BB

RESOLUTION
underwriters

SUBMISSION
IN RESPONSE TO

DRAFT REGULATIONS
ON DEMARCATION BETWEEN HEALTH INSURANCE POLICIES AND MEDICAL SCHEMES

SUBMISSION DATE: 23 APRIL 2012

RESOLUTION underwriters

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23 April 2012

For Attention:

National Treasury

By E-Mail: STDemarcation@treasury.gov.za

Re: Submission in Response to Draft Regulations on Demarcation between Health Insurance Policies and Medical Schemes

Attached please find our submission in response to the above Draft Regulations for your consideration.

Sincerely

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1. Overview

It is our understanding that the draft Demarcation Regulations (Hereinafter the "Regulations") published on 2 March 2012 aims to establish clear guidelines for both Short-Term Insurers and Medical Schemes in what the appropriate role for each would be. Additionally the Regulations aim at protecting Medical Schemes and its membership.

It is imperative that these Regulations protect, rather than impede, consumers and Medical Scheme Members. We believe that the Regulations fall short of this ideal.

We therefor submit herewith our comments on the Regulations and its likely impact.

2. The current state of affairs.

These are various factors making healthcare coverage increasingly expensive and inaccessible for South Africans.

Both Medical Schemes and Short-Term Insurance (Accident and Health) policies are important enablers for consumers to access private healthcare. Only a marginal portion of South Africans are Medical Scheme Members and the proportion has and will remain relatively stable. New entrants into the market mainly enter restricted Schemes, mostly through the Government Employees Medical Scheme, and not open schemes. The larger problems of poor cross-subsidisation are more evident in open schemes.
The growth rate as reported by the Council of Medical Schemes (CMS) bears out the assertion that there is not likely to be a massive spike in the uptake of Medical Scheme Membership, even if all Accident and Health Short-Term Insurance products are removed from the market.

Medical Scheme membership is not compulsory, and less than 17% of South African citizens belong to a Medical Scheme. Medical Scheme Members, like all consumers, have been

adversely affected by the economic climate and many members are as a result downgrading to lower-cost options.

Section RR, page 31 of the 2010-2011 Annual Report from the CMS **(Annexure A)** confirms that their research indicates the main reason for member buy-down as being affordability.

Consumers increasingly tend to opt for hospital plans instead of full comprehensive medical plans. In addition to the affordability issues consumers are also increasingly willing to manage their day-to-day expenses to a larger extent. (This is in any event part of their responsibly on many comprehensive Medical Schemes as consumers are required to manage their medical savings accounts themselves.)

There is ever increasing pressure on our under-resourced, oversubscribed Public Healthcare System which will be monumentally exacerbated if consumers are forced to relinquish scheme membership due to the increasing cost and decreasing benefits offered.

Section RO, page 163 of the 2010-2011 Annual Report from the CMS **(Annexure B)** state *"While expenditure on medical specialists has been increasing steadily since 2000, a trend-break occurred in 2004 with expenditure on specialists starting to increase at a much higher rate".*

This statement clearly links back to the removal of cost containment methods such as collective bargaining, The Health Professions Council South Africa (HPCSA) ethical tariff list and most importantly the National Health Reference Price List (NHRPL) from the system. In effect there is now no limit on the fees that a healthcare practitioner can charge. The only benchmark other than the NHRPL is the "maximum ethical fees" published by the HPCSA and these are most definitely not limited to any "Medical Scheme Rate".

Cost studies performed by the Healthcare profession for the Reference Price List process in any event indicated that professional fees should be between two and three times the then Reference price rate. Practitioners will continue to charge rates that is acceptable and reimburses them commensurate to their skills, investment in their practices and which

allows them to earn an income that they perceive as fair. The blanked enforcement of any rate is not a solution to the perceived gap in the rate at which Medical Schemes reimburse practitioners versus their charges.

Whilst this is already an alarming state of affairs it is by no means exhaustive of the extent of the problem. In reality the vast majority of practitioners charge in excess of Medical Scheme rates with a significant amount charging well in excess of the "maximum ethical fees". Consumers in effect can therefore have an open-ended liability for healthcare cost which is clearly not in their interest.

3. Accident and Health Short-Term Insurance

Accident and Health Short-Term Insurance is any form of insurance compensating an individual for loss as a result of an accident or illness.

The amalgamating of all Accident and Health products under a single "umbrella" leads to significant confusion in the market and amongst consumers. The Regulations and the subsequent comments in the media make it clear that these differing products should be treated as exactly that.

It is not an apples-with-apples comparison to place hospital insurance plans next to a Gap Cover Product and treating the two as similar.

It is therefore prudent to clarify that our comments herewith relates to Gap Cover and Co-Payment Cover Products, which should be clearly distinguished from products classified as "Top-up" covers.

3.1. Available products

Differing Product Offerings currently available include, but are not limited to:

- Hospital Cash Back products
- Hospital Short-Term Insurance products
- Top-Up Cover products
- Co-Payment / Deductible Cover products
- Gap Cover products

3.1.1. Hospital Cash Back products

These products are designed to provide cover at a set amount per day for hospitalisation, usually exceeding a certain time period. This amount is not necessarily related to the actual cost of hospitalisation.

3.1.2. Hospital Short-Term Insurance Products

Hospital Short-Term Insurance products are designed to pay out a stated benefit that is linked to specific procedure or diagnoses. Again, these stated benefits are not necessarily related to the actual cost of hospitalisation.

Both Hospital Cash Back products and Hospital Short-Term Insurance products are still classified as Accident and Health Short-Term Insurance policies under the Regulations. Products under Category 1 of the Regulations are far more likely to be perceived as replacement products for a Medical Scheme, especially so in a market where the average consumer has very little insight in to the actual cost of healthcare.

It is our contention that these products pose a significant risk to Medical Schemes as replacement products.

3.1.3. Top-Up Cover Products

Top –Up Cover products can provide cover in one of two ways:

3.1.3.1. Overall Annual Limit cover is designed to provide additional cover once the overall annual hospital limit on the Medical Scheme has been reached where further hospitalisation is then covered by the Top-Up Cover product.

