



OUT OF POCKET PAYMENTS BY MEDICAL SCHEME MEMBERS

RESEARCH & MONITORING

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EXECUTIVE SUMMARY

Purpose:

The Council for Medical Schemes (CMS) has requested the Research & Monitoring (R&M) Unit to estimate the amount of out of pocket (OOP) expenditure experienced by medical scheme members. This report reviews the environment within which medical schemes operate that affects OOP. The report investigates alternative data sources, estimates the OOP by members, and provides a snapshot of how OOP affects individual members.

Problem Statement:

Currently, the quantum of out of pocket payments within the medical schemes community rated and open enrolment environment are collected through annual statutory returns, however these are not reported in the CMS Annual Report. The CMS needs to implement a formal process identifying, collecting, analysing and reporting on out of pocket payments, in order to, report the cost of utilisation mechanisms and their impact on community rating and financial protection of members.

Objectives:

The primary objectives of the current document are to identify the quantum of OOP for medical scheme members. The secondary objective is to investigate how far OOP affects individual members. Furthermore, this report discusses the context in which medical schemes operate in relation to OOP.

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1. Introduction

The Millennium Development Goals (MDGs) have put health at the heart of the development agenda. Three out of Eight MDG goals directly relate to improvement in health status. These goals and targets emphasize the importance of health as a dimension of poverty. Within this background, it has been recognised that significant out of pocket expenditures exacerbate poverty within many countries, negatively affecting attainment of the MDG goals. For most countries, OOP spending is an inefficient way of financing healthcare and it can have a negative impact on equity and can increase the risk of vulnerable groups slipping into poverty.

Several studies have documented the consequences of a high share of OOP payments in total health financing in developing and developed countries (Berki 1986; Peters et al. 2002; Wagstaff and Van Doorslaer 2003; Krishna 2004; Russell 2004; van Doorslaer et al. 2006), with a higher poverty incidence and a larger proportion of households facing catastrophic expenditures (Xu et al. 2003; O'Donnell et al. 2007).

Whilst, empirical studies have employed either the burden or income approach when measuring the distribution or the impact of all (or one of the) financing mechanisms made by households towards the health system. Both approaches argue that payments by households into the health system should be organised according to their capacity to pay and not by their risks of illness. In the burden approach, capacity to pay is defined as the proportion of a household's income remaining after spending on basic subsistence needs. This is usually referred to as effective income (World Health Organisation, 2000; Xu, 2005). In the income approach, it is defined as income gross of food expenditure and is termed pre-payment income (Wagstaff and van Doorslaer, 2000).

A household's healthcare expenditure is considered to be catastrophic if the ratio between the household's out of pocket health expenditure and its disposable income reaches a certain critical point. A broad benchmark/ guideline offered by the World Health Organisation's (WHO) is that out of pocket should never exceed 15% of the total healthcare expenditure within any health care system. WHO also recommends the following thresholds when measuring OOP, 15%, or 30% or 40% of capacity to pay by patients based on income and the burden approach. For one to undertake such analysis access to the income and household budget information is important.

In South Africa, medical schemes are a form of a prepayment prospective financing system which provides a way to pay for healthcare and ensures access to services for beneficiaries. Cost hikes for healthcare and non-healthcare services have impacted the affordability of medical schemes. Over the years, schemes have sought to limit their liability by applying cost sharing mechanisms and/or limitations or even exclusions on cover for certain conditions or treatments.

Cost sharing mechanisms may take the form of direct or indirect financing methods. The direct mechanisms may take the form of co-payments, coinsurance, and deductibles, whilst, the indirect mechanisms may take the form balance billing, whereby additional charges are required by providers when patients health plan have low reimbursement limits compared to the providers charges, or if the healthcare providers selected by the patient are not included in their health plan and accessing healthcare services not covered by the health plan or through a benefit option design process (which includes patient channelling and coordination of care).

The impact of these cost sharing arrangements for healthcare goes beyond catastrophic spending. Many studies also show that many people may decide not to use healthcare services, simply because they cannot afford either the direct costs associated with care or indirect costs such as transport or exhausting their savings account. Excessive OOP have a potential of pushing patients into poverty because of the adverse effects of illness on their earnings and general welfare. Health shocks, defined as un-predictable illnesses that diminish health status, are amongst the most important factors associated with poverty in this context. Households facing health shocks are often affected by both the payments for medical treatment and the income loss from an inability to work.

Whilst OOP can be regressive, there are several advantages that can be leveraged from their use see Table 1 below:

Table 1: Out of pocket Payments

Advantages	Disadvantages
Demand management and deterring moral hazard to a large extent	Inequitable, increase barriers to access and can limit acces to health-care whilst their objective is to discourage moral hazard they usually fail in achieving their objective
Cost control mechanism (tariffs that make costs explicit assist in encouraging cost-efficiency	Evidence indicates user charges are not effective in containing costs because delayed care/denied care becomes costly care
Contribution to revenue raising	Undermines access to appropriate and effective care and can discriminate against the poor and sick

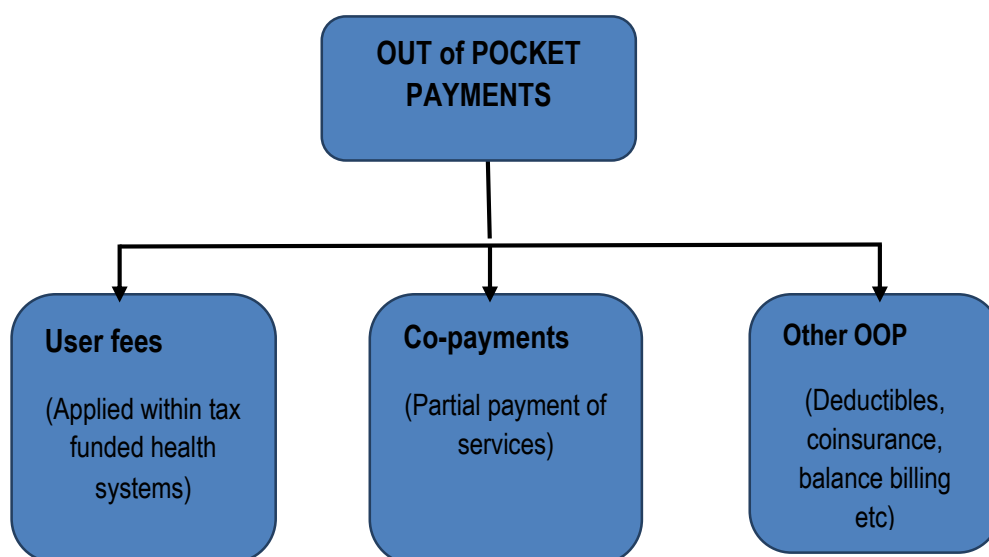
2. Defining out of pocket payments

Out of pocket payment charges at the point of service that meet part of the service cost are called co-payments. The fees can be fixed, such as **fixed payments** for drug prescription charges, or could be proportionate to the costs involved as is the case in most pre-payment private health insurance systems. Within certain health insurance environments proportionate payments of the costs associated with care offered can be referred to as co-insurance. **Co-payments** are one of several types of out of pocket payments for healthcare. They can include any direct payments made by patients to healthcare providers at the point of use. These are also amounts which users are required to pay for healthcare that are separate from any contributions to voluntary or mandatory insurance or through general taxation.

