

**Report to the
South African
Risk Equalization Fund
Task Group**

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Acronyms

BBP	Basic Benefits Package
CDL	Chronic Disease List
C-M-S	Council for Medical Schemes
FCTT	Formula Consultative Task Team
OOPS	Out-of-pocket spending
PMB	Prescribed Minimum Benefits
REF	Risk Equalization Fund
REFTG	Risk Equalization Fund Task Group
SCTT	Subsidy Framework Consultative Task Team
SBP	Supplementary Benefits Packages
SARS	South African Revenue Service
SHA	Save-for-Health Account
SHI	Social Health Insurance

Definitions

Open enrolment: Most medical schemes apply i.e. they must accept any applicant at standard rates

Contribution: The payment due for membership in a medical scheme. In the insurance industry, the term 'premium' is usually used.

Contribution rate-bands: The maximum allowed range in contribution levels for one and the same Supplementary Benefits Package, per medical scheme. The maximum contribution should not exceed the scheme's minimum contribution for the same product by a factor X (e.g. 2, or 3, 4 or 5). This factor X could be lower for more essential supplementary care, and higher for supplementary packages containing more luxurious forms of care. The C-M-S shall determine the factor X.

Beneficiaries: Persons who are entitled to benefits from a medical scheme, regardless of whether they actually draw a benefit currently or not, and regardless of whether they pay a contribution, or it is paid on their behalf by someone else, in part or in full.

A product: A certain benefits package in combination with a list of providers.

Community rating: the principle whereby each beneficiary pays the same contribution - mostly per medical scheme, per product- independent of the beneficiary's age, gender, health status and other risk factors.

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All members of the International Review Panel wish to put on record their high esteem for the proficient, thorough and cautious manner in which the policy change has been considered.

The Panel would like to thank the following persons, holding political or delegated responsibility, for their guidance to and their trust in the Panel: the Honorable Minister of Health Dr. Manto E. Tshabalala-Msimang, the CEO of the Council for Medical Schemes and the Registrar Mr. Patrick Masobe, the members of the Risk Equalization Fund Task Group (REFTG) Ms. Brenda Khunoane (Ministry of Health), Mr. Thabo Rakoloti (Ministry of Health), Dr. Elamin Mohamed (Council for Medical Schemes), and Mr. Alex van der Heever (Adviser to the Council for Medical Schemes)

Special thanks go to Prof. Heather McLeod, Chairperson of the Formula Consultative Task Team (FCTT), and Mr. Anton Roux, Chairperson of the Subsidy Framework Consultative Task Team (SCTT), for having provided essential background material reflecting the views and options considered in the internal process that led up to the Panel's review.

The Panel also extends its thanks to Dr. Mark Blecher of the National Treasury, Mr. Ray Mabope and Dr. Kamy Chetty of the Ministry of Health, to Mr. Stephen Harrison and Mr. Jaap Kugel of the Council for Medical Schemes, for valuable input during the Workshop. Thanks are due for the excellent support provided to the Panel throughout the period of this review. Finally, the Panel thanks Ms. Carrie-Anne Osman for the administrative arrangements.

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Executive Summary

Mandate:

The Department of Health, under the able leadership of the Minister of Health Honorable Dr. Manto E. Tshabalala-Msimang, together with the Council for Medical Schemes (C-M-S), under the able leadership of the Council's CEO (who also acts as Registrar of Medical Schemes) Mr. Patrick Masobe, jointly nominated a "Risk Equalization Fund Task Group" in 2003. In November 2003, the REFTG invited six experts from various countries to serve on an "International Review Panel". The Panel was invited to provide written comments and recommendations on two reports commissioned by the REFTG, one written by the Formula Consultative Task Team, chaired by Prof. Heather McLeod; and the second written by the Subsidy Framework Consultative Task Team, chaired by Mr. Anton Roux.

The context in which the Panel was to offer its advice was defined by the Minister and by the Registrar. The Minister asked the International Panel to refer specifically to the three issues of unfinished reform agenda toward implementing Social Health Insurance, bearing in mind the overall objective of "better life for all": (i) Risk-related cross subsidies; (ii) Income related cross subsidies; (iii) Mandatory cover.

The Registrar added that the Panel should bear in mind how the proposed changes contribute to the overall considerations of equity and efficiency of, and access to the healthcare system.

The current situation:

All medical schemes in South Africa are required to include a "Prescribed Minimum Benefits" package (PMB). 138 medical schemes, both open and restricted ones, are required to calculate contribution levels on scheme-specific community-rating of the benefits package. Scheme-specific community rating implies that contributions are based on risk exposure of each scheme, which is a function of, amongst other things, the age, gender, morbidity structure and the size of membership. The Formula Consultative Task Team established that age profiles differ considerably between the schemes, so that the difference in average cost is a factor of four between the cheapest and the most expensive scheme. This very large distortion in risk exposure of medical schemes is too large to be considered random.

In addition, there is a drop in the number of "restricted" medical schemes and an increase of the number and membership of "open" medical schemes. All open schemes are required to maintain open enrolment. In a scenario of open enrolment and customers' free choice of schemes without risk equalization, schemes have a strong incentive to prefer good risks and retain the higher profits arising from the difference between industry-comparable contributions and scheme-specific lower average costs. These risk selection practices are called "cream-skimming". If schemes have financial incentives to engage in cream skimming, this unavoidably leads to unequal contribution levels for essentially the same package. The schemes with higher-than-average risks, charging higher contribution levels, could face financial problems, thus endangering both their members and the public sector (which would have to pick up the bad risks in case of insolvency of a scheme or non-renewal of the contract of high-cost beneficiaries). Therefore, the current situation is undesirable economically and unjustified from the point of view of public policy.

Risk equalization

The mechanism for adjusting the distribution of risks between the schemes on the basis of an essential set of benefits, valued at efficient cost levels, is called risk equalization. Risk equalization is relevant in a market characterized by multiple payers. In South Africa, upward of one hundred and thirty medical schemes are competing with each other. They cover 16% of the population. The urgency of introducing risk equalization is predicated by the evidence that the government's decision to apply community-rating of PMB cannot be fully implemented and supervised without REF. The urgency is further predicated by imperfect competition that exposes some schemes to financial risk that is unrelated to inefficiency or mismanagement. Risk equalization can improve transparency, thereby enabling customers to compare the different packages and identify efficiency gains that are reflected in the contribution structure. Fairer price competition between medical schemes is desirable both in the interest of the beneficiaries and as a regulating mechanism. This is why risk equalization should be introduced as soon as possible. Waiting longer for the introduction of the REF implies accepting an unnecessary risk that some schemes could be derailed by unfair competition, or that such insolvency of medical schemes could have a negative spill-over to the entire financial services industry.

The REF

The Government of South Africa has decided to move towards the introduction of Social Health Insurance. The medical schemes are supposed to serve as the basis for the introduction of SHI, and it is projected that when SHI is implemented, the number of beneficiaries that will be covered by the open medical schemes will more than double, from just over 7 million beneficiaries today to 15 million. However, at present the cost per capita in the private health sector is almost 7 times higher than in the public health sector, so it is essential that any costs generated by cream skimming and other inefficiencies should be minimized as soon as possible and the cost of delivering the PMB, which is one of the defining components of SHI, should be equalized.

Flow of funds

Two different options for the flow of funds into- and out of the REF are described in the preparatory reports: (i) Modality 1, under which the REF receives a contribution from beneficiaries, and pays the medical schemes. Under this modality, the medical schemes collect directly from their beneficiaries an additional contribution for components of benefits which are not equalized through the REF (for ease of reference we call these components 'PMB+'); and (ii) Modality 2, under which the REF received its income from the medical schemes, and pays out to the medical schemes. There is no direct contribution of the consumer to the REF. Under modality 2, it has been proposed to add a government subsidy through injection of funds into the REF.

The Panel observes that, with the exception of the government subsidy, the payments to and from each of the actors are essentially identical in both modalities. The differences are only in the flow of funds, yet the Panel identified significant advantages to modality 1. For one, the government wishes to move toward implementation of SHI. Therefore, the flow of funds determined now should be compatible with the implementation of SHI, without having to reform the operation of the REF later on. One of the desirable components of SHI is income rating. Even if this cannot be implemented now, such a measure could be implemented in the

future only if reliable income data is available. Under modality 1, it is in the interest of the government to mandate the SARS to collect the REF contribution. SARS is better positioned than any other government agency to implement mandatory payment of contributions, and to apply income rating, when these measures are decided upon (SARS is the only agency that collects income data). Under modality 2, when consumers pay to the medical scheme both a community-rate for PMB and the contribution for PMB+, they are unable to distinguish between the cost of PMB and the added cost of PMB+. This situation of lesser transparency is currently the standard, and it can be remedied without any cost to beneficiaries, the schemes or the government, by choosing modality 1 for the flow of funds.