3.1.3.2. Sub-Limit Cover is designed to provide cover once the insured exhausts a sub-limitation imposed by a Medical Scheme (for instance on a specific disease class). Additional treatment under the sub-limit imposed by the Medical Scheme is then covered by the Top-Up Cover product.

These products are excluded from the definition of Accident and Health Short-Term Insurance products in the Regulations. It is again our contention that these products do pose a risk to Medical Schemes as it might encourage scheme members to buy-down onto a lower cover option which can be enhanced with one of these products.

3.1.4. Co-Payment / Deductible Cover Products

Co-Payment / Deductible Cover products are designed to cover the co-payments/deductibles imposed in terms of Medical Scheme rules. These excesses may be either procedure related or admission related.

Co-Payment Cover products are completely distinct from "Top-Up Cover" insurance or hospital insurance plans and should be treated as such.

3.1.5. Gap Cover Products

Gap Cover Products are designed to cover the difference between the Medical Scheme Rate and Private Rates charged by Healthcare Professionals for in-hospital treatment.

Gap Cover Products are completely distinct from "Top-Up Cover" insurance or hospital insurance plans and our contentions are outlined in our submission.

These products are currently excluded from the Regulations although they do not pose any of the risks the Regulation aim to address. Our further submissions address this contention.

4. Foundation of the reasoning behind the Regulations.

Schedule B, Point 3 of the Regulations clarifies the Policy principles that informed the Regulations as follows:

4.1. To support and enhance the objectives and purpose of the Medical Schemes Act (MSA) (community rating, open enrolment and cross-subsidisation)

Whilst progress has been made in the Medical Schemes Industry on achieving the principles of community rating and open enrolment the fragmented option design and non-implementation of the Risk Equalisation Fund is widely accepted as the biggest reason for cross-subsidisation not effectively being achieved. Constant referral to Accident and Health Short-Term Insurance policies being the biggest risk to Medical Schemes in this regard is completely unfounded in reference to Gap Cover Products.

Gap Cover Products can and should not be judged on the criteria used for Medical Schemes. The entire purpose of the Regulations is to differentiate Medical Schemes and Short-Term Insurance policies. To apply cross-judgement then to Short-Term Insurance products is counterproductive and will only serve to further muddle the waters on product differentiation.

4.2. To counter the possible negative effect Accident and Health Short-Term Insurance policies may have on Medical Schemes

As stated *"Accident & Health Policies may result in –*

- *Younger and healthier persons terminating, limiting or reducing their Medical Scheme cover*
- *A negative impact on the life-cycle protection offered by Medical Schemes*
- *Medical Schemes reducing benefits"*

The wording of the Regulations is indicative of the uncertainty of this statement. There is no empirical evidence that the existence of the majority of Accident and

Health policies have any impact on the decisions of consumers to enter the Medical Scheme market.

Section RR, page 37 of the 2010-2011 Annual Report from the CMS **(Annexure C)** indicates the average Principal Member's Gross Contribution to Medical Schemes at R1 467, 00 per principal member per month.

If one takes account of Scheme Options offered at this average contribution rate the reimbursement rate for practitioners in hospital is 100% of the Scheme rate, most often also linked to a specified network of providers.

The average Scheme member therefor has only the Scheme rate as benefit and any charge in excess of this amount is for the pocket of the scheme member. In essence the average Medical Scheme member will have an out of pocket expense amount that is charged in excess of the scheme rate.

Scheme Options offering reimbursement of in-hospital practitioners at 200% or more of the Scheme rate is priced significantly higher.

This can be evidenced from a breakdown in the most subscribed Medical Schemes' membership as well as the most subscribed Medical Scheme Options.

4.2.1. Most subscribed Medical Schemes

The Annexures to the CMS Annual Report 2010-2011 identifies the most subscribed schemes as Discovery, Bonita's and GEMS (Government Employees Medical Scheme) **(Annexure D & E).**

- The 3 most subscribed Medical Schemes offer 24 Benefit Options.
- Only 7 benefit options will reimburse medical practitioner costs in hospital more than the Medical Scheme rate.
- Only 2 of these options will reimburse practitioner costs at more than 200%.

- 17 of the 24 options will reimburse only 100% of the Medical Scheme rate for practitioner charges.
- The overall average contribution over the 24 options amounts to R1 575, 21.
- The overall average premium allocated to a Medical Savings Account (MSA) across the 24 options amounts to R175.00.

To increase the cover to an option that will provide cover in excess of the Medical Scheme rate, the average premium will increase to R2 118, 29.
The average MSA contribution on such schemes will increase to R 442.71. This is an increase of 34.48% on current contributions.

4.2.2. Most Subscribed Medical Scheme Options

The Annexures to the CMS Annual Report 2010-2011 **(Annexure D & E)** identifies the most subscribed Medical Scheme options as:

(1) GEMS – Emerald,
(2) Discovery -Classic Comprehensive, KeyCare Plus, Classic Saver, Coastal Saver, Classic Priority, Coastal Core, Essential Saver and
(3) Bonitas Standard and Primary.

- Of the 10 most subscribed Medical Scheme options only 3 options will reimburse medical practitioner costs in hospital at 200% of the Medical Scheme Rate
- None of the top 10 subscribed options will reimburse practitioner costs to more than 200%.
- 7 of these options will reimburse practitioner charges to 100% of the Scheme rate only.
- The average contribution on these 10 options amounts to R1 527.50.
- The average premium allocated to a Medical Savings Account (MSA) amounts to R208, 00.

Upgrade to options within these Medical Schemes offering reimbursement at 300% would push up the average contribution to R3 205, 00 and the MSA contribution to R 649.00.

This is an overall increase of 109.82% on current contributions.

It is simply out of reach for the majority of scheme members to afford.

In addition to self –funding the Medical Savings account scheme members already have to provide, on the vast majority of scheme options, all additional practitioner charges (in and out of hospital).