The other forms of OOP include use of deductibles and coinsurance. It is argued that **deductibles** and **coinsurance** may be used to design policies that lead to desirable economic consequences. Such payments by patients/members make beneficiaries more alert of the differences in the true costs of treatment they are purchasing. Charging deductibles discourages frivolous claims and also makes insured individuals more aware of the results of their actions.

Currently, South African medical schemes levy co-payments on a range of services. These are mainly services that fall outside of the Prescribed Minimum Benefits (PMB) package of services, as PMB services are meant to be fully paid for by the medical scheme. For example, co-payments are applied to prescriptions for pharmaceutical items, special investigations and instances where patients do not follow scheme rules, such as obtaining specialist care without a referral from a general practitioner or voluntary use of a non-designated service provider (DSP).

Figure 1: Types of OOP



3. The Environment in which Medical Schemes Operate in South Africa

This section gives a brief overview of the environment in which Medical schemes operate in South Africa. The objective is to put the OOPs into the right context such that potential solutions and recommendations are appropriate. The other aim is also for the reader to understand the context of this report.

3.1 Legislative Framework

This section outlines the legislative framework as outlined in the Medical Schemes Act 131 of 1998 (MSA) with regards to benefit content configuration, pricing of options, cost sharing provisions and registration of benefit options.

a.) Guaranteed Benefits

Regulation 8 (1) of the Medical Schemes Act requires that “*any benefit option that is offered by a medical scheme must pay in full , without **co-payments** or use of **deductibles** , the diagnosis , treatment and care costs of the prescribed minimum benefit conditions*” . This section seeks to:

- Protects the interest of members of medical schemes regardless of the benefit option.
- And to address unfair risk selection and denial of care by medical schemes.

Section 8 (2) (a) further states that “*...The diagnosis, treatment and care costs of a Prescribed Minimum Benefit condition will only be paid in full by the medical scheme if those services are obtained from a Designated Service Provider in respect of that condition...*” Whilst, Section 8 (2) (b) points out that “*...a **co-payment or deductible**, the **quantum** of which is specified in the rules of the medical scheme may be imposed on a member if that member or his/her dependant obtains such services from a provider other than a Designated Service Provider, provided that no co-payment or deductible is payable by a member if the service was involuntary obtained from a provider other than a designated service provider*”

b.) Solvency ratio

Regulation 29 (2) of the Medical Schemes Act regulations requires that “ *medical schemes must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review which may not be less than 25%*”. Related to this section is Section 35 of the Act which seeks to encourage Financial soundness of Medical Schemes through:-

- Stricter controls to extend financial stability
- Statutory determined solvency and financial soundness
- Detailed financial reports, must be able to meet liabilities, mandatory net assets

Within this context, in order to address moral hazard, medical schemes amongst other things will design benefit options with some form of patient channelling mechanisms and cost sharing arrangements especially with regards to accessing the PMB package and access to care within certain benefit options such as network, capitation and efficiency discounted options.

c.) Amendments of scheme rules (S 31)

Section 31 seeks to ensure that the scheme benefit options and their rules **promotes equity** in rule amendments, **discourage prejudice** towards the member through unlawful **exclusion/limitation of benefits** also promote public accountability and transparency.

d.) Approval of benefit options

Section 33 (2) outlines the process to be followed for approval of benefit options. Stated in this section is that *“approval of benefit options will be subject to provision of prescribed minimum benefits, self-supporting in-terms of membership and financial performance, financial sound, the option should not jeopardise the financial soundness of any existing options within the medical scheme”*

e.) Non-discriminatory nature of benefit options

Section 24 (2) (e) states that *“ no medical scheme shall be registered unless the Council is satisfied that.....the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and the state of health.”*

f.) Limits benefits

Regulation 9 states that *“a medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the Prescribed Minimum Benefit (PMB), pro-rata to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned”*

g.) Member communication on benefit change

Section 29 (l) makes it mandatory for the scheme to communicate with their members on any change in contributions, membership fees, or subscription, benefits or any other condition affecting their membership. Whilst subsection (o) states that medical schemes should include in their rules the scope and level of minimum benefits that are to be available to beneficiaries.

Whilst all these sections seek to provide some form of financial protection for members Section 5.3 below provides a snap shot analysis of the complaints database where an illustration is shown that for one reason or the other medical scheme members continue to pay significant out of pocket payments when accessing care within the private healthcare sector in South Africa.

3.2 Benefit Design

Benefit design plays a huge role in benefit structuring which includes some form of cost sharing arrangements. Cost sharing arrangements within benefit design amongst other things seeks to address (a) moral hazard, (b) supply-induced demand and (c) cost effective provision of care and (d) efficient patient channelling through a managed care arrangement. Cost sharing arrangements within benefit options can include the following mechanisms:

- Plan configuration influenced by some cost sharing elements,
- Patient channelling to the appropriate level of care with penalties should a member deviate from the scheme rules,
- Application of benefit option limits¹ and/or sub- option limits to coordinate care,
- Use of financial and non-financial incentives to influence consumption and provision of care

Within this context, benefit options have different cost sharing arrangements. In most cases, less comprehensive plans (e.g. low-cost options such as network, capitation and efficiency discounted options) tend to be designed with some elements of managed care and efficiency measures with some penalty should a member deviate from the scheme rules. Whilst most traditional comprehensive plans are often open, allowing members to utilise service providers of their choice (with limited patient channelling); with some form of managed care interventions applied to manage high-cost items since these options generally have old and sick members.