Subsidies for the REF

The SCTT report contains a proposal that the government should pay a subsidy to enhance the income of REF and that the consumers' contributions towards the REF should only fund the difference between the costs of 'PMB conditions' in the private and public sectors. This will create a structural shortfall for the REF, because the payments out of the REF are related to the costs of PMB in the private sector. Rather than engaging public subsidies which might defy the whole purpose of the REF, the solution is to fix the consumers' contributions to the REF based on the costs of the PMB in the private sector (and not only the cost difference between the private and public sectors). This calculation would prevent a structural shortfall and guarantee that the REF remains self-funded. The issue of allocating direct public subsidies for the operation of REF at this stage also raises equity concerns, because this mechanism will serve only those who are beneficiaries of the medical schemes, but not other population segments. Hence, the Panel favors that the REF should be structurally self-funded, in which case government subsidies would not be necessary.

Equalized risks

The basis for risk equalization should be the set of cost-generating events, which all medical schemes should face at about the same level. This basic package should be limited to a reasonable, socially acceptable minimum level of services, delivered efficiently and in compliance with international treatment guidelines. The costs associated with "PMB conditions", including chronic diseases, is a reasonable basis for the introduction of risk equalization. Calculation of the average PMB cost should ideally be based on data on all beneficiaries from all schemes participating in the REF. In implementing the REF in 2005, the calculation of weights attached to the risk factors should be based on 2003 claims data. In the first instance, the following factors should be retained for risk equalization:

Age - using age ranges: 0, 1-4, 5-9, 10-14... 75-79, 80-84, 85+. The age band of 75+ years should be split into three separate age bands, and that definition of birth year should be standardized to mean "age in years on 1 January".

Gender – based upon interactions with age.

CDL – should be phased in as a factor for REF calculations, with a weight of 10% in the first instance. An additional maternity / pregnancy indicator column should be added to the CDL. A beneficiary should be recorded as belonging to the maternity category if she had an episode of maternity utilization in the last year prior to the returns.

REF will equalize only the costs of benefits, but not the cost of administration. Therefore, the schemes will retain cost gains generated by efficient administration.

'Basic Benefits Package' and primary care

The C-M-S, together with the industry, must ensure that the PMB becomes a marketable package. This requires developing a standardized Basic Benefits Package (BBP), composed of the PMB and the minimum additional benefits to make it a marketable package. The Panel strongly recommends including primary care, i.e. 'all the care that is usually delivered by primary care physicians'. The role of primary care in the medical schemes environment may currently be undervalued. Currently, it represents less than 10% of spending through the medical schemes risk pool, and only 14% of the costs through MSA. However 77% of all South African GPs work in the private sector, so there is a strong case for inclusion of primary care in the BBP, and its importance will likely grow with more managed care, and in the realization of efficiency gains in the framework of SHI. The inclusion of primary health care into the BBP serves two purposes: Firstly, it bridges the divide between the range of services considered essential in the public sector and the current medical schemes setting. When primary care is included, the open medical schemes will be able to attract a broader range of the population. Secondly, it introduces new efficiency tools in terms of managed care into the medical schemes logic, and another important step towards SHI.

The difference between the cost of the Basic Benefits Package and that of the PMB, if not equalized, could provide medical schemes with an incentive for cream skinning. Therefore, when sufficient data are available, the BBP should become the common package on which the REF-contribution table is based.

As stated by the Minister of Health, the whole objective of the reform is, ultimately, to pave the way for SHI, not just to clean up the present flaws in the industry. With a view to the development of SHI, the Panel raises the question how outpatient drugs should be dealt with in the context of the BBP. Stopping short of recommending the inclusion of medicines, the Panel suggests that the government should consider an adequate structure of co-payments for drugs when SHI is introduced, with possible waivers for low-income persons.

Supplementary Benefits packages

In addition to the BBP, the medical schemes should be allowed to offer a few (say 3 to 5) supplementary benefits packages (SBP). Standardization will reduce product competition based on the design of numerous benefits packages (which hardly benefits the consumer) and increase price competition among the medical schemes. This type of regulation of benefits packages exists elsewhere; for example, in the USA, insurers are only allowed to sell a restricted number of standardized benefits packages as a supplement to Medicare (the so-called Medigap-insurance).

The standardized SBP should not be included in the REF, at least not at present. Medical schemes offering these packages would not be entitled to any payment from the REF for this segment of their business. In order to reduce risk selection, SBP should be sold in combination with contribution rate-bands. Contribution rate-bands mean that the maximum contribution for one and the same SBP product does not exceed the scheme's minimum contribution for the same product by a factor X (e.g. 2, or 3, 4 or 5). This factor X could be lower for more essential supplementary care, and higher for supplementary packages containing more luxurious forms of care. The C-M-S shall determine the factor X.

Transparency and stability

The full impact of standardization of the BBP and the SBP will be achieved only when beneficiaries can obtain reliable and understandable information about such products. Therefore, the C-M-S, together with the industry and consumer organizations, should publish the list of benefits and their rate tables for each product. A product is defined as a certain benefits package in combination with a list of providers. The list should include region/province-specific information.

It is our understanding that currently, monthly contracts are the norm in South Africa, which means that beneficiaries can leave a scheme without any prior notice. Medical schemes should be given time to adjust to the departure of customers. Therefore, a standard minimum subscription period of 12 months should be set, with a mandatory advance notice for cancellation of at least four weeks. At the same time, the practice of ‘churning’, whereby brokers have an incentive to move beneficiaries between schemes, also weakens stability of membership. In order to stop this source of instability, medical schemes should be forbidden to pay a fee to brokers. On the other hand, individuals should be free to change between schemes within the stated limitations. To facilitate such transfers, and reduce costs, a reply card should be sent with the annual brochure mentioned earlier.

Late-joiner penalty

Some people refrain from joining a medical scheme when they are well, but enter when they expect the need for expensive medical care (known as “free-riders”). Medical schemes that are required to offer open enrolment may wish to protect themselves against this form of adverse selection by imposing a “late-joiner penalty”. The late-joiner penalty would be inappropriate in the case of persons who are required to pay to the REF the ‘industry REF community rate for PMB’ (initially persons with high incomes, many of whom are already affiliated; see below). Nor should this penalty be imposed on persons joining a medical scheme on a voluntary basis and buying the BBP only, or from persons with SBP and who switch medical scheme, because this penalty might then reduce the possibility for the high-risk persons to switch medical scheme for the BBP. On the other hand, the medical schemes should be free to decide on collecting this penalty from persons who buy a SBP and who in the previous 12 months had no SBP. The medical schemes could also apply differential late-joiner penalties according to the SBP selected. An overall rider is that the late-joiner penalty should not discriminate between two potential beneficiaries of the same risk group and that the total penalty payable will be part of, and capped by the relevant contribution rate-band for that SBP.

Solvency

Provisions must be made to ensure that the REF remains solvent from launch. Based on numbers provided to the International Review Panel, it seems that a 10% difference between actual and envisaged beneficiary (membership) experience would translate to a deficit of less than 1% of the current total contribution income for the industry. If a deficit scenario were to occur, bridging capital would be needed to cover this deficit in the short-term. The Panel suggests that any such deficit should be financed by a loan from the National Treasury. In then long term, deficits should be covered by an increase of subsequent payments from the beneficiaries

As for solvency of medical schemes, the introduction of REF will arguably improve the solvency of most, as the risks associated with ‘cream-skimming’ are removed. Also, the introduction of REF should be accompanied by a change to the solvency requirements of medical schemes. These should in principle be calculated based upon both the volume of business written by each medical scheme, as measured by written contributions (i.e. the sum of payments received by the medical scheme from both the consumer and the REF on a written accounting basis) and the cost of benefits each scheme has to pay (i.e. claims incurred). In the longer term, the Panel would favor retaining a risk-based capital approach.

The regulator should also take measures to protect individual beneficiaries in case their medical scheme becomes insolvent.

Mandatory affiliation to the REF

All medical schemes that are required to provide the PMB should also be required to participate in the REF. This should apply to all new medical schemes that will be accredited in the future.

Mandatory payment of REF contribution should be applied to high-income earners, regardless of whether they are currently beneficiaries in a medical scheme. Secondly, mandatory payment of REF contribution should be widened gradually to middle and lower-income groups as well as to all beneficiaries of medical schemes.

The International Panel is in principle favorable to the introduction of income rating as part of SHI. International experience confirms that income-rating which is applied to the majority of the population, while not a suitable factor for risk equalization, is a more equitable method to finance healthcare than flat-rate contributions regardless of the absolute level of the contribution or the level applied to income rating. The Panel recognizes that this measure cannot be applied in South Africa immediately.

Institutional arrangements

The Board of the REF should be composed of members of the Board of the C-M-S, plus other persons who can increase its capacity in certain areas of special pertinence to the REF.

The C-M-S should administer the REF and finance the administrative costs incurred by the REF.

The State Auditor General should audit the accounts of the REF separately from those of the C-M-S.