It would therefore be questionable to expect any significant buy-up on Medical Schemes where the increased cost does not guarantee that the member would not continue to have significant out of pocket expenses which is now to be coupled with a significantly higher scheme contribution. It is far more likely that consumers will downgrade to lower cost options and merely then maintain their self-funding of additional healthcare expenses.

There is no empirical evidence that consumers will buy-down on options as a result of having Gap Cover Products. In essence consumers view Gap Cover Products as essential additional cover for costs that is not covered by a Medical Scheme but which can amount to a substantial cost to the consumer.

4.3. To ensure that consumer rights are protected and consumers are adequately advised of the difference between Accident and Health Short-Term Insurance versus Medical Scheme Membership.

As stated *"The absence of clear demarcation may result in consumers believing:*

- *That accident and health policies offer the same protection as a Medical Scheme , when in fact the protection is partial and conditional and/or*
- *that accident and health policies are Medical Schemes"*

The wording of the Regulations is indicative of the uncertainty of this statement.

The cover provided under both Gap Cover Products and Co-Payment products is in no way a replacement for a Medical Scheme and is not perceived in the market as such. It is clearly positioned to provide cover completely outside of what a Medical Scheme would do. In fact – Gap Cover Products will only ever cover self-payment portions that a Medical Scheme would not cover.

The preamble to the **Consumer Protection Act 68 of 2008** clearly states the enactment of legislation to:

- *"promote and protect the economic interests of consumers;*
- *improve access to, and the quality of, information that is necessary so that consumers are able to make informed choices according to their individual wishes and needs; and*
- *promote and provide for consumer education, including education concerning the social and economic effects of consumer choices;.."*

In essence denying consumers the ability to provide for costs NOT covered by a Medical Scheme, in addition to already self-funding a Medical Savings Account, cannot possibly fit this description. It is contrary to the economic interest of consumers to be denied the ability to protect their own interests.

A clear need exists to enable consumers to be educated on the extent of exposure they currently have to out-of-pocket expenses, as well as existing mechanisms to address this exposure as they see fit. Additionally it is imperative that cognisance is taken of the devastating economic effect that the withdrawal of this right would have on them.

Consumers will not support a product that does not provide value. It is clear form the amount of Gap Cover Products that exist in the market that consumers are vocal in their support of these products.

Consumers not only want to have the peace of mind that Gap Cover Products provides – they need to have a vehicle of funding the significant shortfalls that they will incur when hospitalised.

Existing legislation under the FAIS Act 37 of 2002 provides for the responsibility of Financial Advisors to adequately explain benefits and products and provide the consumer with the most appropriate product for their needs. Again, with reference to the existence of policies in the marketplace, it is clear that these are valuable products that fill a required need.

Recourse exists under the FAIS act where a consumer is provided with incorrect financial advice. The decrease of focus on the important role of intermediaries within the Medical Schemes market contributes to the poor state of member education on the benefits and limitations that exist within the Medical Scheme sphere.

This is not the case within the Gap market. Costs, benefits and exclusions are clearly disclosed in terms of the applicable legislation. Business is placed through licenced Intermediaries only and, in terms of the Binder Regulations, this will continue to be the state of affairs.

To reiterate - Gap Cover Products are not confused with Medical Scheme Membership and positioning Gap Cover Products as such is not logical.

5. Additional comments

5.1. Constitution of the Republic of South Africa 108 of 1996

Section 27 of the **Constitution of the Republic of South Africa 108 of 1996** outlines the overriding governing principles related to Healthcare:

27. Health care, food, water and social security.-

1) Everyone has the right to have access to –

a) health care services, including reproductive health care;

2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

There is no dispute as to the inequality within the Healthcare structures. The Medical Schemes environment is by no means the representative body of the majority of citizens. As such legislation that protects only its rights in comparison to others can and should never be enacted. Whilst there is general agreement that Medical Schemes should be protected the blanket banning of products that allow citizens to access healthcare is contrary to the interest of South Africans.

5.2. Dangers of Self-Funding of healthcare

Benefit options on most Medical Schemes already places primary healthcare into a 'self-managed' saving component. Once the members' *own* funds in this pool are depleted such a member would have to continue *self-funding* any required care whilst still having to fund a Medical Scheme contribution.

In effect members who are unable to fund their own care will hold off on procedures or tests which, as early intervention, would enable the member to access appropriate health care timeously.

These members therefor only access healthcare when they have no other choice, at a point where they are evidentially ill. As such the treatment period and intensity would be much higher, resulting in higher costs to both the member and the Medical Scheme.

The same principles apply to scheme members who are unable to fund the self-payment gap on Medical Scheme co-payments or specialist costs in hospital. In effect, Gap Cover Product policies provide a much needed safety net to enable

members, who are aware that their costs will not be covered by their Medical Schemes, and who are unable to fund this shortfall themselves, to access appropriate medical care timeously.

5.3. Prescribed Minimum Benefit (PMB's)

Whilst a laudable objective issues around PMB's must be resolved and contending that this is a cure-all for consumer healthcare is inaccurate.

Much has been made in the media on the *locus standi* finding in the Board of Healthcare Funders (BHF) application regarding PMB's. The fact is that the finding did not address the validity of **Regulation 8 of the Medical Schemes Act** and that this regulation therefor remains open to future challenge. Additionally the PMB condition list has not been reviewed every two years as required, and has not been revised since 2000.

The PMB list is by no means exhaustive of all medical treatment required. In practice benefits for non-PMB treatment will continue to decrease to accommodate the subsidisation of PMB treatment, especially since these have to be paid in full as invoiced.

6. Challenges to the Objectives and purpose of the Medical Schemes Act

6.1. Open enrolment

Open enrolment provides that no one may be declined membership of an open Medical Scheme, irrespective of their age or state of health.

Open enrolment therefor allows the consumer, when he chooses to join a Medical Scheme, to do so. It does not incentivise such a consumer to do so at the earliest opportunity – in fact, it encourages him to do so only when the need arises. The attitude of "I will wait for the NHI / wait until I have a family/don't need it right now"

is well entrenched. Anti-selection is a consistent risk to Medical Schemes as well as insurance companies and is most practiced by pregnant women and those who with serious chronic disease.

