DEPARTMENT OF SOCIAL DEVELOPMENT

MEDICAL SCHEME CONTRIBUTION PROTECTION

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DRAFT FOR DISCUSSION

CONTENTS

FIGURES

DEFINITIONS

Accredited Retirement Institution ("ARI"): This refers to private retirement arrangements that are authorised to manage mandatory individual accounts.

Basic Contributory Pension ("BCP"): This refers to a DB arrangement which is mandatory for all people above a designated income.

Beneficiaries: This refers to those people, whether members or dependents of members, who are entitled to social security benefits.

Ceiling: This refers to any currency-denominated upper contribution parameter. For example, this would occur where a threshold of 6% of gross income is applied up to a specified annual income level.

Collecting agent: This refers to the *South African Revenue Services* ("SARS"), which is assumed to be the collecting agent for "required social security contributions".

Contribution floor: This refers to the income value which is deducted from total income for the purposes of determining the social security contribution. Thus if the contribution floor is R12,000 per annum, the social security contribution will only be calculated from the income above R12,000 for all members. People earning below the contribution floor would therefore not be included in the contributory social security system.

Contributors: This refers to those persons or entities that are required to make a social security contribution, e.g. "members", "employers" and "government".

Defined benefit ("DB"): This refers to a retirement arrangement where the benefit entitlements are specified independently of the value of individual contributions.

Defined contribution ("DC"): This refers to a retirement arrangement where benefit entitlements are dependent on the value of contributions plus investment returns less the expenses for operating the arrangement.

Government contribution credit ("GCC"): This is an assumed social security government contribution subsidy targeted at lower income groups, permitting them to participate as "members" in the contributory social security system.

Mandatory individual account ("MIA"): This refers to a DC arrangement which is mandatory for all people above a designated income.

Mandatory Risk benefit ("MRB"): This refers to a centralised mandatory insurance (risk-pooled) arrangement which provides benefits to a "member", or "beneficiary", where the "member" dies or becomes disabled (and therefore unable to work), for any reason.

Member: This refers to the person who either makes a contribution toward social security, or in respect of whom a contribution is made. It does not refer to dependents, which are instead defined as "beneficiaries".

Minimum wage: This is a statutorily set minimum level of wages that must apply to employees in the formal sector.

National Social Security Fund ("NSSF"): This refers to the statutory retirement fund established for the purpose of managing mandatory retirement risk benefit and basic benefit arrangements as well as mandatory individual accounts placed with the fund.

Notional defined contribution ("NDC"): This is a PAYG DC arrangement, PAYG in the sense that benefits are paid from current contributions and DC in the sense that benefit entitlements are based on contributions plus returns less expenses. The essential link in the system, since there is no funding, is the notional net investment return, usually given by the net increase to the amount of the covered wages in the system..

Pay-as-you-go ("PAYG"): This refers to any system of retirement or risk benefits that are paid from current contributions.

Social security contribution: This refers to the required contribution toward all social security programmes required in respect of a member.

Social security benefits: This refers generally to the benefits of both "retirement benefit" and "risk benefit" arrangements.

State Old Age Pension ("SOAP"): This refers to the existing means tested social assistance benefit provided to females over the age of 60 and males over the age of 65.

Threshold: This refers to any upper contribution parameter defined as a percentage of the member's gross income. For example, where a contribution is defined as 6% of gross income.

Universal Basic Pension ("UBP"): This refers to the non-contributory pension available to all qualifying residents in South Africa. This would replace the current SOAP.

1. OVERVIEW

Health insurance typically forms one of the key pillars of any mandatory social security system. There has been some discussion about putting health reform on a distinct "track" separate from consideration of retirement, risk, and unemployment provision. Although there appears little to gain and much to lose from such an approach, this section only raises health reform issues as they relate to medical scheme contribution protection options (which is not a health policy matter).

Medical scheme contribution protection forms part of retirement and risk benefit reform and deals specifically with protecting families and individuals from becoming unable to continue membership of the contributory healthcare system due to the death or disability of a breadwinner or during old age. An important consideration with respect to the latter is that healthcare need rises with age, as does the prevalence of disability.