The existing external auditors of medical schemes should carry out the auditing requirements for REF. However, the C-M-S should be empowered to validate the audit, including requesting additional information. Because the audited returns will determine the amount that each scheme is entitled to from REF, the Panel suggests that the margin of materiality for audit of the REF payments should be lower than that fixed for general financial audit (e.g. a materiality level of 1%, compared to the traditional level of 10% applies to financial audits).

Administration

The contribution table should be based on prospective assessment.

The Board of the REF should ascertain the independence of ongoing reviews of the risk factors, weights applied to each risk factor, cost of the PMB and the operational terms of the REF.

The REF should make quarterly payments to medical schemes, with annual adjustment for inflation and cost changes.

Medical schemes should make quarterly reports to the REF. If unknowing errors are found in report to the REF, the C-M-S should determine if the corrections are significant enough to justify recalculation of transfers for previous quarters. If deliberate errors are found, the C-M-S should impose penalties; and in particularly severe cases, the Council should consider whether the penal responsibility of the Directors of the medical scheme should be engaged.

Taxation

The C-M-S, together with the industry and the South African Institute of Chartered Accountants should elaborate a 'best practice' standard for reporting REF payments in the accounts of the schemes.

Research, development and follow-up

- The risk factors used for equalization, the weights to be attached to these, and risk-specific costs included in the cells of the contribution table should be reviewed from time to time (see Recommendation 24), and shall then remain unchanged until the next update.
- The Panel recommends that an index should be developed for determination of adjustments for inflation, medical technology and cost changes in the contribution table. This index should take into account retrospective salary-related and price-related figures, which will be weighted and inflated forward.
- The C-M-S should establish a Working Party to propose cost containment measures in the South African healthcare industry.
- The South African government should widen the arrangements already in place to encourage savings for health purposes, ensuring that the poor can benefit as well. In the short term, the government and the C-M-S should develop a 'Save-for-Health Account' programme, which will offer a government subsidy to encourage willingness to pay for healthcare among low-income persons. This Save-for-Health Account programme should be launched as soon as possible after the establishment of the REF.
- The Ministry of Health and the C-M-S should appoint a Task Team to review opportunities and constraints of improving equity and extending access to healthcare in the informal sector, notably through support for community-based pooling schemes. The Panel recommends that this should be done in the context of implementing the REF, to abate concerns about equity. The ultimate objective should be to elaborate a feasible proposal to sustain, both financially and operationally, informal sector community schemes which service the poor. The Task Team should report on its findings to a broad-based consultation with stakeholders, government agencies and civil society (including pertinent NGOs).

Caveat

The Panel considers that implementation of its recommendations as a set will generate better results than partial implementation, or measures taken in isolation from the overall plan recommended in this report.

This executive summary deals with policy issues, but the reader is strongly urged to peruse the detailed development of arguments and solutions, notably on the technical considerations pertaining to the REF, which can be found in the report.

The views and recommendations contained in this report are those of the entire Panel.

Respectfully submitted by the International Review Panel (in alphabetical order of last name):

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1 Introduction & Terms of Reference

In this chapter an overview is presented of the reasons for the report, the objectives of the report and the overall structure of the report.

The Department of Health, under the able leadership of the Minister of Health, the Honorable Dr. Manto E. Tshabalala-Msimang, together with the C-M-S, under the able leadership of the Council's CEO who also acts as Registrar of Medical Schemes, Mr. Patrick Masobe, jointly initiated the establishment of a Risk Equalization Fund Task Group (REFTG)¹ in 2003. In November 2003, the REFTG invited six experts from various countries² to serve on an "International Review Panel" (hereafter "the Panel") to discuss draft reports of two consultative task teams, set up in July 2003, to develop a formula for a risk equalization fund ("the Formula Consultative Task Team" - FCTT) and to consider changes to the tax system that would identify funding options for a risk equalization fund (hereafter "the REF"), and possibly also make it more affordable for lower-income earners to join medical schemes ("the Subsidy Consultative Task Team - SCTT")³. In a later communication, the Panel's role was further defined to provide written comments and recommendations, by the end of February 2004, based on discussions, to be held in a Workshop in Cape Town from 26 to 30 January 2004, of the draft reports produced by the two Consultative Task Teams.

In her Address to the Risk Equalization International Review Panel Workshop, the Minister of Health, the Honorable Dr. Manto E. Tshabalala-Msimang, stated that the government felt ready to press forward with reforms in the healthcare industry, linked to the policy position to move toward establishing a social health insurance system in South Africa.

The Honorable Minister of Health identified three issues that were particularly important in the unfinished reform agenda (that started with democratization, a decade ago):

1. Risk-related cross subsidies
2. Income related cross subsidies
3. Mandatory cover

The Minister invited the International Panel to offer advice on the three issues, bearing in mind the overall objective of "better life for all", a concern that implementation should unfold without destabilizing the current market of medical schemes, technical and institutional capacity, as well as timing and sequencing considerations.

During the Workshop, the CEO of the Council and Registrar of Medical Schemes, Mr. Patrick Masobe, stated that the Panel's analysis and recommendations should bear in mind how the

¹ The Risk Equalization Fund Task Group (REFTG) is composed of Ms. Brenda Khunoane (Ministry of Health), Mr. Thabo Rakoloti (Ministry of Health), Dr. Elamin Mohamed (C-M-S), and Mr. Alex van der Heever (Adviser to the C-M-S).

² The Panel has been composed of Mr. John Armstrong (Ireland), Prof. John Deeble (Australia), Dr. David Dror (Israel, now France), Dr. Nigel Rice (UK), Dr. Michael Thiede (Germany, now South Africa), and Prof. Wynand van de Ven (Netherlands) (names listed in alphabetical order of last name).

³ The REFTG set up two consultative task teams: the Formula Task Team (FCTT), chaired by Prof. Heather McLeod, and the Subsidy Framework Task Team (SCTT), chaired by Mr. Anton Roux.

proposed changes contribute to the overall considerations of equity and efficiency of, and access to the healthcare system.

Ms. Brenda Khunoane, Director of Social Health Insurance at the Ministry of Health, added that the Ministry intended to press ahead with implementation of the Risk Equalization Fund and revisions in tax subsidies as from January 2005, subject to a final policy decision that should follow the submission of the reports of the Consultative Task Teams as well as the Panel's report and reasoned recommendations.

Considering the Minister's invitation requires it to go beyond the topics treated in the reports of the Consultative Task Teams, and bearing in mind the Registrar's concerns, the Panel reached a consensus that it can provide reasoned arguments and recommendations relating to the three issues identified by the Minister.

Chapter two of this report deals with risk-related cross subsidization. This includes a detailed discussion of the rationale for introducing Risk Equalization between South African medical schemes. The chapter deals both with the principle and with the technical aspects of risk equalization, notably the flow of funds, the justification for making this regime mandatory to prevent adverse selection, and issues related to the components that should be equalized, considerations in favor of standardization of benefits packages, as well as the regulatory regime that should apply to these components. Finally, this chapter also contains the Panel's considerations of the institutional arrangements and the measures to reduce the risk of error or failure in implementing risk-based cross subsidization.

Chapter three deals with income-related cross subsidies. This chapter is closely related to the government's intention to extend access to a risk-pooled financial system that will, in the future, bear the characteristics of social health insurance. This chapter deals with several mechanisms that improve the equity of the system, through redistribution across age groups, income groups and morbidity groups. The chapter does not propose changes to the existing system of "tax subsidy" (health-related tax deductions that individuals and employers can claim under the existing regulatory framework). It does however contain the Panel's proposals for the introduction of a few pro-poor measures that could ease the way for social health insurance and the advancement of "better life for all" among persons living and working in the informal economy. While these proposals of the Panel do not arise from the reports of the Consultative Task Teams, they relate directly to the topics flagged by the Minister. The REFTG is thus invited to consider these proposals as part of the Panel's position on income-related cross subsidization.

The third issue identified by the Minister, mandatory cover, is relevant for the two preceding chapters and has therefore been dealt with in context, rather than as a separate chapter. The main measures are recapitulated in a special section.

The last chapter of this report contains a summary of the Panel's recommendations, for ease of reference, perusal and action.

The Panel considers that implementation of its recommendations as a set will generate better results than partial implementation or measures taken in isolation from the overall plan drawn up in this report.

The views and recommendations contained in this report are those of the entire Panel, unless otherwise stated. The Panel will be pleased to elucidate any queries the REFTG might have in relation to this report.

February 16, 2004

2 Risk-related cross subsidies: The REF

In this chapter we present the problems that can be solved through a risk equalization mechanism, followed by a detailed discussion of the risks that should be equalized, the flow of funds into- and out of the REF, standardization of packages, solvency and stability considerations, as well as issues related to implementation and appropriate institutional arrangements.

2.1 The objective of Risk Equalization

Medical schemes are currently required to base contributions on scheme-specific community-rating of the benefits package. Legitimate grounds for differentiation in the contribution include differences in the coverage, the number of dependants, and whether the beneficiary is a child or an adult. Differentiation by age or medical condition of the beneficiary is not permitted, and most medical schemes apply “open enrolment”, i.e. they must accept any applicant at standard rates.