As Medical Scheme membership remains non-mandatory for the employed the abolition of Accident and Health policies by itself will not incentivise young people to join Medical Schemes. It is additionally important to note that not all Gap Cover Products impose exclusions based on the age of an applicant. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

6.2. Community rating

Community rating provides that Medical Scheme contribution rates may not differ based on a person's age or state of health.

Again, it is important to note that not all Gap Cover Products require differing contribution rates based on age or state of health. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

6.3. Cross Subsidisation

Cross-Subsidisation aims at offsetting the posed risk of sick, usually older members by subsidising them through the contribution of healthier, mostly younger members. In essence a balance must be found between healthier and sicker members to ensure that a product would remain sustainable.

As previously noted, in the absence of making membership to a scheme compulsory for a large group of people, the tendency to not spend money on such membership until it becomes a necessity will continue.

Yet again, it is important to note that Gap Cover Products rely on the principles of cross-subsidisation as much as Medical Schemes do. There is therefor, on the majority of Gap Cover Products, no conflict in terms of this principle.

7. Utilisation experience

During 2010 the average claim submitted amounted to R 3 624.01
During 2011 the average claim submitted amounted to R 4 083.80

This represents an increase of 12.69% in claim amounts.

8. The actual impact

We note with interest the statements contained in the Comments on the National Health Insurance Policy Paper of 12 August 2011 specifically related to current healthcare spend.
Point 14.3, page 42 of the report **(Annexure F)** states:
"..... out-of-pocket payment, which is the most regressive form of healthcare financing, amounts to only 1.5% of GDP in South Africa, way below the international median."

With reference to Table 8 South African Healthcare expenditure in the public and private sectors 2007/08 to 2013/14 (3), page 41 **(Annexure G)** however, no indication is given of the proportion of Healthcare spend that currently is self-funded through Medical Savings Accounts.

Additionally there is no indication as to whether these figures include the current spend through insurance products – rather than only contributions to such products. In essence the current spend is underreported with regards to real Healthcare spend effect from the fees paid by Insurers, the non-reporting of Medical Savings Accounts as well as the real out-of-pocket spend that results from this.

9. Closing

The objectives of open-enrolment, community–rating and cross subsidisation are commendable. So are the principles supporting Prescribed Minimum benefits. Unfortunately various challenges still exist to these principles and objectives and these must be resolved.

To place the blame for these objectives not being met at the door of Short-Term Insurance products is disingenuous at best whilst the damage to the consumer on the removal of such products will be vast.

The Regulations should provide much needed protection to Medical Schemes and its principles – however, to position Gap Cover Product policies as a threat to Medical Schemes and its supporting principles cannot be viewed as a solution.

The Healthcare environment is challenging – all role-players acknowledge this. To provide access to quality healthcare should remain a high priority and this can only be achieved by taking cognisance of all the available mechanisms and utilising these correctly.

It remains our contention that a great deal of uncertainty as to the actual impact of the removal of Gap Cover Products from the definition of Accident and Health policies still remains and must be fully explored.

In the absence of a sensical review of the real impact the Regulations as they stand will cause more harm than good.

The CMS itself has repeatedly acknowledged that affordability of contributions is the biggest barrier to entry into the market. Healthcare costs have consistently increased at levels above inflation and the same is true of contributions and self-payments gaps on Medical Schemes. In addition consumers are increasingly under pressure to fund ever-higher food, transport, electricity and other costs.

In light of the economic environment it would be nonsensical to expect Medical Scheme membership to increase where the income levels of households and individuals are decreasing. Likewise, consumers are unlikely to buy up to higher priced options on Medical Schemes as the benefit of these options is not outweighed by the cost.

It is delusory to state that the reason for consumers not taking up Medical Scheme membership is related to the availability of Gap Cover Products and a review of the Regulations is there for imperative.

Annexure A

How members use healthcare services

This project was a continuation of our efforts to advance cost regulation in the private health sector. Its overall objective was to explore the way in which members of medical schemes use healthcare services and to recommend strategies to mitigate cost escalation in the medical schemes industry.

It is important to understand the major trends in the utilisation of healthcare services so as to determine areas of potential cost flare-ups more accurately. Appropriate cost control strategies can then be designed and recommendations can be made for roll-out in the entire private health sector.
Our Research & Monitoring Unit compiled a list of 10 healthcare utilisation indicators which included in- and out-of-hospital care, specialists, diagnostic devices and medicines. The piloting exercise involved selected medical schemes, administrators and private healthcare providers, based on a non-random sampling technique.

The following key issues emerged from the analysis:

- Medical schemes use different information technology (IT) platforms to capture and interpret member information.
- There is inconsistency in how medical schemes and administrators capture ICD-10 codes. Some schemes capture only primary codes while others also include secondary codes.
- Schemes have limited access to patients' clinical notes which makes it difficult for them to collect utilisation data.
- There is inconsistent use of alternative reimbursement systems, with some medical schemes using diagnosis-related groups (DRGs) and others still on fee-for-service.
- There are valid differences in the risk-adjustment methodologies that different stakeholders use.
- There are no industry norms or standards on utilisation measures.

The next phase of this project will entail collecting actual utilisation data from medical schemes from which trends will be ascertained.

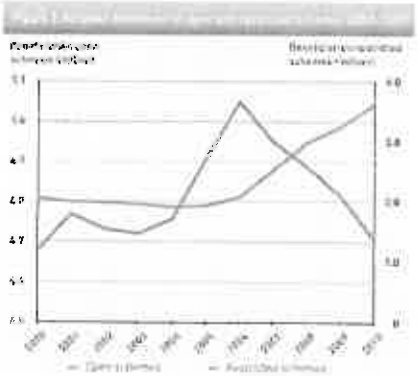
How members move between schemes and options

The Research & Monitoring Unit conducted a study on member movement in the medical schemes industry.

The study explored member movement at both scheme and option level. It looked at movement trends from open to restricted schemes and from high-cost to lower-cost options. The study also analysed the factors which influence members' decisions to change benefit options within their medical scheme.

The research findings confirmed a trend towards consolidation among medical schemes.