The specific configuration that medical scheme contribution protection takes is affected by the prevailing healthcare policy regime in place. Were healthcare to form part of the general social security reform it would be possible to integrate the contribution protection environment specifically into the general reform. This would be possible because of the opportunity to match the mandatory contributions toward retirement and other risk benefits with those for healthcare.

However, in the absence of a clear health policy regime consistent with the rest of the social security system it will remain possible to constitute a sound medical scheme contribution protection framework with an alternative modality. It would however be essential to develop this framework in such a way that it can adapt appropriately when the health policy track catches up with the rest of the social security reform process.

Various possible modalities have been evaluated in some depth in DoSD (2007e) with and without social security healthcare reform. The approach discussed in this section however assumes that no health reform other than that approved to date occurs in the medium-term.

2. POLICY CONSIDERATIONS

The central social security concerns associated with this reform fall into the following categories:

1. **Death and disability of a breadwinner**: There is presently no effective framework to protect the ability of families to continue with medical scheme contributions when the principal breadwinner dies or becomes unable to work due to disability. Although these families may receive general income replacement through insurance arrangements, these are often not sufficient to protect former levels of cover.

2. **Income smoothing**: Many employers now fail to provide any subsidy or support to former employees in retirement. In the past employers provided this protection almost universally. However, the poorly

considered implementation of an accounting standard (AC116) was seen by many commercial retirement and insurance players as a business opportunity, the net result of which was the virtually universal withdrawal of this employer benefit.[1]

The policy option going forward is to establish a system of mandatory contributions toward *insurance* and *income smoothing* requirements. This would need to be done in relation to a voluntary medical schemes market. The protection offered through this arrangement ensures that anyone participating in a medical scheme arrangement will have contribution protection in relation to the relevant contingencies.

However, given the absence of mandatory medical scheme participation, there is the accumulation of anti-selection risk. Voluntary health insurance markets are vulnerable to people joining only when they fall seriously ill. Adding contribution protection to a voluntary health insurance market raises the possibility that people only join a medical scheme when they become aware of a fatal or disabling condition. This is one of the perverse consequences arising from the failure to match the timing of health reform with general social security reform. However, this particular risk can be mitigated through *anti-selection measures* discussed in **section 5** below.[2]

3. POLICY ASSUMPTIONS

The policy recommendations made here are based on an approved healthcare policy configuration being in place. These are:

1. **Risk equalisation fund ("REF")**: a REF has been implemented which prospectively risk equalises a basic package of prescribed (in regulation) minimum mandatory medical scheme benefits (referred to hereafter as "PMBs").

2. **Prescribed Minimum Benefits ("PMBs")**: a set of PMBs has been explicitly identified in regulations which every medical scheme must offer and every medical scheme member must take out.

3. **Medical scheme participation is voluntary**: membership of a medical scheme is not mandated by Government for a specified group of income earners and their families.

4. **Beneficiary Registry**: a registry has been established which maintains the full details of medical scheme members and beneficiaries, and their family relationships, in real time. This registry would be managed by

[1] This is discussed more fully in DoSD (2007e). The business opportunities involved commercial role-players advising employers to establish fully funded post-retirement benefits, which, of course would be managed by the relevant role players or their related parties. As many employers were unwilling to accumulate such reserves, they mostly abandoned the subsidy. A few employers established post-retirement reserves through the practice of removing pension fund surpluses and transferring them into "grey" post-retirement fund arrangements. Member entitlements to these benefits were often left undefined with significant employer discretion possible.

[2] Anti-selection measures typically involve waiting periods or contribution penalties. They manage the anti-selection problem using instruments that are exclusionary. Social security systems are in a position to remove anti-selection using instruments that avoid the exclusion of particular groups.

the REF and updated continuously by medical schemes. The registry would contain a continuous history of medical scheme participation and associated clinical information necessary for prospectively equalising risk profiles between medical schemes.

5. **Medical scheme participation in REF**: all medical schemes would be required to participate in the REF without exclusion or exemption.

6. **Net REF transfers**: the REF intermediates net transfers for the purposes of risk equalisation, based on a formula prescribed in regulation, on a quarterly basis within each benefit year in real time. The importance of this assumption is that all medical scheme contributions paid by members discount the affect of net risk equalisation transfers. These net transfers will occur via an electronic inter-bank arrangement and occur over a four-day period each quarter.