In a scenario of open enrolment and customers’ free choice of schemes without risk equalization, schemes have a strong incentive to prefer good risks and retain the higher profits arising from the difference between industry-comparable contributions and scheme-specific lower average costs. These risk selection practices are called “cream-skimming”. People who are good risks also prefer to enjoy a lower contribution and/or more benefits, notably benefits that are not limited only to health services.

If schemes are allowed to engage in cream skimming, this unavoidably leads to unequal contribution levels for essentially the same package. Yet, price differences between schemes for equal packages should only reflect differences in efficiency, which at present is not identifiable and is perhaps not passed on to members in full. The schemes with higher-than-average risks could face financial problems, thus endangering both their members and the public sector (which would have to pick up the bad risks in case of insolvency of a scheme or non-renewal of the contract of high-cost beneficiaries). Therefore, the current situation is undesirable economically and unjustified from the point of view of public policy. The remedy is Risk Equalization.

In South Africa, the C-M-S has introduced a requirement that all schemes must offer a “Prescribed Minimum Benefits” (PMB), thinking that this would reduce the incentive of medical schemes to select risk. While it is assumed that all schemes apply the requirement to offer the PMB, it is also noted that none of the schemes markets or sells the PMB as a distinct package at present. Therefore, membership in a medical scheme normally entails buying a benefits package that includes more than the PMB. And, any attempt on the part of beneficiaries to compare packages across medical schemes, or identify the share of the cost relating to the coverage they have over-&-above the PMB is bound to be frustrated by lack of the necessary information.

Scheme-specific community rating implies that contributions are based on risk exposure of each scheme, which is a function of, amongst other things, the age, gender, morbidity

structure and the size of membership. The FCTT⁴ established that age profiles differ considerably between the schemes. Calculations of the cost of community-rated PMB based on these different age distributions show that the cost of the scheme with the most unfavorable age structure is about 142 percent above the industry average, whereas the cost of the scheme with the most favorable age structure is about 38 percent below the average. The difference between the two extremes is a factor of four, which is very large.

Such a distortion in risk exposure of medical schemes is too large to be considered random. In fact, this large difference suggests that despite the introduction of open enrolment, the PMB and community-rating, some medical schemes have been very successful in attracting good risks by applying advanced marketing techniques and by offering differential benefits packages with differential pricing based on different risk structure, when the basis of coverage and of the contribution should have been an identical, community-rated PMB. These cream-skimming practices have increased the imbalances between medical schemes to such high levels that they can seriously endanger fair competition and the viability of weaker schemes.

The mechanism of adjusting the distribution of risks between the schemes on the basis of an essential set of benefits, valued at efficient cost levels, is called risk equalization. Several countries have accumulated considerable positive experience with risk equalization, in an environment of multiple schemes competing with each other successfully. Risk equalization also improves transparency, thereby enabling customers to compare the different packages and identify efficiency gains that are reflected in the contribution structure. This is why risk equalization also improves the competition between schemes.

Risk equalization is relevant in a market characterized by multiple payers. In South Africa, upward of one hundred and thirty medical schemes are competing with each other⁵. They cover 16% of the population. Of these, 67.9 percent of the beneficiaries were affiliated with an “open medical scheme” (a scheme that accepts any applicant), while 28.5 percent of beneficiaries were affiliated with a “closed medical scheme” (open only to persons linked to a specific employer or industry). The Government of South Africa has decided to move towards the introduction of social health insurance (SHI) in stages. The medical schemes are supposed to serve as the basis for the introduction of SHI, and it is projected that when SHI is implemented, the number of beneficiaries that will be covered by the open medical schemes will more than double, from just over 7 million beneficiaries to 15.2 million (FCTT report, p.11). However, at present the cost per capita in the private health sector is almost 7 times higher than in the public health sector, so it is essential that any costs generated by cream skimming should be minimized as soon as possible and the cost of delivering the PMB, which is one of the defining components of SHI, should be equalized.

Recommendation 1:

The International Review Panel regards the introduction of risk equalization across the medical schemes in South Africa as an essential prerequisite for the introduction of SHI, as a vital mechanism to improve fair competition between medical schemes under open enrolment,

⁴ McLeod, H, Matisson, S, Fourie, I, Grobler, P, Mynhardt, S, Marx, G : *The Determination of the Formula for the Risk Equalization Fund in South Africa*, (Pretoria), Unpublished working paper prepared for the REFTG and submitted for discussion with the International Review Panel, January 2004

⁵ According to the C-M-S, there are 50 registered open schemes and 88 restricted schemes in February 2004 (42 and 94 respectively, on 31.12.2002)

and as a means toward the efficient implementation of PMB as the basis for coverage and community-rating as the basis for the contribution.

2.2 *Why do it now*

The reasoning on why REF should be introduced now covers retrospective and prospective considerations.

2.2.1 Why has it not been done before?

Before 1994, the policy had been to allow radical deregulation of medical schemes. This led to the virtual exclusion of vulnerable and low-income population segments and to drastic cost increases. Since the first democratic elections in 1994, there was more concern with equity, which also influenced the South African health system. The new government, aiming to enhance the principle of social solidarity and more equity across population segments and fairer competition between schemes, brought about a number of reforms, the latest of which was the Medical Schemes Act of 1998.

One of the most significant elements of that Act has been the re-introduction of PMB with effect from January 2000, and the introduction of open enrolment and community rating. The definition of the PMB has been widened and refined over the last few years. On 1 January 2000, a list of 271 diagnosis and treatment pairs (PMB-DTP) was introduced. On 1 January 2003, a set of emergency medical conditions (PMB-EMC) were added. And as from 1 January 2004, a list of 25 defined chronic conditions (PMB-CDL) was added.

The introduction of the PMB and the extension of its definition were driven by the desire to achieve two objectives: Firstly, by defining diagnosis-treatment combinations, and specifying that the medical schemes have to pay for them in full, it was intended to prevent medical schemes from ‘dumping’ seriously-ill patients onto the public sector, by requiring those people to pay a prohibitive contribution or reduce their coverage. Secondly, basing the competition on one and the same PMB for all schemes was expected to generate efficiency gains. It was thought that the legal measures would produce the desired objectives.

2.2.2 Why not wait further?

Experience with the PMB hitherto suggests that it will only be possible to identify the full extent of efficiency gains when a system of risk equalization between the medical schemes is put in place. And the present environment shows that some schemes are increasingly in danger of becoming loaded with high-cost beneficiaries, which may in the long term thwart the government’s first objective. The solution for both problems is the introduction of risk equalization as soon as possible.

In addition to distortions in risk exposure, the FCTT discovered that some schemes, notably some closed schemes, maintained insufficient or flawed data sets. Without reliable data on age, gender and other parameters, it is impossible for schemes to calculate PMB-related, scheme-specific community rating. The introduction of a REF will be accompanied by an obligation to meet technical standards that will remedy this situation throughout the industry.

These standards are also indispensable for a successful policy to level off differential pharmaceutical pricing. Drugs represent a large component of medical costs, and therefore illicit or unfair breach of competition among providers on this item can change the cost-

structure of medical benefits dramatically. REF is the technical tool to ascertain an efficient economic culture in the health sector, without which the entire industry risks stagnating due to imperfect competition.

In summary, now that it is clear that the implementation of policy measures already taken (such as the PMB and community-rating) is far from perfect, corrective measures need to be undertaken. The urgency of introducing risk equalization is predicated by the evidence that the government's decision to apply community-rating of PMB cannot be fully implemented and supervised without REF. The urgency is further predicated by imperfect competition that exposes some schemes to financial risk that is unrelated to inefficiency or mismanagement. The introduction of REF can improve fairer price competition between medical schemes which at present compete mainly through package design rather than through price; and it will enable to ascertain fair competition on drug purchasing. Waiting much longer for the introduction of the REF represents a risk that some schemes could be derailed by an environment of unfair competition, which also carries a risk of a negative spill-over to the entire financial services industry. Such risk must be avoided. Delaying the introduction of REF is therefore undesirable.

Recommendation 2:

The Panel strongly recommends introducing risk equalization as soon as technically possible; the target date of 1 January 2005 that has been proposed by the REFTG is endorsed by the Panel.

2.3 Cost (of benefits) that should be equalized

The risk structure associated with a set of cost-generating events, which all medical schemes should face at about the same level, is the desirable basis of risk equalization. It is recalled that the basic package should ideally comprise the range of health services covering all risks that could jeopardize individuals' livelihoods if no insurance cover exists. The basic package should be limited to a reasonable, socially acceptable minimum level of services, delivered efficiently and in compliance with international treatment guidelines. The range of healthcare services included in the package may increase over time, as the SHI framework is expanded. In a later section of this report we provide details on the specific components that should be equalized through the REF initially.