Open schemes have experienced a significant loss of membership in recent years while membership in restricted schemes has been growing; this can be explained by government employees moving from open to restricted schemes.



The study on member movement also revealed the effect of contribution increases on the industry and members of medical schemes when they move between benefit options within their scheme.

The nominal increase in average risk contributions per average beneficiary (as per scheme financials) in 2006/2007 was 10.0% and the comparative figure for 2009/2010 was 11.8% for open schemes; this was slightly higher than restricted schemes.

The average increase for restricted schemes in gross contributions per average beneficiary per month was 8.9% for 2006/2007 and the comparative figure for 2009/2010 was 11.8%.

The contribution increases proposed by schemes in 2009/2010 were 15.7% for open schemes (a deviation of 4.2% from the actual increase that the CMS eventually approved) and 12.7% for restricted schemes (a deviation of 1.1% from the final increase). The considerable difference between these estimated contribution increases and the actual increase in the average contribution income of medical schemes indicates that some members trading down from more comprehensive options to cheaper options with the consequent effect on contributions; this phenomenon is more pronounced in open schemes.

An online survey was conducted to understand how members of medical schemes choose or change a benefit option. This survey was part of the member movement study and was used to better understand why members move between benefit options. We asked members of a restricted scheme if they had changed benefit options in 2008 and 2009. The study revealed that the most common reason why members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options. The other common reason for changing benefit options was limited access to benefits, i.e. when members feel that they do not have adequate benefits in their current option, they seek out an option that offers the benefits that meet their needs.

Finally, this study on member movement established that medical schemes do compete against one another for membership. Very few schemes compete based on efficiency measures when purchasing healthcare for their beneficiaries. Overall, medical schemes still resort to fee-for-service measures and simply increase their contributions to accommodate the ever-increasing healthcare costs.

Practice Code Numbering System (PCNS)

Regulation 5 of the Medical Schemes Act requires suppliers of healthcare services to include a practice code number on accounts submitted to medical schemes for payment.

The CMS accordingly has the responsibility to ensure that a system is in place for the issuing of such practice code numbers.

Currently the Practice Code Numbering System (PCNS) is contracted out to the Board of Healthcare Funders of Southern Africa (BHF).

The CMS monitors on a quarterly basis the key statistical information about all providers registered in the PCNS.

Annexure B

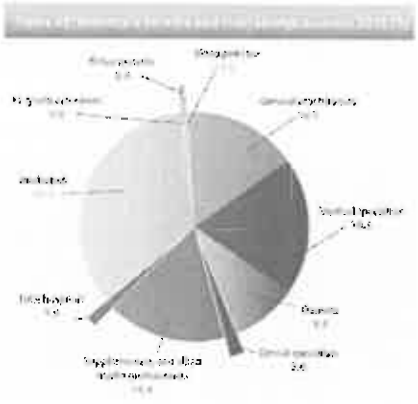
Healthcare benefits paid from medical savings accounts

Healthcare benefits paid from medical savings accounts amounted to R8.3 billion (10.0%) of total benefits in 2010.

Figure 21 shows that medicines took up the largest share of medical savings accounts expenditure in 2010 (24.2%). Medical specialists accounted for 19.3% and GPs for 16.1%.

Supplementary healthcare providers took 16.4% of benefits paid from medical savings accounts.

As in previous years, expenditure on hospitals and dental specialists accounted for a comparatively small proportion of benefits paid from medical savings accounts (1.5% and 7.0% respectively).



Trends in total healthcare benefits paid

Figure 21 shows the distribution of healthcare benefits paid by medical schemes to different types of providers since 2000. These figures have been adjusted for inflation.

By 2010, medical scheme expenditure on private hospitals had increased in real terms by 121.0% to R30.3 billion compared to R13.7 billion in 2000. Private hospital expenditure accounted for 29.9% of all healthcare benefits paid in 2000; the comparative figure for 2001 was 25.6%.

Expenditure on private hospitals appeared to stabilise between 2004 and 2005 but a steep upward trend began to emerge in 2006 onwards such that in 2010 private hospital expenditure accounted for 36.4% of all healthcare benefits paid by medical schemes; this was slightly less than the 36.7% noted in 2009.

Benefits paid to medical specialists in 2010 amounted to R18.8 billion, an increase of 104.4% in real terms when compared to the R9.2 billion that was spent on this item in 2000. While expenditure on medical specialists has been increasing steadily since 2000, a trend-break occurred in 2004 with expenditure on specialists starting to increase at a much higher rate.

Expenditure on medicines increased by 11.1% to R14.0 billion in 2010 from R12.6 billion in 2000 but as a proportion of total healthcare benefits, it decreased from 27.0% in 2000 to 19.0% in 2004. In 2005-2010, medicines expenditure remained consistently at 17.0% relative to all benefits paid.

Total expenditure on GPs amounted to R4.2 billion in 2010, which is an increase of 65.2% compared with the R3.6 billion spent in 2000. There was an increase of 4.2% on benefits paid to dentists, from R2.4 billion in 2009 to R2.5 billion in 2010.

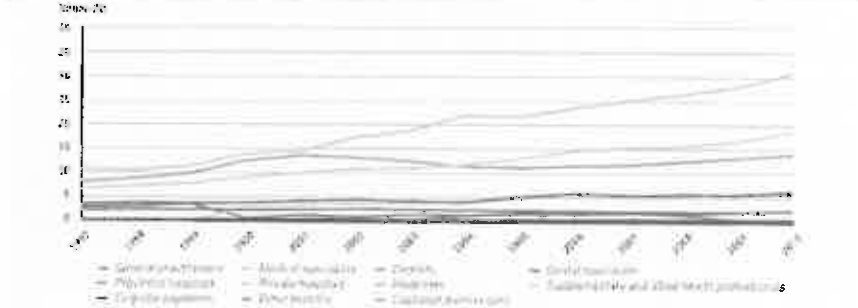
Healthcare benefits paid per beneficiary

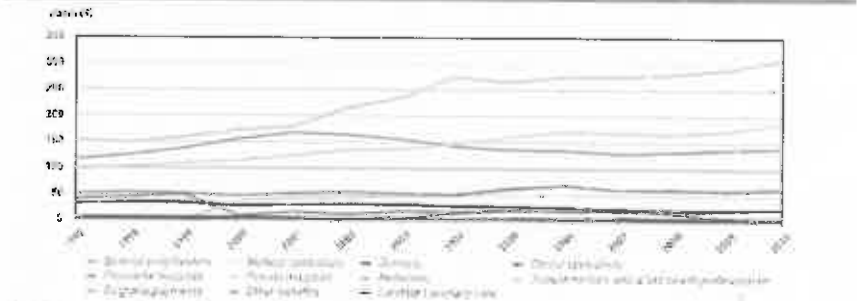
Figure 22 shows the changes in healthcare expenditure per beneficiary per month (pbpm) from 2000 to 2010.