For example, traditional comprehensive options offer major medical and out-of-hospital supplementary benefits at full risk cover with no or little out of pocket payment or cost-sharing arrangements. Partial traditional cover options offer some supplementary benefits but not all benefits have full risk cover compared to traditional options. Major medical plans are distinguished from comprehensive and partial traditional benefit options in that they offer mainly in-hospital benefits and control the severity and frequency of day to day benefit claims through the use of personal medical savings accounts, application of thresholds, and other out of pocket payment requirements. On average most benefit option's cost sharing and /or penalties requirements range between, 10% to 40% OOP, depending on the option, access to a particular benefit, the scheme rules and member's health seeking behaviour².

¹ Supplementary benefits

²Based on BMU assessment of cost sharing arrangements within options

Co-payment benefit designs are distinguishable from major medical benefit options in that they make use of specified co-payments or levies payable by the member on accessing benefits rather than fixed monetary service-user charges that apply for major medical benefit designs. It has been assumed that the impact of a co-payment on the severity and frequency of expected claims is of a different nature to that of a major medical benefit.

The distinguishing characteristic of capitation benefit options relative to the others, including co-payment plans, is the capping by medical schemes of the risk exposure relating to the severity and frequency of expected monetary claims through fixed-fee contracts with service providers per beneficiary covered in these benefit options³. The use of deductibles, co-payments and/or coinsurance⁴ within the less comprehensive plans helps to configure benefit options that lead to desirable economic consequences. With co-payments, it is argued that beneficiaries are more alert to the true costs of treatment; co-payments discourage frivolous claims and make the insured individuals more aware of the results of their actions.

3.3 Health Insurance Products

This section provides an outline of member's perspective of medical schemes cover and the need for supplementary cover in a form of health insurance products with the objective of protection from catastrophic healthcare costs associated with accessing private healthcare in South Africa. Amongst other things, for most medical schemes members who buy health insurance products the following reasons have been cited:

- Insufficient medical scheme cover including dissatisfaction with co-payments, deductibles and payment of PMB's,
- Affordability of medical schemes cover,
- Protection against catastrophic financial losses due to OOP,
- Health professional fees are high, and
- Statutory pricing side regulation.

The table below summarises the most common reasons why people purchase health insurance products. The comments listed below were collected from the submissions made on the Demarcation Regulation to National Treasury. National Treasury had invited stakeholders to comment on the proposed amendments of the Long Term and Short Terms Insurance Acts.

³ *Research Brief 2*, CMS, 2008

⁴ Co-sharing is an agreement between the insured and the insurer under a health insurance policy which provides that the insured will cover a set percentage of the covered costs after the deductible has been paid.

Table 2: Consumers perspective of Health insurance cover

Key concerns/input	Members of Public	Insurers	Brokers
Insufficient medical scheme cover	24%	11%	19%
Affordability of medical schemes cover	18%	9%	12%
Need/ demand for gap cover	14%	8%	12%
Gap cover protects households against catastrophic financial losses.	15%	10%	8%

Source: National Treasury Demarcation Regulation Submissions

4. Methodology

4.1 *Various sources of Out of Pocket Payment data*

One of the objectives of this document is to report on various data sources that report on co-payments for medical scheme members. This document goes on further to outline limitations of such various data sources and proposes an approach in making such data available, particularly for reporting in the annual statutory returns.

4.2 *Statistics South Africa Income Expenditure Survey*

There currently are a number of various sources of data that report on out of pocket payments; however such data has limitations in as far as how it is reported. On a national scale, The Statistics South Africa (STATSSA) Income & Expenditure Survey (IES) estimates household expenditure for a basket of goods and services. The method is based on the COICOP⁵ classification system and household expenditures are reported in terms of income quintiles.

The Income and Expenditure data estimates covers all out of pocket expenditures related to healthcare service utilisation. That said, there are limitations that should be noted in using these sources of data, these include:

- The income quintiles related to out of pocket healthcare expenditure are such that households of members of medical insurance are in the upper end of quintile 5;
- Most of the out of pocket payments, collected in the survey for healthcare would thus be for non-medical scheme members; and
- The classification system does not classify household expenditure related to health insurance under medical services, due to the COICOP classification system.

Thus the implications of using the STATSSA income surveys is that, these data are crude estimates and unable to report the true reflection of OOP by members of medical schemes. These limitations are further outlined in the STATSSA Income and Expenditure Surveys (IES) and by the discussion document on the out of pocket medical expenditure by the Actuarial Society of South Africa NHI Model (ASSA, 2010).

⁵ The **Classification of individual consumption by purpose**, abbreviated as **COICOP**, is a nomenclature developed by the United Nations Statistics Division to classify and analyse individual consumption expenditures incurred by households, non-profit institutions serving households and general government according to their purpose. It includes categories such as clothing and footwear, housing, water, electricity, and gas and other fuels.

Table 3: Advantages and disadvantages – IES data sources

Advantages	Disadvantages
<ol style="list-style-type: none"> 1. The data if captured accurately includes all expenses related to healthcare 2. The data set is reasonably accurate as it has been tested and was used for other purposes 3. The data is also split by income/ total expenditure allowing more flexibility when using the data 	<ol style="list-style-type: none"> 1. The data is out-dated, the survey was carried out almost four years ago 2. There is a risk in that a large portion of the sample surveyed does not reflect the same characteristics of medical scheme beneficiaries 3. The definition of OOP maybe inconsistent with what CMS uses

4.3 Using Statutory Return Data

CMS currently collects data on payments paid by members to the providers; however this data is not readily available and is sometimes under reported at scheme level. For example for the financial year under review 13.8% of schemes did not report on this line item, a better result compared to 24.6% in 2011. Figure 2 below illustrates “field” currently collected on Part 3.1 of the ASR.

Figure 2: Collected Annual Statutory Return Data

		Total amount charged by supplier	Risk amount paid by scheme	Savings amount paid by scheme on behalf of member	Amount paid by member	Discount received
		R	R	R	R	R
3.1.1	General Practitioners	1,187,663,240	483,894,239	404,399,748	299,359,253	0
3.1.2	Medical Specialists	4,672,665,663	2,756,690,003	784,878,096	1,131,097,658	0
3.1.3	Dentists	968,641,168	195,671,312	428,501,392	344,468,464	0
3.1.4	Dental Specialists	304,966,957	83,220,190	85,341,872	136,404,895	0
3.1.5	Supplementary and Allied Health Professionals	1,777,165,769	656,324,675	654,727,206	466,113,885	0
3.1.0	Hospitals					
3.1.0.1	<i>Unattached Operating Theatres/ Day Clinics</i>					
3.1.8.1.1	Ward Fees	12,888,658	9,171,760	2,185,235	1,531,663	0

Further exploration of the 2013 statutory returns data reveals that schemes under-report the line item on fees paid by a member, most schemes do not report on line item, lastly these data are reported at scheme

level as opposed to option level. Table 3 below depicts advantages and disadvantages on the currently collected data on OOP.