7. **Operationalisation of the REF**: the REF is implemented in a timeline consistent with the general social security reform.

8. **Medical scheme contributions**: it is presumed that contributions toward PMBs have been fully community rated in respect of adult members and beneficiaries such that no contribution distinction is made between a principal member ("PM") and adult dependant ("AD"). It is furthermore assumed that a two-tier child contribution is in place. One applicable to children under the age of 18, and one applicable to children from the ages 19-25. All these contributions will be at fixed (and lower) ratios to the adult contribution.

The implication of the above framework is that there will be no significant difference between a DB or DC arrangement used to finance both the insurance and the retirement benefit. The mandatory contribution can be specified as a fixed percentage of the PMB contribution, which will be transparent and roughly similar as between schemes (due to risk-equalisation).

4. POLICY FRAMEWORK

The recommended policy framework is as follows (also see **figure 4.1**):

1. *A mandatory contribution (defined contribution) is collected from medical scheme members based on the contribution toward PMBs less administration fees, plus a prescribed rand amount in respect of non-health expenses.*

2. *The mandatory contribution would be based on a uniform PMB monthly contribution average for the market as a whole estimated by the REF for each benefit year and communicated to the collection agent (recommended to be the South African Revenue Services ("SARS")). The contribution toward both retirement and risk benefits would be based on adult medical scheme contributions only.*

3. *The individual accounts would be established in the names of medical scheme beneficiaries rather than principal members. This will ensure that the entitlement is fully protected where families break up due to divorce.*

4. *To simplify the system it is proposed that risk benefits not be differentiated by family size or the age of members. In this way risk benefits are fully pooled across the working age contributors.*

5. *Each scheme would then transfer the mandatory contribution to a statutory collection agent, recommended here to be the SARS. The REF will validate the required contributions and supply the appropriate information to the SARS to ensure that contributions are correct.*

6. *The SARS would then transfer the contribution income to the NSSF, which would operate both the insurance and retirement benefit arrangements.*

7. *The retirement benefits, paid out by the NSSF, would be based on individual account accumulations and smoothed investment returns less expenses.*

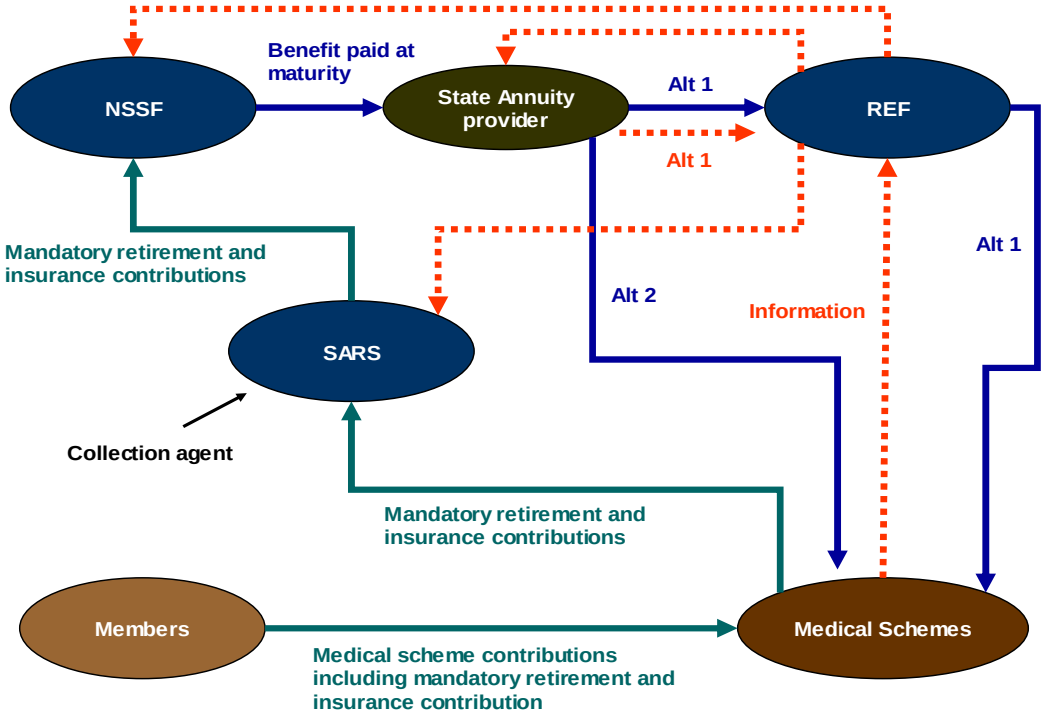
8. *The NSSF would purchase an annuity when a scheme beneficiary reaches retirement age based on the value of the accumulated individual accounts at the time of maturity. This annuity could pay benefits via the REF (alternative 1 indicated in **figure 4.1**) or directly to the relevant medical scheme (alternative 2 in **figure 4.1**). The latter option arises as the REF will have an inter-bank facility permitting it to transfer funds to schemes in respect of individuals. The REF will also have the most up-to-date registry of medical scheme beneficiaries. It is however not recommended that the payment be made to individuals.*