When adjusted for inflation and membership, expenditure on private hospitals increased by 75.4% from R172.9 pbpm in 2000 to R303.0 pbpm in 2010. An upward trend could be observed between 2000 and 2004 followed by slight stabilisation in 2004-2005. From 2006 the trend in private hospitals expenditure per beneficiary per month started accelerating remarkably and the steep upward trend continued in 2010.

After peaking in 2001, expenditure on medicines continued to decline until 2007. It was R155.6 pbpm in 2000 and declined by 10.0% to R140.0 pbpm in 2002.

Per-beneficiary expenditure on medical specialists increased by 65.0% over the 11-year period from 2000 to 2010, from R113.7 pbpm to R187.6 pbpm respectively; that on GPs increased by 30.1% from R47.6 pbpm in 2000 to R61.9 pbpm in 2010. Medical schemes spent 19.3% less on dentists; they paid R29.3 pbpm in 2000 and R25.4 pbpm in 2010. Spending on dental specialists also declined, namely by 1.8% from R6.1 pbpm in 2000 to R6.0 pbpm in 2010. Medical scheme expenditure on supplementary and allied health professionals increased by 77.5% - from R37.8 pbpm in 2000 to R67.1 pbpm in 2010.





Annexure C

Status of option	Open scheme options	Restricted scheme options	Total
Options registered in January 2010	174	158	332
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	-4	-7	-1[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	7	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
Approved options 1 January 2011 (excluding [illegible])	14[illegible]	145	2[illegible]4
[illegible]	[illegible]	[illegible]	[illegible]
Registered options 1 January 2011	171	145	316

* [illegible]

open and restricted schemes to determine whether this deviation from the norm was a once-off occurrence or the beginning of a new trend.

The observation above also highlights the fact that the average family contribution in restricted schemes is 11.5% lower than in open schemes. This substantiates the purpose of restricted schemes: they are able to provide medical scheme benefits at a more affordable level than open schemes can.

The fact that restricted schemes have, for the first time, increased their contributions by more than open schemes have is concerning because if this continues to happen, the differential between open scheme contributions and restricted scheme contributions may reduce. This in turn raises the issue whether it is preferable to have restricted schemes in an environment where the traditional advantages of lower contributions are being eroded by the various challenges facing the industry.

The gross contribution increase is based on the actual number of principal members and adult and child dependants in medical schemes. The information in this section is a summary based on medical scheme submissions in respect of the annual benefit changes and contribution increases for 2011; it is based on projections in these submissions.

The average gross contribution increase was 9.1% per principal member, 9.4% per adult dependant, and 9.1% per child dependant. In open medical schemes, it was 9.1% per principal member, 9.3% per adult dependant, and 8.3% per child dependant. In restricted medical schemes, it was 9.0% per principal member, 9.7% per adult dependant, and 9.5% per child dependant.

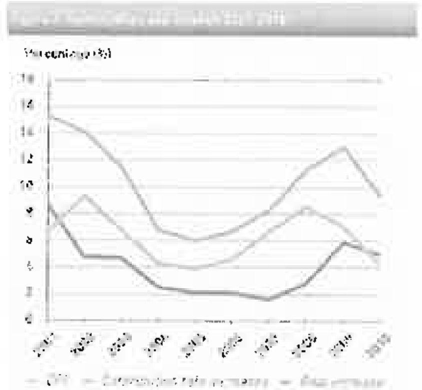
Risk contributions: year-on-year percentage rate changes

The average risk contribution increase for all medical schemes in 2011 was 9.1%. The comparative increases for open and restricted schemes were 8.7% and 9.7%, respectively.

The average risk contribution increase was 8.9% per principal member, 9.5% per adult dependant and 9.0% per child dependant. The principal member, adult dependant and child dependant risk contribution percentage increases for open schemes was 8.7%, 9.2% and 8.0% respectively. The principal member, adult dependant and child dependant risk contribution percentage increases for restricted schemes was 9.3%, 10.1% and 10.1% respectively.

Contribution rates relative to general price indicators

Figure 3 shows the historical and current trends in the Consumer Price Index (CPI) (or inflation) relative to contribution rates in medical schemes between 2001 and 2010. We also incorporated the real increase in medical scheme contributions (amount by which medical contribution increases are greater than inflation).



Our research shows that since the year 2002, medical scheme contributions have been similar to inflation.

The trend noted for the past 10 years, of contribution increases in open schemes being higher than in restricted schemes, was not maintained in the period under review. It is interesting to note that the average real increase in contributions throughout the period 2001 to 2010 is in the region of 4.0%. This is higher than the CPI + 3% range recommended by the Office and has implications for the long-term affordability of the medical schemes industry as increases in salaries may not necessarily be able to keep pace with contribution increases.

From the graph we can also infer that there were two periods in which the real increase in medical scheme contributions was double the inflation rate at the time, i.e. in the years 2001 and 2010. This is worrying. As a result the contribution rate for 2011 is 48.0% higher than the 2001 contribution rate in real terms. This means that the average medical schemes contribution rate in 2011 is 48.0% higher than the 2001 contribution after the impact of inflation has been removed.