Table 4 : Advantages and Disadvantages – ASR Data Source

Advantages	Disadvantages
<ol style="list-style-type: none"> 1. The data gives a good high level quantification of total out of pocket payments made 2. The data set currently exists 3. The records reflect typical ICD10 diagnosis types 4. The data reflects actual claims expenditure and does not need to be estimated 	<ol style="list-style-type: none"> 1. The data does not reflect the quantum of point of service levies charged by the provider. 2. The data are collected at scheme level, and not at option level 3. The data do not take into account health needs differences between different types of benefit design configurations 4. Aggregated data at scheme level is difficult to use in reporting the impact of out of pocket payments for assessing appropriate levels of thresholds

4.4 Quantifying Out of Pocket Payments by Medical Scheme Members

This section discusses the method and approach of determining the quantum of out of pocket payments experienced by members in 2013.

- a.) Proposed method of determining amount of out of pocket payments

Determination of OOP:

$\text{Out of Pocket Payments} = \text{amount claimed} - \text{amount paid by the scheme (risk amount + savings amount)} - \text{discount received.}$

Amount claimed: What the provider asks for a service. The aggregate amount claimed is driven by the demand for the service – morbidity and the tariffs charged by the provider. These drivers change over time and cannot be accurately predicted in advance. We have to rely on historical data provided by the schemes. Where members have exhausted their benefits (usually day to day benefits) they do not need to claim hence we miss out on some OOP expenditure by using claims data. The aggregate figures we obtain will be an underestimate.

The other difficulty of using amount claimed is not all expenses are claimed by the beneficiaries. In cases where beneficiaries realise that the scheme will not be paying for the benefits there is no incentive to claim. The amount claimed from schemes therefore under estimates the cost of health services. Members on options with thresholds have an incentive to claim. Their data can be used to determine the total cost of health services paid out of pocket in their case.

The other short coming of the amount claimed figure is that it misses out co-payments. On some options members have to pay first before they receive a service like hospital admissions. The service provider submits claims which do not include these co-payments as they have already received cash. It would be more accurate if we collect the total amount the service provider charges for the service rather than the amount claimed.

b.) How reliable is the amount claimed figure we receive?

The reason why members join medical schemes is so that they get financial protection from significant financial strain that is as a result of ill-health. It is therefore a reasonable assumption that whenever scheme members are faced with large medical bills they will claim. From the member's perspective, it's the reason why they join schemes and there is no harm in claiming. We can therefore place strong confidence on the amount claimed that CMS collects from the schemes. The amount claimed includes most, if not all of the large medical expenses faced by members.

Admittedly; it does miss out on small claims where members decide not to claim as well as some co-payments as explained earlier.

Amount paid: The amount the scheme pays for benefits. This depends on the benefit option and available benefits. This should be the easiest to determine and is for purposes of this exercise accurate.

Discount received: Some providers tend to give discounts when they realise members have to pay for shortfalls. The aggregate amounts of discounts are almost impossible to determine accurately as it varies from provider to provider as well as by beneficiary. For purposes of this exercise it is reasonable to ignore discounts completely.

Gap cover products: Gap cover is designed to provide individuals with financial assistance in cases where they have to make OOP. In most instances these relate to hospitalisation cases. If we are looking at the effect of OOP at a global level gap cover products do reduce OOP in a few instances – only where it's necessary. In aggregate, beneficiaries with Gap cover are net payers as insurers price these products such that total claims are less than premium.

It's important to note that; badly structured gap covers and other health insurance products can induce unnecessary demand. As explained above, the aggregate premiums members pay are more than the aggregate payouts they receive from gap cover products, it therefore makes sense to ignore the gap cover products.

c.) How reliable is the result?

We have already discussed why we think the amount claimed is the good approximation of total cost of healthcare – it captures all the significant claim amounts. It in essence allows us to calculate the minimum value of the OOP – the floor.

We can also determine the maximum reasonable value of the OOPs. The amount that members pay out of pocket is limited by affordability. Beneficiaries do not always have the financial resources to make OOP. For instance it would not make sense for beneficiaries to pay out of pocket the same amount they pay for their contributions – unless they are seriously ill.

Beneficiaries; as rational consumers when faced with expensive treatment – have an option to use state facilities which are more affordable and may be within their financial means. For most of the beneficiaries they will behave as above.

There are some individuals who may choose not to use state facilities and rather pay for the services themselves. I do not believe they will constitute a significant number.

The OOP we will calculate will be an underestimation of the total OOP across all beneficiaries. There is not much evidence to suggest that the actual OOP would be significantly above this estimate.

4.5 *The rationale behind this method*

The amount of OOP varies from year to year. It's very difficult to determine it accurately for several reasons. It's important to get a clear definition of what we mean by OOP to ensure there is consistency between beneficiaries.

Secondly since not all healthcare cost are claimed by individuals – the most accurate way of determining OOP would be asking the beneficiaries and through a detailed review of benefit option design. This then points to the strong value of evidence of the Income and expenditure survey. At an aggregate level the results of this survey could add significant value on this study. Adjustments can be made to allow for the difference in income groups (medical scheme beneficiaries vs. the surveyed population).

It is reasonable to assume the value of OOP payments that would be made using the Annual - returns data approach would represent the minimum value of OOP. The value obtained using survey data would also be an underestimate since the income group of beneficiaries are higher than the surveyed population on average – unless if suitable adjustments are made.

5 Results

5.1 Analysis of the current ASR data

The section below assesses a review of the annual statutory returns data submitted by medical schemes, the review period covers data submitted in 2013. Benefits data was assessed for expenditure by medical schemes and those paid by members. On benefits paid data, we assess major categories mainly payments towards general practitioners, medical specialists, medicines, hospitals (public and private), dentists, dental specialists, supplementary and allied health professionals, and the other category.