Recommendation 3:

The Panel recommends that, with a view to implementing SHI through the medical schemes, all medical schemes should face the same (equalized) basic risk, representing the coverage for an essential healthcare package to all their beneficiaries.

2.4 Definition of the PMB

Section 29 (1) of the Medical Schemes Act requires medical schemes to pay in full, without co-payment or deductibles, the cost of diagnosis, treatment and care of services included in the PMB, and to provide this PMB within any benefits option the medical scheme offers. The Panel regards the costs associated with "PMB conditions", including chronic diseases, as a reasonable basis for the introduction of risk equalization. On the other hand, bearing in mind that PMB is not sold as a stand-alone package, the imperfect quality of data about utilization and the Panel's reservations regarding the comprehensiveness of the PMB catalogue

(including the difficulty that from an insurance perspective it is somewhat meaningless if it refers to pathologies rather than to treatment), the Panel recommends to revisit and review the composition of the PMB, and to exercise prudence in applying the full weight of the chronic diseases list (PMB-CDL) in the initial risk equalization formula. A partial weighting proposal is discussed in Section 2.8.6 of this report.

Recommendation 4:

The Panel regards the PMB package as a reasonable basis for risk equalization, but recommends that the present composition should be reviewed from time to time, with a view to changing the services that may be deemed essential (see Section 2.9.5 of the Report).

2.5 REF related flow of funds

The Panel was given copies of two reports prepared for its review: the report of the FCTT (referenced earlier in footnote 4) and the report of the SCTT⁶. The Panel observes that these two reports describe two different options for the flow of funds into- and out of the REF. We shall refer to the two options as modality 1 and modality 2 (please see Figures 1 and 2 in Appendix A).

On page 13 of the FCTT report and on page 47 of the SCTT report one can find the reference to modality 1, under which the REF receives a contribution from beneficiaries, and pays the medical schemes. The medical schemes also receive a contribution from their members directly.

On page 76 of the FCTT report one can find reference to the modality 2 flow of funds. Under this modality, REF gets its income from the medical schemes, and pays out to the medical schemes. There is no direct contribution of the consumer to the REF. There is reference to a government subsidy through injection of funds into the REF.

The Panel observes that, with the exception of the government subsidy, the payments to and from each of the actors are essentially identical in both modalities, even if at first sight the two options seem to yield different amounts. The differences are only in the flow of funds, yet the Panel can see some significant advantages to modality 1 over modality 2. These advantages are discussed next.

It should be recalled that although we discuss here the implementation of the REF within the context of the current market of medical schemes (all other things being equal), the government adopted a policy to move toward SHI in the future. Therefore, the modality for the flow of funds determined now should be compatible with the implementation of SHI, without having to reform the operation of the REF. Some of the pertinent considerations include a gradual and seamless integration of such components of SHI as income rating, or the extension of risk equalization to schemes covering low-income persons.

The total contribution by consumers can be decomposed into two components: (1) the industry REF community-rate for PMB; and (2) a scheme-specific community-rated

⁶ Roux, A (on behalf of the SCTT) : *The Funding of the Risk Equalization Fund in South Africa*, (Pretoria), unpublished working paper prepared for the REFTG and submitted for discussion with the International Review Panel, January 2004

contribution for “PMB+”. These two components can be paid separately, as foreseen under modality 1, or jointly, as foreseen under modality 2. The REF equalizes risk across schemes by paying to medical schemes an amount representing their risk-rating, by applying the REF Contribution Table (based on the national PBM expenditures profile). In a competitive environment, the medical schemes should deduct this amount from the consumer’s contribution; the net payment due from the consumers to the schemes should in theory be equal to the contribution for benefits over-&-above the PMB (which we refer to as PMB+), plus/minus the difference between the cost of national PMB and the cost of the scheme-specific PMB. We think that in practice, a negative premium for PMB+ will not arise. When consumers pay the ‘industry community-rate for PMB’ directly to the REF, the additional payment they owe the medical schemes should be limited to the PMB+ which will also include an amount for administration costs and profit. This gives consumers a greater assurance that they pay only for what they buy over-&-above the PMB. It is important to emphasize that only the cost of benefits will be equalized, not the cost of administration. Therefore, an administratively efficient scheme will retain its gains from lower administration cost. Under modality 2, when consumers pay both components to the medical scheme, they are unable to distinguish between the cost of PMB and the added cost of PMB+. This situation of lesser transparency is currently the standard, and it can be remedied without any cost to clients, the schemes or the government by choosing modality 1 for the flow of funds.

Table 1 provides a compilation of the differences between modality 1 and modality 2. As can be seen, the indirect implications are quite far-reaching. The Panel considers modality 1 to be more compatible with the introduction, in the future, of mandatory membership in medical schemes and of the more progressive income-rating of the contribution.

Table 1: Comparison between the Flow of Funds under Modality 1 and Modality 2

Item:	Modality 1	Modality 2
Payment of the industry (national) community-rate for PMB (REF PMB)	Payable by consumers to the REF	Payable by consumer to the chosen medical scheme; the medical scheme then has to pay to the REF
Payment of the contribution for the benefits over and above the PMB (PMB+), plus/minus the difference between the REF PMB and the scheme-specific PMB-expenses.	Payable by consumers to the chosen medical scheme (Identical for both modalities)	
Payment from REF to the medical schemes	Equal to the ex-ante amount calculated on the basis of the national REF PBM, and payable to medical schemes according to their specific risk profile, as per the REF Contribution Table (Identical for both modalities)	
Net payments from REF to medical schemes	All medical schemes receive net payments according to the formula described above.	A medical scheme with an above-average risk profile on balance receives an amount out of the REF, while a

		medical scheme with a below-average risk profile will only pay the REF (see page 76 of the FCTT report).
“Winner-loser” nexus	All medical schemes receive payments from the REF; it is easy to explain the fairness of the system whereby schemes receive a low payment for a low-risk consumer and a high payment for a high-risk consumer.	Medical schemes may have the perception of being “winners” or “losers”, depending on whether the net balance of their payments into- and out of the REF is positive (zero or) negative. This “winner-loser” image might not be beneficial for the acceptance of the REF.
Mandatory payments to REF to prevent adverse selection (see section 2.6)	Easily implemented, a government agency is responsible for collection from all persons	More difficult to implement because medical schemes will collect only from their members
Implementing income-rating (as part of SHI)	Consumers’ contribution can be income-based if collected through the SARS (the only agency entitled to obtain full income information). Income related cross-subsidies are reflected in consumers’ payments into the REF.	It is not possible to calculate consumers’ income-related payments because medical schemes do not know the consumers’ income.
Volumes that flow through REF	The actual amount flowing into and out of the REF will be large, reflecting the full risk adjustment across the entire industry.	The actual payments are dependent on the risk profiles of the medical schemes. For example, when some schemes cover only above average-risk consumers and other schemes cover only below average-risk consumers, the flow of funds will be very large. But if all medical schemes have the same risk profile (as far as the REF-risk factors are concerned) net payments between the REF and the medical schemes will be zero.

Recommendation 5:

Based on the differences discussed above, the Panel recommends that modality 1 be retained for the flow of funds into- and out of the REF from inception.

2.6 *Mandatory contribution to the REF*

On pages 124-125 of the FCTT report, concern is expressed about the potential instability of the current voluntary system with open enrolment and community rating. Each single medical scheme runs the risk of making sudden underwriting losses if it (i) attracts older and unhealthy members and/or (ii) loses young and healthy members. This could spark a vicious circle of further increases in community-rated contribution, leading to the withdrawal of more good risks. We share this view. Although the REF may reduce this risk of an adverse selection spiral for each single medical scheme, the implementation of the REF might create another destabilizing spiral. The argument could be made that under open enrolment and community-rating without a REF, young customers may be attracted to join a young pool with a low community rated contribution (and a benefits package attractive to them and unattractive to the elderly); while the elderly would then be in another pool with a high community rated contribution. The huge gap in rates of community-rated contribution that has been observed in practice, whereby the rate of the most expensive open medical scheme is four times higher than the rate of the cheapest open scheme, is a clear indication of such segregated pooling (see FCTT-report, p. 21 and Sections 2.1 and 2.2 above). However, such segregated pooling may not be sustainable after the implementation of the REF, because young consumers will have to pay the ‘industry community-rate for PMB’ to the REF, which might induce them to leave the market. This is why the REF may reduce the risk of adverse selection for each single medical scheme, and at the same time it could increase the risk of adverse selection for the entire industry.

This potential instability in the industry can be prevented by enforcing mandatory affiliation to a medical scheme, or by making the payment of the ‘industry community rate for PMB’ to the REF mandatory for relevant subgroups. This measure is endorsed by the Panel. In line with the ‘proportionality principle’, whereby the regulation should go no further than necessary to achieve its goal, we prefer the latter measure. The other corrective measure would be charging a late-joiner penalty (See Section 2.7.4 below).