Gross contributions and risk contributions 2011

The average monthly gross contribution for 2011 per principal member, adult dependant, child dependant and family was as follows:

Monthly gross contribution in 2011	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 54[illegible]	R1 [illegible]	[illegible]	R[illegible]
Restricted schemes	R1 [illegible]	R1 1[illegible]	[illegible]	R[illegible]
All schemes	R1 [illegible]7	R1 2[illegible]	R[illegible]3	R2 472

The average monthly risk contribution for 2011 per principal member, adult dependant, child dependant and family was as follows:

Monthly risk contribution in 2011	Principal member	Adult dependant	Child dependant	Family
Open schemes	R1 [illegible]	R1 2[illegible]7	[illegible]	R[illegible]
Restricted schemes	R1 2[illegible]	R1 [illegible]	R[illegible]	R2 [illegible]
All schemes	R1 [illegible]	R1 [illegible]	R[illegible]	R[illegible]0

Non-health expenditure increases compared to gross contribution increases

The average increase in total non-health expenditure – which includes administration costs associated with collecting contributions and paying out benefits, printing costs associated with schemes' brochures and benefit guides, the cost of running call centres and legal costs – for all medical schemes in 2011 was 6.[illegible]%. The comparative increases for open and restricted schemes were 5.6% and 7.1% respectively.

The principal member, adult dependant and child dependant non-health cost increases for all medical schemes were 6.2%, 5.6% and 5.0% respectively.