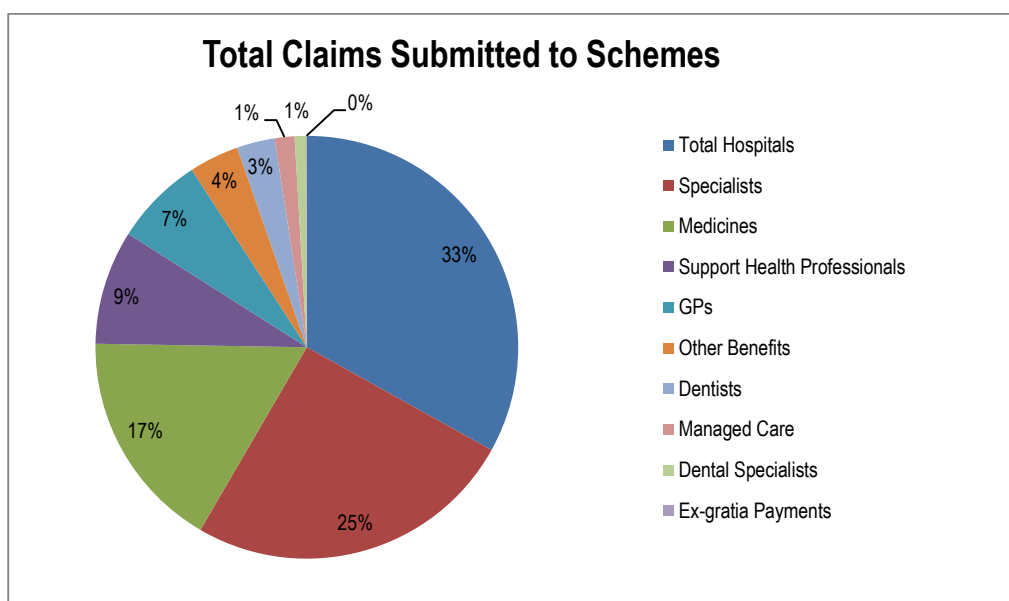
a.) Study Population Characteristics

The current section assesses comparison analysis on the amounts paid by members for the 2013 financial period. The analysis is based on 87 (23 open and 67 restricted) medical schemes in 2013, this data represented on average 8.8 million covered lives in 2013.

b.) Analysis of Claims Submitted to Medical Schemes

During the financial year 2013, a total of R124.6 billion claims were submitted to the medical schemes. This figure is off-course an under estimate of the total cost of healthcare by scheme members as discussed earlier. Some members do not claim once they realise they have exhausted their benefits.

Figure 3: Distribution of the claims submitted by category

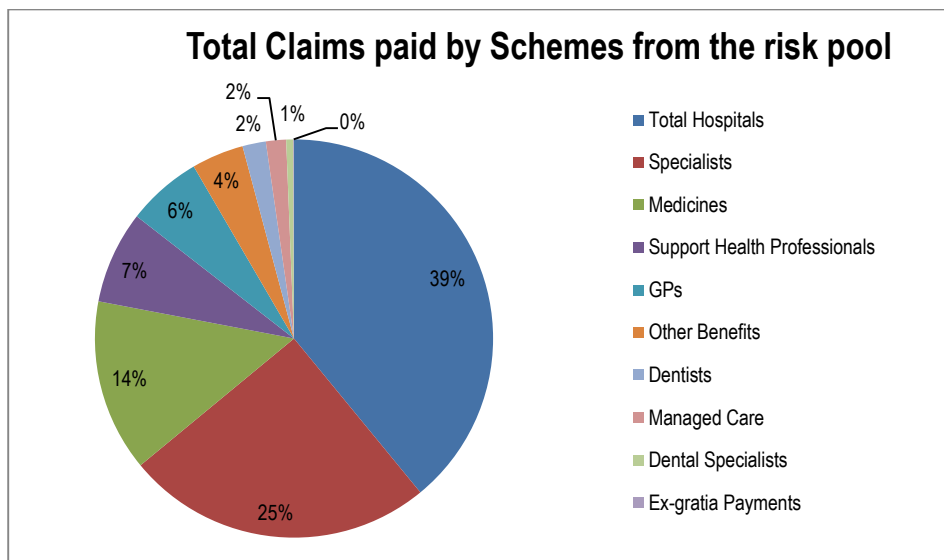


Hospitalisation (including state and Hospital related Managed care) submitted the lion's share of the claims. The next highest claiming category was specialists. The cost of medication was also significant during the year. GPs and Support Health Professionals contributed to 16% of the claims submitted.

c.) Analysis of Benefits Paid by Medical Schemes from the risk pool

During the financial year 2013, a total of R101.3 billion was paid by medical schemes from the risk pools. This figure is an accurate representation of the total cost of healthcare by the schemes.

Figure 4: Distribution of the claims paid from risk pool by category

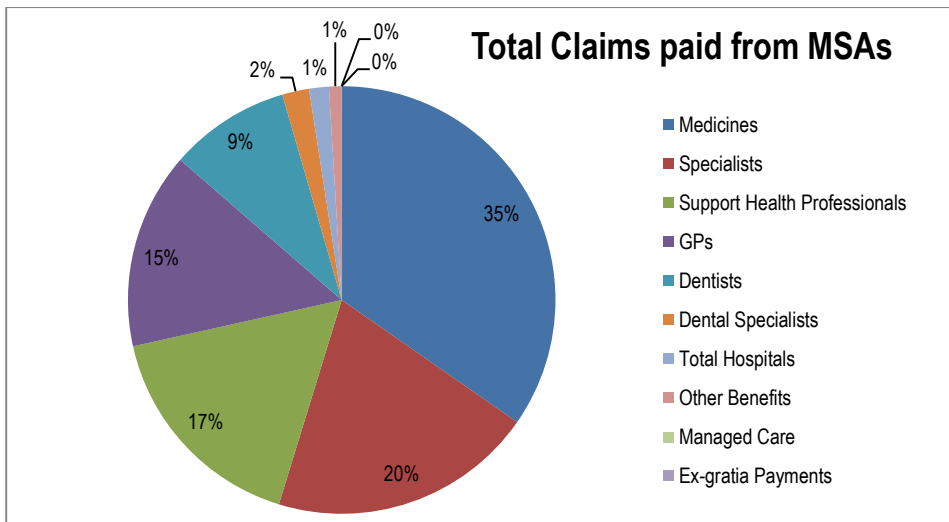


The highest portion of payments was made to hospitals; this is consistent with the claims submitted. The Specialists category was the next category receiving 25% of all the payments. GPs received less payments compared to Support Health Professionals - the opposite of claims submitted.

d.) Analysis of Benefits Paid by Medical Schemes from the MSAs

During the financial year 2013, a total of R11.1 billion was paid by the medical schemes from the Member savings accounts (MSAs). This figure is also an accurate representation of the cost of healthcare paid by the schemes from the MSAs.