Recommendation 6:

The Panel recommends that payment of the ‘industry community-rate for PMB’ (hereafter “the contribution”) to the REF should be mandatory; and that implementation of compulsory payment of the contribution should be gradual. The application of this measure to the highest income group (say, the 10 percent with the highest income) should coincide with the implementation of the REF. Mandatory payment of the contribution should then be gradually applied to other income brackets, as well as other persons who enter the group of beneficiaries of a medical scheme.

Recommendation 7

The Panel recommends that the SARS should collect the mandatory contribution from beneficiaries on behalf of REF, and transfer the total amount collected directly to the REF, since SARS is the only institution that can establish the income of individuals.

2.7 *Premium regulation and standardization of benefits packages*

2.7.1 Basic benefits package

The Panel thinks that the C-M-S, together with the industry, must ensure that the PMB becomes a marketable package. This would require developing a standardized Basic Benefits Package (BBP), composed of the PMB and the minimum additional benefits to make it a marketable package. For reasons given in section 2.10, we strongly recommend the additional benefits should include primary care, i.e. ‘all the care that is usually delivered by primary care physicians’.

The BBP would be a standard requirement under open enrolment and at a scheme-specific community-rated contribution, and all medical schemes would be required to offer this BBP. This would prevent medical schemes from offering only benefits packages that are designed to attract certain profitable segments of the market. The difference between the cost of the Basic Benefits Package and that of the PMB, if not equalized, could provide medical schemes with an incentive for cream skinning. Therefore, when sufficient data are available, the BBP should become the common package on which the REF-contribution table is based.

Recommendation 8:

The Panel recommends that all medical schemes should be required to offer a standardized “Basic Benefits Package” under open enrollment and at a scheme-specific community-rated contribution.

Recommendation 9:

The Panel recommends that the Basic Benefits Package (BBP) should include PMB conditions and primary care, i.e. ‘all the care that is usually delivered by primary care physicians’ (see also Section 2.10 below).

2.7.2 Supplementary benefits packages

In addition to the BBP, the medical schemes should be allowed to offer a few (say 3 to 5) supplementary benefits packages (SBP). The C-M-S, together with the industry, should develop such standardized SBP. Standardization will reduce product competition based on the design of numerous benefits packages (which hardly benefits the consumer) and increase price competition among the medical schemes. Standardization of the SBP should discourage medical schemes from selling benefits packages that are specially designed for risk selection. This type of regulation of benefits packages exists elsewhere; for example, it exists in the USA, where insurers are only allowed to sell a restricted number of standardized benefits packages as a supplement to Medicare (the so-called Medigap-insurance).

Selling the SBP under open enrolment and community rating without risk adjustment through the REF may give the medical schemes very strong incentives for selection (as currently is the case for the entire range of products). In order to reduce this risk selection, the open enrolment into the standardized supplementary benefits packages should be combined with contribution rate bands. Contribution rate bands mean that the same supplementary benefits package can be sold to different risk groups at different prices, provided that the maximum contribution does not exceed the scheme’s minimum contribution for the same product by a factor X (e.g. 2, or 3, or 5). The factor X should be determined by the C-M-S. The factor X could be lower for more essential supplementary care, and higher for supplementary packages containing more luxurious forms of care. Insurers should be free to use any risk factors they want, but must accept any applicant (open enrolment) at a price within the approved

contribution rate band. Medical schemes should be required to record essential data relating to the operation of the SBP, for use to review these packages from time to time.

Recommendation 10:

The Panel recommends that the C-M-S initiate a process of standardization of supplementary benefits packages (SBP). SBP will be sold under open enrolment in combination with contribution rate bands. The C-M-S will determine the factor X applicable for contribution rate banding for each SBP.

Recommendation 11:

The Panel also recommends that the operating of the SBP is reviewed on a regular basis.

The Panel considers that the standardized SBP should not be included in the REF, at least not at present; and medical schemes offering these packages would not be entitled to any payment from the REF for this segment of their business. Alternatively, if it is established that SBP increase risk selection significantly, one might consider applying some form of risk equalization to (some of) these packages. This option would require recording the relevant information, which for the time being is lacking. As a first proxy, one could envisage using, for the time being, the REF-based payments per risk group (as given in the REF Contribution Table). The way it would work is to load a certain percentage onto these payments, and this loading could differ for the various supplementary packages. Incidentally, the flow of funds in respect of this additional risk equalization could follow the pattern described earlier as modality 2, because these payments are not related to income, and because the SARS would not know which consumers buy a supplementary package.

Recommendation 12:

The Panel recommends that medical schemes that sell SBP should not be entitled to receive any payment from the REF for this business.

Recommendation 13:

As an alternative/additional way to prevent risk selection, some form of risk equalization may be applied to (some of) the SBP (with modality 2 flow of funds).

2.7.3 Transparent presentation of BBP and SBP

The full impact of standardization of basic and supplementary benefits packages will be achieved only when customers can obtain reliable and understandable information about the medical schemes that sell such products. Therefore, medical schemes should be required to publish the list of benefits and their rate tables for each product. A product is defined as a certain benefits package in combination with a list of providers. As the providers' list will vary from one region to another, the medical schemes should publish the information by region/province.

The C-M-S, together with the industry and consumer organizations, should develop a brochure listing the BBP and all the SBP, with prices and providers' list for each region/province (please see Section 2.8.7 below for a discussion of differences in prices according to region). This brochure should be updated annually, easily available to the public and widely distributed. The brochure should also contain a reply card, to be sent to a central "clearinghouse" by all customers who wish to switch affiliation from one medical scheme to

another. The clearinghouse will then inform the consumer's current medical scheme and the newly chosen medical scheme about the consumer's change of affiliation. Publication of such a brochure with a reply-card will increase the transparency in the market and will reduce the consumers' transaction costs in switching between medical schemes.

Recommendation 14:

The Panel recommends publishing an annual brochure with information on the component of the BBP and the standardized SBP, qualifying conditions that may apply and their cost (including region/province specific differences as relevant). The brochure should also include a simple reply-card that members will use to announce switches in affiliation from one medical scheme to another. This measure should be implemented together with the Panel's recommendation to introduce a minimum subscription period (See Section 2.13.3 below, and Recommendation 30).

2.7.4 Late-joiner penalty

Some people who can join a medical scheme refrain from doing so when they are well, expecting that they will be able to enter a scheme when they will need expensive medical care (known as "free-riders"). Medical schemes that are required to offer open enrolment may wish to protect themselves from this form of adverse selection by imposing a "late-joiner penalty". One should recognize two trade-offs to a late-joiner penalty: (i) it discourages people from affiliating to a scheme due to the higher contribution they should pay; when the government's policy is to extend access to the medical schemes, notably to population segments that were hitherto unable to join, the late-joiner penalty may counteract the wide-access policy. (ii) This penalty may be actuarially insufficient if the late joiners are very bad risks.

With these thoughts in mind, the Panel is of the view that this practice needs to be applied differently for the Basic Benefits Package and for Supplementary Benefits Packages. The late-joiner penalty would be inappropriate in the case of persons who are required to pay to the REF the 'industry REF community rate for PMB' (initially persons with high income, many of whom are already affiliated). Nor should this penalty be imposed on persons joining a medical scheme on a voluntary basis and buying the BBP, because the penalty would interfere with the public policy aiming to increase membership in medical schemes. The same logic applies to persons with SBP and who switch medical scheme: a late-entry penalty might reduce the possibility for high-risk persons to switch a medical scheme for the BBP.

On the other hand, the Panel considers that the medical schemes should be free to decide on this penalty on persons who buy one of the SBP and did not have cover for that SBP in the last 12 months. The medical schemes may perhaps apply differential late-joiner penalty according to the SBP selected. An overall rider is that the late-joiner penalty should not discriminate between two potential beneficiaries of the same risk group because one is perceived to be a better risk than another. The total penalty payable will be part of, and capped by the relevant contribution rate-band for that SBP.

Recommendation 15:

The Panel recommends that the medical schemes be disallowed to charge late-joiner penalties from persons buying the BBP, or from persons from persons with SBP and who switch medical scheme, because this penalty might reduce the possibility for the high-risk persons to

switch medical scheme for the BBP. On the other hand, the medical schemes should be allowed to decide whether or not to charge this penalty from persons buying one or more SBP, subject to the overriding rule that the contribution payable, including the penalty, falls within the approved contribution rate bands for the package(s).

2.8 Risk factors

2.8.1 Appropriate method for selecting risk factors

In choosing the appropriate risk factors to be equalized, it is important to compare relative variations in observed utilization based upon the equalized level of benefits rather than all benefits. For example, the comparison of age variation for healthcare use should be undertaken only for benefits included in the PMB (rather, the BBP when introduced).

It must also be recognized that this comparison does not take into account differences in utilization as a result of relative efficiencies or inefficiencies of specific medical schemes. It is therefore important to consider underlying links between morbidity characteristics and socio-economic factors.