Annexure D

Annexure O: Detailed financial information per option: registered schemes

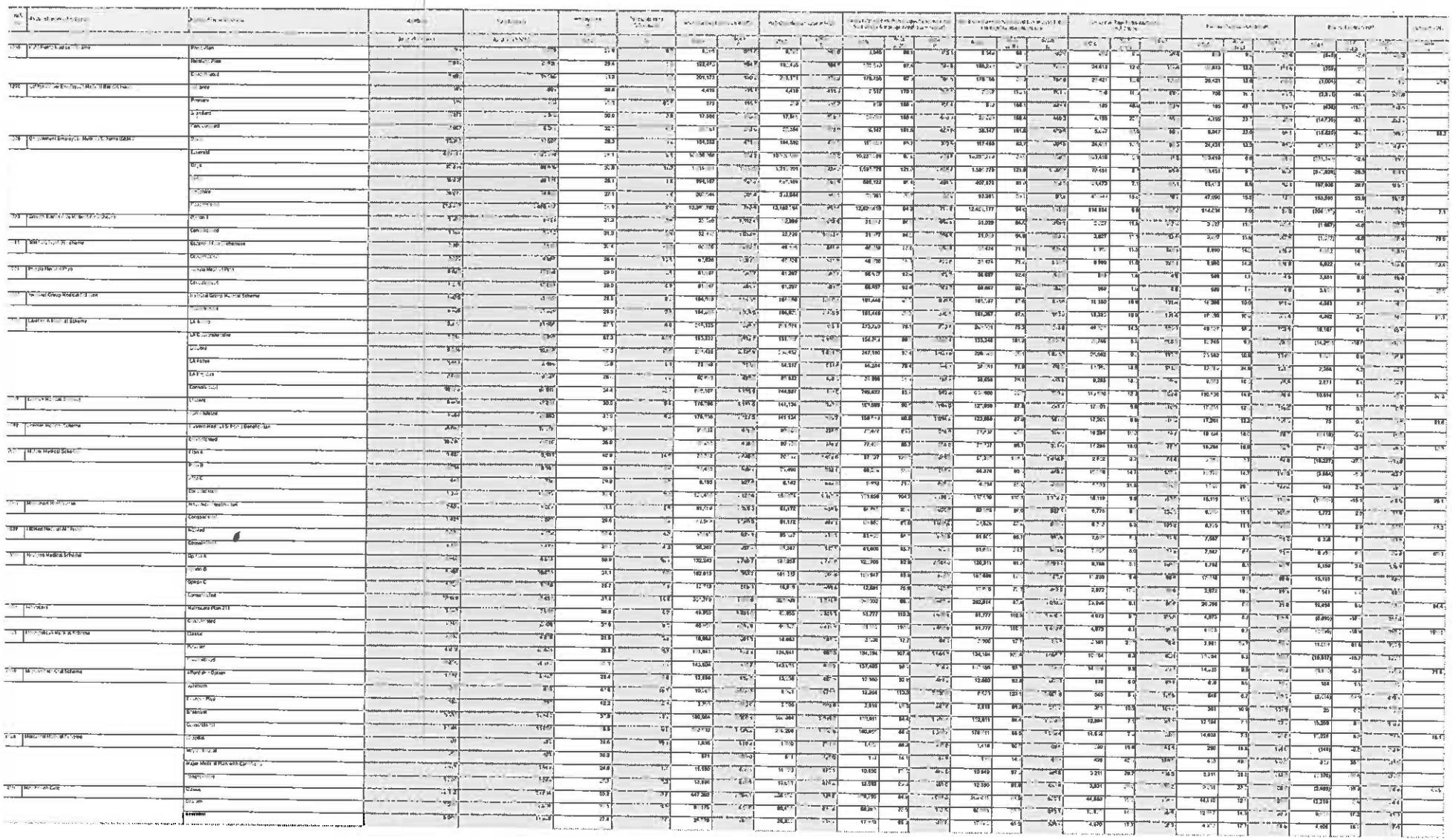
for the year ended 31 December 2010

No.	Name of medical scheme	Name of benefit option	[illegible]
	Open schemes		
[illegible]	Bonitas Medical Fund	[illegible]	[illegible]
		Dual Plan	29.3
		[illegible]	47.9
		[illegible]	63.1
		Millennium Basic	29.1
		Millennium [illegible]	48.1
		Millennium [illegible]	38.1
		Platinum	47.1
		Top [illegible]	41.9
		[illegible] Care	32.4
		Consolidated	37.5
[illegible]	[illegible]	[illegible]	34.5
		[illegible] Comprehensive	39.1
		[illegible]	30.9
		[illegible]	[illegible]
		Primary	27.0
		[illegible]	[illegible]
		Consolidated	30.9
[illegible]	Cape Medical Plan	[illegible]	[illegible]
		[illegible]	[illegible]
		[illegible]	[illegible]
		Consolidated	[illegible]
[illegible]	Community Medical Aid Scheme (COMMED)	[illegible]	[illegible]
		Deluxe	44.8
		Standard	34.2
		Consolidated	37.5
[illegible]	[illegible]	[illegible]	40.4
		[illegible]	42.8
		[illegible]	48.5
		[illegible]	31.7
		[illegible]	34.7
		[illegible]	[illegible]
		[illegible]	[illegible]
		Consolidated	38.5
[illegible]	Discovery Health Medical Scheme	[illegible]	38.6
		Classic [illegible]	[illegible]
		Classic Priority	32.1
		Classic Saver	[illegible]
		[illegible]	34.1
		[illegible] Saver	30.3
		Essential Comprehensive	38.2
		Essential Core	[illegible]
		[illegible]	[illegible]
		Essential Saver	[illegible]
		[illegible]	37.9
		[illegible] Care	[illegible]
		[illegible]	31.9
		KeyCare Plus	[illegible]
		Consolidated	31.6
[illegible]	[illegible] Medical Scheme	[illegible]	[illegible]
		[illegible]	[illegible]
		[illegible]	[illegible]
		[illegible]	38.2
		[illegible]	44.0
		[illegible] Standard	[illegible]
		[illegible]	48.8

Annexure E

Annexure 0: Detailed financial information per option: registered schemes

for the Year Ended 31 December 2019



Annexure F

Figure 21: **Incomplete cover even in high-end medical schemes (59)**

Many members are dissatisfied with this arrangement (59). Note that, even though irritating, in comparison with catastrophic health events, the total cost of day-to-day care per household is not material. The social impact of not having cover for catastrophic events is that many households will become insolvent. Day-to-day care does not result in insolvencies (unless these are lifetime chronic conditions - the PMB chronic conditions are covered in full, while many medical schemes offer extended cover for other chronic conditions).

Figure 20 above shows that out-of-pocket payment, which is the most regressive form of healthcare financing, amounts to only 1.5% of GDP in South Africa, way below the international median. The corresponding percentages in the USA, Korea, Chile, and Ghana are 2.0%, 2.3%, 2.8%, and 3% respectively. This low South African percentage *includes* the out-of-pocket payments to private providers by the public who are not covered by medical schemes. Note that many members who do not belong to medical schemes make use of private providers (51 pp. 83, table 5.5)(12)(15). Through the implementation of NHI and improved service delivery in the public sector, this percentage will reduce.

14.3.2 Medical scheme costs

Paragraph 33 of the green paper (1 p. 11)states that there are very high administrator fees, broker costs and managed care costs, and that these increases have resulted in wage inflation.

Figure 22 (page 44) shows that the bulk of non-health costs are due to administration costs, and amounted to R949 pabpa in 2010. This part of the costs were R521 pabpa in 2000, when the office of the CMS was established, and then grew dramatically to peak at R1,137 pabpa in 2005. Various actions and interventions by the CMS has lead thereto that this, and other non-health costs have been reduced to 2002 levels in 2010. Further reductions in these costs are possible through improved governance and broker regulation.

Annexure G

Table 8: **South African Healthcare expenditure in the public and private sectors 2007/08 to 2013/14 (3)**

Rand million	07/08	08/09	09/10	10/11	11/12	12/13	13/14	Annual real % change [18]
Public sector								
National department of health	1,210	1,436	1,645	1,736	1,784	1,864	1,961	2.2%
Provincial departments of health	62,582	75,120	88,593	98,066	110,014	119,003	126,831	7.0%
Defence	1,878	2,177	2,483	2,770	2,961	3,201	3,377	4.3%
Correctional services	261	282	300	318	339	356	374	0.1%
Local government (own revenue)	1,625	1,793	1,829	1,865	1,977	2,096	2,221	-0.7%
Workmen's Compensation	1,287	1,415	1,529	1,651	1,718	1,804	1,894	0.5%
Road Accident Fund	764	797	740	860	980	1,029	1,080	-0.2%
Education	1,833	2,134	2,350	2,503	2,653	2,812	2,981	2.3%
Total public sector health	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Public sector increase on previous year		19%	17%	10%	12%	8%	6%	
Private sector								
Medical schemes	65,468	74,089	84,863	96,482	104,008	112,120	120,866	4.9%
Out of pocket	14,694	15,429	16,200	17,172	18,202	19,294	20,452	-0.4%
Medical insurance	2,179	2,452	2,660	2,870	3,094	3,336	3,596	2.6%
Employer private	1,041	1,172	1,271	1,372	1,479	1,594	1,718	2.6%
Total private sector health	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Donors or NGOs	3,835	5,212	6,319	5,787	5,308	5,574	5,852	1.1%
Total	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total as % of GDP	7.6%	7.9%	8.6%	8.8%	8.7%	8.6%	8.3%	
Public as % of GDP	3.4%	3.7%	4.1%	4.1%	4.2%	4.0%	4.0%	
Public as % of total government expenditure (non-interest)	13.9%	14.0%	13.8%	14.1%	14.7%	14.7%	14.6%	
Private financing as % of total	52.6	50.8	49.8	50.5	49.8	49.7	50.0	
Public sector real rand per capita 10/11 prices	2,131	2,300	2,512	2,635	2,766	2,812	2,816	
Public per family of four per month real 10/11 prices	710	767	837	878	922	937	939	

14.2 Key trends in the public sector

Figure 18 (page 41) shows that the growth in expenditure by provincial departments in growing at a faster rate than the growth in expenditure by medical schemes. The implementation of the proposals in section 11.2 (page 18) and section 11.3 (page 22), which will contribute to control expenditure in the private sector, will accelerate this positive trend. An increase in public expenditures to achieve the 15% of total government expenditure in accordance with the Abuja agreement, will further support the correction of the inequitable funding. Such increased funding could be motivated through increased performance (see Recommendation 2, page 14).

[18] This percentage was recalculated based on the latest inflation figures and represent the annual real percentage change form 07/08 to 13/14