Figure 5: Distribution of the claims paid from MSAs by category

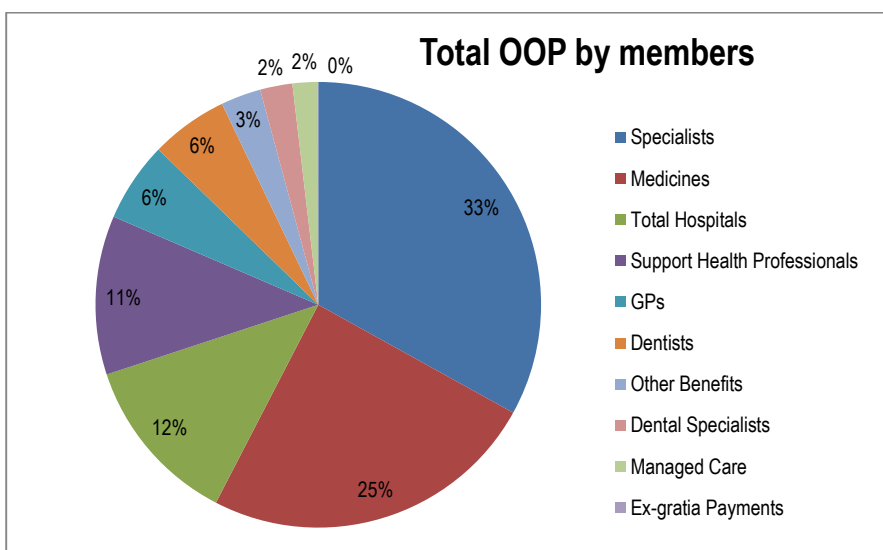


Most of the MSAs were spend on Medicines about 35%. Specialists were paid a significant portion as well – 20%. Dentists’, GPs and Support Health Professionals all received significant, but lower portions of the MSAs. Very little was spent on hospitalisation. This indicates that the day to day benefits are being shared between the schemes and the members. We can conclude that the bulk of OOP therefore should also come from the day to day benefits.

e.) Analysis of Benefits Paid by members (OOP)

During the financial year 2013, a total of R12.2 billion was paid by members out of pocket. This amount has been calculated using the method in section 4.4 of this report.

Figure 6: Distribution of the OOP by category

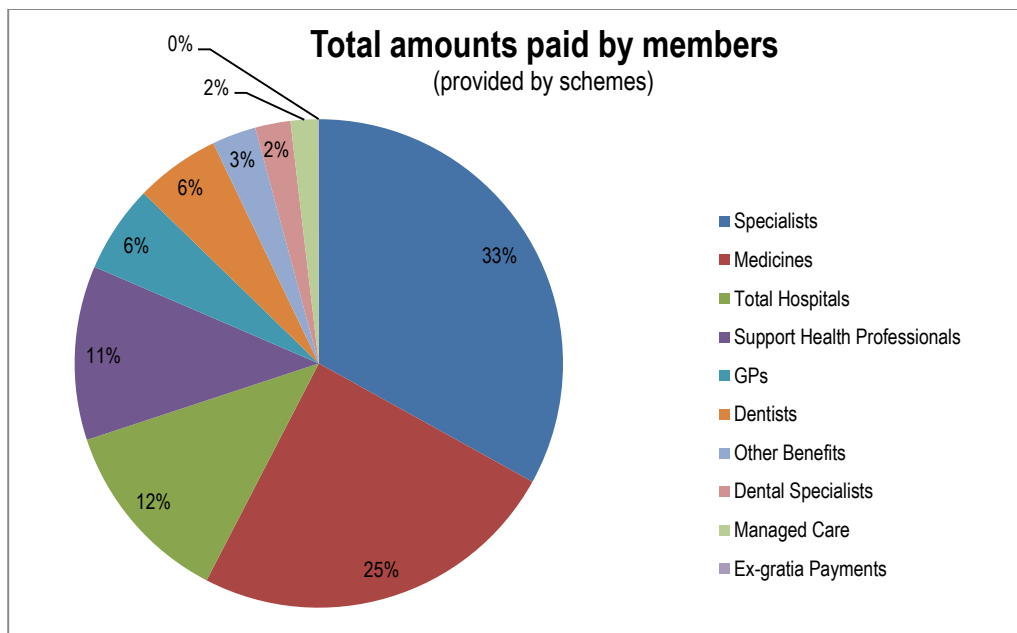


The distribution of the OOP is consistent with our expectations. Most of these payments were for day to day benefits i.e. Specialists; Medicines; Support Health Professionals; Dentists and GPs. It is interesting to note that the amount of shortfalls from hospitals amounted to 12% of OOP. This 12% of OOP relating to hospitalisation may have been paid through Gap cover products to some extent.

f.) Analysis of Benefits Paid by members as provided by schemes

According to the Annual returns data submitted for the financial year 2013, a total of R5.7 billion was paid by members out of pocket. This amount has been provided by the schemes. Of the 87 Schemes, 12 Schemes did not populate this field. Interpretation of this figure is very difficult as it's not clear what the schemes were capturing. We would expect this number to be closely related to the R12.2 billion, we calculated.

Figure 7: Distribution of the Amount paid by member by category (provided by schemes)



However, the distribution of the OOP is consistent with our expectations. Most of these payments were for day to day benefits i.e. Medicines; Specialists; Support Health Professionals, Dentists and GPs.

5.2 Estimation of OOP using survey data

The average spent on healthcare per household for healthcare as per 2011 income and expenditure survey was R1 357 per house hold per year. If this figure is escalated by the increase in CPI from March

2011 to June 2013, it amounts to R1 523 per household per year. This is an underestimate as there is sufficient historical evidence to suggest that the cost of healthcare exceeds CPI inflation.

