness of information made available to us and, except where expressly stated in the report, Insight have not independently verified the accuracy of the facts or the bases of the information supplied.
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7. Annexure 5: Reference list

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