The Panel considered that the following criteria should be met for a risk factor to be retained for equalization:

- **Measurable:** The factor should be clearly defined and easy to determine for each medical scheme. It should not be contaminated through measurement error.
- **Determinant of utilization:** Each factor must have a credible link to underlying morbidity and must explain variations in healthcare utilization.
- **Easily recordable:** It should be possible for the schemes to gather the information required for each risk factor easily, administratively feasible and without undue expenditure of time or money.
- **Free from perverse incentives:** The risk factor should not offer incentives for inefficient practice, and should not be open to manipulation by medical schemes, administrators and/or providers.
- **Validated:** It should be possible to verify the factor independently.

2.8.2 Age

Based upon the evidence presented, the Panel agrees that age is an appropriate factor to be used for the equalization. It is suggested that the age ranges 0, 1-4, 5-9, 10-14, ... , 75-79, 80-84, 85+ be adopted. This would mean that the age band of 75+ years used hitherto should be split into three separate age bands, and that the definition of birth year should be standardized to mean "age in years on 1 January".

2.8.3 Gender

Gender is often used as a criterion for risk equalization in other countries. Information on gender is easy to collect, requires no updating and allows schemes to plan prospectively.

While in general it is quite difficult to cream-skim on the basis of gender alone, there are considerable variations in healthcare utilization by gender in certain age groups: women between the ages 25 to 40 attract higher healthcare costs compared to men; and men aged 60 and above outweigh women in terms of expenditure, particularly within the medium/high

socio-economic group. Further investigation into the observed differences in expenditures by gender among babies should be done to consider gender-age inequality among this sub-group as well. The adjustment for gender should therefore capture appropriately the gender differentials in healthcare expenditures across the full age profile, by including interactions with age. Interactions with all age categories are preferable and should be considered seriously. As a minimum, gender-age interactions should be performed between ages 25 to 40 and 60 upwards.

In the reality of South Africa, considerable variations in the gender profile of existing schemes are likely, due to the occupational nature of some medical schemes. This needs to be verified and if confirmed an adjustment should be made.

The Panel tends to consider gender as a more appropriate factor to equalize than the suggested pregnancy maternity indicator, subject however to the next section.

2.8.4 Pregnancy/Maternity indicator

Considerable statistical evidence has been presented to the Panel about the significance of maternity as a risk factor. Based upon this information, the Panel agrees that the pregnancy / maternity indicator could be a better explanatory variable of health costs for women within the maternity age groups than gender. The Panel does however have concerns that using the maternity indicator alone, without the gender indicator, may raise problems for other age groups where cost variations between males and females are unrelated to maternity expenditures.

The Panel concludes that the age / gender interaction factor should be primarily used, with an additional allowance for maternity as part of the CDL (and therefore introduced with the same weighting as applied to the CDL factor). This will allow recording the considerable variation in utilization between females within the maternity age group to be reflected in the contribution table.

The basis for identifying female beneficiaries within the maternity age group could be according to whether or not there was a maternity episode within the last year preceding the latest REF claims data.

2.8.5 Ethnicity

Based on the evidence provided to it, the Panel agrees that ethnicity should not be used as a factor for equalization.

2.8.6 Chronic diseases list (CDL)

All other things being equal, CDL should be used as a factor for equalization. However, the following observations suggest that, in the short term, it will be impractical to count on having sufficient data to enable the use of this list as a factor:

- The 'cross-over' algorithms that the FCTT needed to develop for the purposes of considering CDL as a factor suggest that the definitions used currently may be imprecise.
- There are no established criteria or protocols for a review of the CDL.
- Many medical schemes are currently unable to report the CDL that apply to their beneficiaries;

- The assignment of CDL to beneficiaries may be subjective and not clearly defined.
- The criteria for monitoring that the assignment of CDL to beneficiaries continues to be valid over time are not clear. For example, childhood asthma may ameliorate with age.
- Providers and schemes may have a financial incentive to up-code their categorization of beneficiaries. And
- The auditing of CDL categorizations is likely to prove problematic.

The Panel recognizes the empirical evidence of a link between CDL and healthcare expenditures, and the underlying rationale that the CDL reflect morbidity characteristics of beneficiaries. However, until such a time that the issues raised above are resolved, the Panel considers that CDL is not yet usable to its full extent as a basis for equalization.

On the other hand, medical schemes should be encouraged to collect accurate information on assignment of CDL to beneficiaries. The Panel therefore recommends a gradual phasing-in of the CDL component in the calculation of the REF, starting with a weight of 10% in the first instance. This would reduce the adverse effect of the potential pitfalls flagged above, but introduce morbidity elements into risk equalization. This would also provide a clear incentive to the schemes to apply the CDL assignment to their beneficiaries for more accurate calculation of the REF formula. Schemes that are unable to provide CDL data will not be able to claim payment from REF in respect of this component, or load CDL costs onto their contribution.

Changing the weight attached to CDL should be based both on resolution of the issues raised above and on analysis of the experience with using the CDL as a factor for risk equalization at a weight of 10%.

2.8.7 Geographic region

The Panel agrees that geographic region should not be used as a factor for risk equalization. At present there may not be enough data to support regional variations and the data is not captured very well. However, the Panel recalls that prices of many goods and services may differ across regions, that the price of most medical goods and services is not regulated and that the REF does not equalize prices. In addition, the large regional differences in the supply of health care facilities result in different levels of utilization, which -*ceteris paribus*- are not equalized by the REF. Therefore, the price of the identical BBP and of the standardized SBP may command region-specific contribution levels, if the medical schemes set the price of their products according to the different cost levels. Such regional differences in contribution for an identical package exist elsewhere, e.g. in Switzerland (where the place of residence determines the applicable regional rate, rather than the place where healthcare is obtained). This is also why the Panel recommended that the information brochures should specify the region-specific prices for the BBP and all SBP (see Section 2.7.3 and Recommendation 14).

If the C-M-S considers that region-specific differences in contribution levels are undesirable, it would have to elaborate a mechanism outside the REF to equalize prices. Further consideration should also be given to epidemiological evidence of differences in healthcare needs between geographic areas, which might translate into different CDL profiles.

2.8.8 Family size and member status

The Panel agrees that this factor should not be used as a factor for equalization in the first instance. Some members of the Panel stressed that while they agree that there is no commercial reason to include family size as an equalization factor, they could envisage that the government, in any effort to mandate SHI for lower income people, will consider support for large families as being a significant social factor. Therefore, the recommendation should be qualified to state that while not commercially justified, family size may nevertheless become policy-relevant in an SHI situation.

2.8.9 HIV/AIDS

HIV/AIDS should be incorporated in the CDL methodology, and it will thus weigh in the risk equalization formula.

2.8.10 Income

This factor has been used in many countries in risk adjustment formulae as a proxy to explain variations in health care needs. However, as indicated in the FCTT Report, there are considerable difficulties in using this factor as a basis for risk adjustment in the South African context, despite significant variations in income levels. These problems include:

- The income-utilization profile of existing beneficiaries would reward schemes that have a predominantly high-income profile to the detriment of schemes with a low-income profile;
- Medical schemes do not record income data of their beneficiaries;
- Collecting and validating income levels accurately for all individuals will be impossible through the operation of the REF, unless modality 1 is retained for the flow of funds (see Section 2.5 above) and SARS – the only agency able to collect reliable income data – were to collect payments for REF. This issue should thus be revisited together with the implementation of recommendation 7 and the passage to an income-related contribution as part of SHI (see Section 3.2 below, and Recommendation 41).

2.8.11 High-cost & low-incidence events

The Panel does not consider it appropriate to include a separate factor for high-cost & low incidence events. It agrees with the proposal made by the FCTT, in its report, that this factor could be incorporated into the CDL list.

2.8.12 First and last year of life

The Panel considers that no special allowance should be made for costs incurred in the first and last year of life.

Recommendation 16:

The Panel recommends inclusion of the following factors for risk equalization:

1. **Age** - using age ranges: 0, 1-4, 5-9, 10-14... 75-79, 80-84, 85+. The age band of 75+ years should be split into three separate age bands, and that definition of birth year should be standardized to mean “age in years on 1 January”.
2. **Gender** – based upon interactions with age.
3. **CDL** – should be phased in as a factor for REF calculations, with a weight of 10% in the first instance. An additional maternity / pregnancy indicator column should be added to

the CDL. A beneficiary should be recorded as belonging to the maternity category if she had an episode of maternity utilization in the last year prior to the returns.

2.9 *Technical aspects of the risk equalization formula*

2.9.1 Methodological considerations

The Panel is satisfied with the statistical methods used by the FCTT to select appropriate risk factors and to define the weights attached to each factor. However, ongoing analysis will have to accompany the operation of the REF. Future analyses should take into account the following recommendations:

Recommendation 17:

Future assessments of appropriate risk factors and the weights to be attached to these should ideally be based on data on all beneficiaries from all schemes participating in the REF. If this is not possible, there is a possibility that risk equalization could be contaminated by biases brought about through use of an unrepresentative sample of data. This risk should be assessed, both in relation to the choice of risk factors and to their weights.