There were R3.9 million principal members at 31 December 2013. The OOP using this approach amounts to R5.9 billion. This figure is a gross under estimate as this survey is based on a population sample that represents the whole of the South African Population and not beneficiaries of the medical schemes. Only 17% of the South African population are members of a medical scheme.

a.) Nature of Survey carried out

The income and expenditure survey (IES) was carried out of the period September 2010 to August 2011 to investigate the appropriate Consumer Price index (CPI) basket to use for determining inflation. A total of 25 328 households were asked to submit their expenditure figure for the year. Amongst other items of expenditure they were asked to submit the total amount they spent on healthcare outside medical scheme contributions.

b.) Income distribution

Table 5: Annual Income distribution of the households surveyed

Annual Income range	R 0 - R 4 543	R 4 544 - R 9 886	R 9 887 - R 21 002	R 21 003 – R 57 099	Above R 57 100
Proportion of households in income band	20%	20%	20%	20%	20%

From the above table we can conclude that 80% of the households earning below R57 099 per year cannot afford subscription to a medical scheme. We can for purposes of this exercise work with the results of the members in the group earning above R57 099. This is a good approximation as it is consistent with the 18% of the national population which has medical schemes cover. However, there is still a possibility that reality may be different.

c.) Possible income distributions and OOP amounts

The table below shows the distribution of expenditure of the population surveyed. The expenditure profiles are split into 10 groups. For each expenditure decile, the table shows the annual OOP per household and the total expenditure per household. As an example, a household in decile 8, the household would spend R1 354 per year on OOP and their total expenditure for the year amounts to R101 897.

Table 6: Annual Expenditure distribution of the households surveyed

	Expenditure Deciles										
	1	2	3	4	5	6	7	8	9	10	Total
Out of Pocket payments from survey (R)	158	261	332	441	590	663	923	1 354	2 578	6 430	1 357
Total Expenditure (R)	9 457	16 534	22 365	28 859	37 000	48 467	66 446	101 897	175 168	445 409	95 183

Considering affordability, it is reasonable that households covered by schemes are found in deciles 6 and upwards. The exact distribution of the households in these top five deciles among medical schemes members is unknown.

Table 7: OOP derived from possible distributions of households by expenditure deciles

	Expenditure Deciles					Estimated Out of Pocket Payments* (R billions)
	6	7	8	9	10	
Total expenditure (R)	48 467	66 446	101 897	175 168	445 409	
Out of Pocket payments from survey (R)	633	923	1 354	2 578	6 430	
Possible Distribution of Household Expenditure	20%	20%	20%	20%	20%	10.338
	10%	10%	30%	30%	20%	11.369
	10%	10%	35%	35%	10%	9.432
	10%	10%	20%	20%	40%	15.241
	5%	5%	40%	40%	10%	9.948
	5%	5%	35%	40%	15%	11.048

* In calculating the estimated cost an adjustment to the cost due to inflation has been made. It's the same adjustment explained in section 5.2 of this report.

From the table above, an estimate of the OOP could be approximately in the range of R10 billion to R15 billion. The highest result in the table of R15.2 billion is highly unlikely as it is based on a scenario of 40% of the beneficiary households spending in excess of R445 409 per year.

The results in the table provide us with reasonable comfort on the R12.2 billion we calculated using the ASR data. While we acknowledge this R12.2 billion is the minimum value, the actual cost of OOP could be slightly higher than this amount considering the possible amounts from the table above.

In using the census data it's important to note the following:

- Accuracy of data can be questionable – when data was collected, the population had to estimate most of the figures they provided.

- Data is for a sample representing the national population and not beneficiaries – medical scheme beneficiary's amount to only 17% of the national population. The feature of scheme beneficiaries may be significantly different from the national population. Scheme member may have better morbidity than the population thereby exhibiting lower OOP payments.
- There is great variation in the average cost in the national population data across income categories. If income distribution of the schemes members is not consistent with the national population then the average cost is thrown out further.
- Medical cost inflation has been higher than CPI in the past year, our escalation of the IES by just CPI is an under estimation.

5.3 The extent which Out Of Pocket Payments affect Individual Members

CMS does not receive individual claims data therefore it is not easy to quantify exactly how OOP affects individual members. Council however receives complaints data. This is mostly submitted by members who are unhappy with the amounts they are required to pay for medical expenses. They will be of the view that their schemes should cover such costs. This data does not cover all claims but only those that are reported to Council.

From this data we can actually see the payment gap that individual members are required to finance out of pocket. This section of the report discusses the complaints trends and discusses a few of the cases where members had to pay out of pocket. For some individuals the amounts are very large and financially significant.

a.) Complaints trends

CMS resolves thousands of complaints every year - and this number keeps growing. As consumers of healthcare, beneficiaries of medical schemes should get value for their hard-earned money and must continue to enjoy protection against unpredictable and potentially catastrophic health events. CMS consistently adjudicates complaints from members of medical schemes where some schemes fail to offer the desired financial protection for their members. Below is an analysis of CMS 2013/14 valid complaints.

In 2013/14 CMS received and adjudicated on 5 473 valid complaints. The number of complaints received per 1000 beneficiaries was 0.6. These 5 473 complaints represent an increase of 17.6% from 2012 valid complaints. Within this increase, technical complaints which include short payment of PMB accounts, non-payment of PMB claims, short payment of non PMB claims as well as non-payment of PMB claims accounted for about 56.2 % compared to 58.4% in 2012 whilst overall number of valid complaints accounted for 43.8% in 2013 (See table 8).

Table 8: Complaints trends

Valid clinical complaints	2013	2012
Technical/clinical complaints	56.2 %	58.2 %
Other complaints	43.8 %	41.8 %
Total number of complaints	100 %	100 %

Technical/clinical complaints relate to non-payment, short payment or reversals of PMB and Non PMB claims paid. As will be illustrated by different types of member complaints below, payment of PMB's at the scheme tariff continues to be a huge challenge within the industry. Other complaints often relate to the use of DSP, and application of clinical protocols. Table 8 provides an illustration of complaints trends stratified complaint type. As can be observed, payment of PMB claims is a huge challenge within the industry. As indicated by the MSA, medical schemes must pay for PMB conditions in full, according to the healthcare providers invoice, from the risk pool not from day to day benefits.

The MSA further empowers medical schemes to ensure both appropriate clinical and prudent financial governance of the schemes with regards to PMB level of care. Within the bounds of evidence-based medicine, proven cost effectiveness, and affordability, the schemes have rules with regards to access to PMBs. These rules include amongst other things use of managed care protocols and formularies.

The schemes also stipulate the use of DSPs. For medical schemes to provide sufficient financial protection for their members in compliance to the MSA, effective member communication is paramount. Member empowerment about their rights and responsibilities is therefore a cornerstone of ensuring cost effective access to the PMB package. The MSA is clear that where such interventions prejudice the access to the PMB level of care significantly for members they cannot be used to restrict access to care, nor should schemes expect members to incur any form of co-payment penalty. It is therefore a concerning trend that some medical schemes continue to either refuse payment of PMB claims or pay them at the scheme rate.