9. *As the benefit operates at the level of the beneficiary, where one spouse reaches retirement age while the other is below retirement age, a contribution to the NSSF will still be required in respect of the younger spouse.*

10. *Where the principal breadwinner dies or becomes disabled an insurance benefit will be paid out at the value of the PMB contribution (as provided by the REF) in respect of the surviving spouse until death, and children to the age of 25.*

11. *All benefit payments would be pegged to the annual increases of the PMB as calculated each year by the REF.*

Figure 4.1: Policy framework for medical scheme contribution protection



5. ANTI-SELECTION MEASURES

Given that membership of medical schemes is voluntary the risk of anti-selection is significantly increased. Without a mandatory environment a degree of anti-selection is inevitable the consequence of which is a higher average cost of contribution. The higher cost arises as the system-wide liability is fixed in relation to a group that exceeds the group responsible for contributions, i.e. some beneficiaries free-ride off the contributions of others.

The mechanisms used to minimise anti-selection within medical schemes are:

1. **Late-joiner penalties** for people who join a medical scheme for the first time late in life;

2. **General waiting periods**, which require that people wait three months upon joining a scheme before they can claim benefits; and

3. **Pre-existing condition waiting periods**, which allow schemes to avoid paying benefits in respect of any medical condition treated or diagnosed in the 12 months prior to joining a scheme, where a member was previously not on a medical scheme.

Despite these mechanisms, anti-selection is clearly detectable in the age bands 18 to 30, where participation is below what would be expected for the income groups that typically participate in medical schemes. From the age of 30, however, participation is close to optimal.

The introduction of medical scheme contribution insurance raises the possibility that people only join a medical scheme when they develop a life threatening medical condition. Given that the insurance benefit creates a living annuity for survivors, its expense is significant relative to the potential premium that established the entitlement.

To mitigate the risk of abuse, *it is recommended that, in addition to the existing medical scheme related anti-selection measures, that a more stringent pre-existing condition waiting period be established in respect of the death and disability benefit.* This would exclude the payment of any benefit if the death or disability results from a condition identified in the 12-months before joining a scheme, where the death or disability occurs within 3-years of joining a medical scheme.

Once a mandatory medical scheme environment is introduced, all waiting periods, both in relation to medical scheme participation and contribution protection, can be removed as anti-selection will no longer constitute a systemic risk to the cost of insurance. Furthermore, the anti-selection measures, which are exclusionary in nature, can be removed in favour of more sustainable social security measures such as mandatory contributions.

6. INSTITUTIONAL FRAMEWORK

The policy framework envisages the following organisations:

1. *The REF, which will provide the information required to quantify as well as finally pay the benefits.*

2. *The NSSF which would manage the individual accounts and entitlements, from both a retirement and insurance perspective.*

3. *The SARS which will operate as the collection agent of contributions from medical schemes. It will also transfer these funds to the NSSF.*

4. *A state annuity provider, which will provide annuities in respect of insurance and retirement benefits. This will be the same annuity provider envisaged for the BCP, i.e. the NSSF.*

It is recommended that this benefit framework be provided exclusively by the NSSF in conjunction with the other statutory organisations and entities. Permitting private providers to offer this arrangement will severely complicate the system which can be operated in a fairly straightforward manner.

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