Table 9: Types of valid Technical/clinical complaints

Valid Technical/clinical complaints	2013	2012
Short payment of PMB's	2 116	1 814
Non-payment of PMB's	620	592
Short payment of non PMB's	179	121
Non-payment of non PMB's	163	180
Total number of technical/clinical complaints	3 078	2 707

Source: 2012-2013 CMS Annual Report

b.) Extent of OOP for selected individuals

This section provides a snap-shot overview of the impact of out of pocket payments on individual members within the medical schemes industry. A total of 16 clinical complaints were reviewed and the extent of out of pocket payments made was analysed. As illustrated in table 9 below, most medical schemes tend to refuse paying valid claims by members until the member approaches CMS to complain.

Short payment is a huge problem, where some members are expected to pay amounts above R100 000. Such payments can be viewed as catastrophic for particular members leading to denied care and even impoverishment. Whilst the medical schemes are refusing to pay in full most members are forced to negotiate monthly payments with the providers including accessing loans or sell assets so as to be able to afford the providers bill. In certain instances doctors and the private hospitals often enter into agreements with the members to wait for the ruling from CMS before care can be provided or the member will make partial payments towards their account, and submit proof of payment to the scheme for refund. Although through the complaints and adjudication system schemes eventually pay all valid claims, there is a huge opportunity cost for members which is associated with pain and suffering.

The most regressive form of out of pocket payments is cases where disputes between the medical schemes and the members last for longer than a year and the member is liable to pay their accounts in full up until the complaint has been settled. This happened with some of the cases illustrated below. It is within this background that most members with chronic conditions purchase additional health insurance cover in order to supplement their medical scheme's cover (see table 10 below).

Table 10: Short payment by medical schemes

Treatment costs incurred	Scheme payment	Short fall
R10 000	R 9 000	R 1 000
R 9 000	No payment until CMS ruling*	R 9 000
R11 4 00	No payment until CMS ruling	R 11 400
R114 000	No payment until CMS ruling	R 114 000
R171 684	R160 000	R 11 684
R114 000	R 102 600	R 11 400
R95 000	R75 000	R20 000
R108 000	R100 000	R 8 000
R1 484 439	R1 269 086	R 215 352
R103 710	R29 715	R 73 995
R 200 260	No payment until CMS ruling	R 200 260

*The payment was only made after the CMS ruling which ruled in favour of the beneficiary – this data is only for valid claims.

Within this context, the decision on the level of out of pocket payments has to balance the need to protect individuals from catastrophic healthcare costs, to ensure that the private health care system is efficient. The higher the level and extent of out of pocket payments the less the protection against the financial risks of ill health and the lower the access to needed services, particularly among those who can't afford. It is therefore not appropriate to apply severe penalties as a cost sharing arrangements to the beneficiaries who have not been properly empowered about their rights and responsibilities.

6 Conclusion

The analysis undertaken in this report explored OOP expenditure, while also exploring the current available sources of data. The reviewed literature on the currently available data was mainly based on estimates sourced from the Income Expenditure Surveys published by Statistics South Africa.

The current report also assessed data collected through the annual statutory returns data; this data is currently collected by the Office of the Registrar but not publicly available.

The results showed consistent trends between these two data sets and the analysis revealed main categories that significantly impact OOP by medical scheme members. This included expenditure on services rendered by medical specialists, medicines and the allied health professions. The data outlines OOP towards medical specialist as a significant impact taking more than a third of the reported OOP, while nearly a quarter of the OOP was towards pharmacies for medicines.

The important consideration is what is the optimal OOP members should pay? It is my view in answering this question that the amount paid from member savings account is also included in the OOP figure. The MSAs are amounts which belong to members which they contribute in advance – rand for rand cover. If this approach is taken then the portion of healthcare paid for by schemes is 81.3% of the total cost of healthcare.

Currently, medical scheme members cover at least 18.7% of the total cost of healthcare from their own resources. Given the importance of healthcare, asking members to contribute this portion as well as paying for medical scheme contributions is too excessive. Other forms of insurance like general insurance (motor and household) provide more cover with excesses (equivalent of co-payments in medical schemes) being introduced as a way of reducing moral hazard rather than cost sharing as is the case with medical schemes.

7 Recommendations

a.) Publishing out of pocket expenditure in ASR

Analysis undertaken in the current report is an attempt to assess OOP in order to assess OOP as it relates to healthcare. The analysis is critical in the context of the envisaged NHI and estimates from the data collected from schemes could probably provide better estimates, particularly with regards to medical scheme members. These data are important as source information for evaluating the GAP cover products as well as the Demarcation Regulations.

Another added advantage of collecting data on OOP is to assess the financial burden experienced by medical scheme members. The data presented is currently collected at a consolidated level and thus limit a comprehensive analysis of OOP from the benefit offering point of view, in that regard we make the following recommendations to enhance this process.

b.) Collecting OOP data at option level in the ASR

The Annual Statutory Returns data specification has been modified to reflect actual benefits paid by option, it is noted that these data would still be underreported; however it would give a magnitude of benefit offerings that are impacted by the co-payments. It will help identify if there are significant differences between options with thresholds and those with no thresholds.

c.) Refining data from STATSSA

Finally it is recommended that collaboration with other agencies such as Statistics South Africa, particularly in the design of a data collection tool that clearly distinguish between medical schemes and non-medical scheme members, would enhance the current crude estimates reported by Statistics South Africa.

d.) Improving member education

There is a need to educate members on benefit utilisation and health seeking behaviour in order to avoid paying out of pocket payments. Whilst CMS accepts sometimes scheme rules can use obscure and inaccessible language, the continuous scrutiny of scheme rules during the annual registration process is important. This process will enable the member to understand:

- benefit content and/or entitlements,
- what are the exclusion and/or limitations within the entitlements, and
- how to avoid paying co-payments.

e.) Non-compliance – payment of PMBs

Where an issue of non-compliance by the scheme has been identified by the scheme, that information should be shared with BMU so that it will inform the process of schemes benefit review and registration. This may lead to less OOP and less work for the complaints unit.

f.) Improving efficiency

Managed care, patient channelling especially within options requiring use of Designated Services Providers and a network of doctors and proper coordination of care is key towards achieving sufficient financial protection within pre-payment healthcare systems.

g.) Improving efficiency

Use of penalties by the schemes to manage utilisation and/or channel members should not be too aggressive to the point of creating a heavy burden for patients. It is therefore recommended that such penalties should seek to conform to international standards whereby OOP is often capped at 15% of the household budget.

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