Recommendation 18:

Given the potentially huge number of observations available for statistical analysis when all schemes contribute data, the REFTG may wish to consider analyzing a sub-set of observations selected at random, provided that the sample size provides sufficient coverage of all categories of the risk factors being considered.

Recommendation 19:

The Panel recommends running a model on a single dataset to select risk factors; this is said in relation to the “stepwise methodology” used to select the risk factors as described in section 5.3. (i) of the FCTT Report.

Recommendation 20:

An alternative approach to assessing the predictive ability of a given model is suggested. The data provided by the medical schemes could be split at random into two subsets (but not necessarily of equal amounts). One dataset would then be used to define the appropriate weights to be applied to the risk factors. The second dataset would be used to calculate the expected expenditure claims given the risk factors and weights attached to these. A comparison of expected expenditures to actual expenditures will then be possible. This would provide a useful out-of-sample assessment of the predictive power of the risk equalization model to complement measures of fit provided through R-squared and mean-squared error statistics.

Recommendation 21:

Independent validation should be envisaged of future reviews of (i) the appropriate risk factors to be used for risk equalization, and (ii) the weights to be attached to each factor.

Recommendation 22:

In the implementing the REF in 2005, the calculation of weights attached to the risk factors (recommended in section 2.8) should be based on 2003 claims data.

2.9.2 Contribution table calculation

The Panel is satisfied with the methods used by the FCTT to calculate the contribution table and recommends that they be maintained.

As stated in Recommendation 17, calculation of the average PMB⁷ cost used in the construction of the contribution table should ideally be based on data on all beneficiaries from all schemes participating in the REF. If this is not possible, the amount of data should be as large as possible. If less than full data is used, there is a possibility that risk equalization could be contaminated by biases brought about through use of an unrepresentative sample of data. This risk should be assessed, both in relation to the choice of risk factors and to their weights.

As stated in recommendation 21, the calculation of the contribution table should be open to scrutiny and independent validation.

As stated in Recommendation 22, the calculation of the contribution table for implementation of REF in 2005 should be based on 2003 claims data.

2.9.3 Credibility of the data

The Panel considers that the data underlying the analysis presented in the FCTT Report and the Technical Annex thereto is credible. The Panel is also satisfied with the credibility of data used for the determination of the specimen contribution table. In this regard, two technical points need to be made here:

Recommendation 23:

The age band of 75 years and above should be split into three separate age bands of 75-79, 80-84 and 85+ years. We understand that this information is not routinely recorded by schemes for these age bands, but we suggest recording this information in the future. This is because of the variation in the usage profile for health services of these three sub-groups.

As discussed above, data on the profile of beneficiaries by CDL may not be credible at present and measures should be put in place to ensure more accurate classification of beneficiaries by these classes before this factor is used in full to equalize risk profiles.

2.9.4 Periodic updates of risk factors and formula

Recommendation 24:

The risk factors used for equalization, the weights to be attached to these, and the costs entered into the contribution table should be updated periodically.

The periodic updates will ensure that risk equalization is based upon the most appropriate set of risk factors, that the weights reflect latest risk-factor to utilization patterns, and that most appropriate cost of providing the PMB (or BBP) package is properly reflected in the contribution table. We recommend the following review periods on an on-going basis:

- Risk factors to enter into risk equalization should be reviewed every three years;

⁷ replace by BBP when it is introduced

- Weights attached to risk factors should be reviewed every year in the first instance and subsequently every two years. However, an annual review of major fluctuations in costs may be required to ascertain whether a further review of weights is required.
- The contribution table needs to be updated annually with a medical inflation factor used as basis for change.

The process of review needs to be independent of the administrators, schemes, and providers and should be open to scrutiny and independent validation.

2.10 Role of primary care and outpatient drugs

The Panel's Recommendations 8 and 9 deal with introduction of the BBP. As stated in Section 2.7.1 above, the inclusion of primary care constitutes a key focus of health services provision, particularly in the public sector, as it is the entry point of patients into the health system. For instance, a GP acting as gate-keeper is in a position to determine the purchase of hospital care. The role of primary care in the medical schemes environment may currently be undervalued. It is true that primary care represents less than 10% of spending through the medical schemes risk pool at present and only 14% of the costs through MSA. However 77% of all South African GPs work in the private sector, so there must be quite a substantial expenditure which is not reflected fully in the considerations brought before the Panel. Furthermore, in some countries (e.g. Australia), the drive to universalize coverage in medical insurance actually started from primary care. The Panel therefore thinks that there is a strong case for inclusion of primary care in the BBP, and its importance will likely grow with more managed care. Primary care will become a crucial factor for the realization of efficiency gains in the framework of SHI.

The gradual inclusion of primary health care into the BBP serves at least two purposes: Firstly, it bridges the divide between the range of services considered essential in the public sector and the current medical schemes setting. Thus, the inclusion of primary care will help attract to open medical schemes a broader range of the population. Secondly, it introduces new efficiency tools in terms of managed care into the medical schemes logic, which may be another important step towards SHI.

The gradual inclusion of primary care needs to be monitored for the continuous expansion of risk equalization.

Closely related to primary care is the issue of outpatient drugs. These play an important role in the provision of essential health care services. The Panel understands that the South African government has put large efforts into lowering the price of drugs in the private sector, noticeably by introducing new regulations on pharmaceutical pricing, due to come into effect on 2 May 2004. These steps are expected to reduce retail prices by between 30 and 70 percent.

With a view to the development of SHI, the Panel raises the question how outpatient drugs should be dealt with in the context of the BBP. Stopping short of recommending the inclusion of medicines, the Panel suggests that the government should consider an adequate structure of co-payments for drugs when SHI is introduced, with possible waivers for low-income persons.

Again, the inclusion of these extra elements will have to be accounted for in the monitoring of the contribution table within the risk equalization process.

Recommendation 25:

The Panel sees strong arguments in favor of the expansion of the basic package to include primary care and outpatient drugs, and deems these as necessary prerequisites on the way towards SHI. While refraining from formulating concrete suggestions as to scope and timing, the Panel recommends that work should continue on how these steps can be introduced, notably in the risk equalization formula.

2.11 Solvency

2.11.1 Of the REF

Owing to the method that is used to calculate payments into the REF, there is a risk that REF may not be adequately funded in the immediate period following its introduction. This may result from significant changes in the beneficiary profiles of schemes between the date of the calculation of the REF contribution table and the making of payments to the REF together with uncertainty as to the true cost of providing the PMB to beneficiaries. Based upon numbers provided to the Review Panel, it seems that a 10% difference between actual and envisaged beneficiary (membership) experience would mean that there would be a deficit of less than 1% of the current total contribution income for the industry. The risk of insolvency of the REF due to this reason should diminish over time, as better information becomes available to determine the contribution tables and the industry cost for the PMB. If a deficit were to occur, it would have to be balanced by increased subsequent payments from beneficiaries.

Recommendation 26:

The Panel recommends that further modeling needs to be undertaken to determine the likelihood of the REF becoming insolvent. In the short term, if a deficit scenario were to occur for the newly launched REF, there would be a need for short term bridging capital to cover the deficit. The Panel suggests that any such deficit should be financed by a loan from the National Treasury, or if this is impossible, by a loan from a commercial financial institution or existing medical schemes. The deficit should be covered by an increase of subsequent payments from the beneficiaries.

2.11.2 Of the medical schemes

The introduction of REF will arguably improve the solvency of most schemes, as the risks associated with ‘cream-skimming’ are removed. Single medical schemes who charge a contribution which is inconsistent with their risk profiles, and who will receive from the REF lower amounts than they expect, may become insolvent after the introduction of the REF. While such developments would be unwelcome, the Panel thinks that the regulator should be concerned with underlying solvency of the industry as a whole, rather than with the solvency of a single scheme. The regulator will have to ensure that individual beneficiaries in medical schemes that become insolvent are protected. This is the underlying logic why medical schemes are required to meet a minimum level of solvency.

Introduction of the REF should be accompanied by a change to solvency requirements that medical schemes must meet. The current method of calculating the minimum solvency level is based upon written contributions (premiums), and takes no account of the underlying expected level of claims the schemes will pay. The Panel thinks that in the longer term, the best method to determine minimum solvency requirements is a risk-based capital approach, a method that, we understand, is under consideration.

In the interim, the introduction of REF should be accompanied by a change to current solvency requirements; the adjusted written contribution levels (premiums) for schemes will be based upon the REF contribution table, rather than the underlying contribution that could be charged by those schemes.

Recommendation 27:

After the introduction of REF, solvency requirements of medical schemes should in principle be calculated based upon both the volume of business written by each medical scheme, as measured by written contributions (i.e. the sum of payments received by the medical scheme from both the consumer and the REF on a written accounting basis) and the cost of benefits each scheme has to pay (i.e. claims incurred). In the longer term, the Panel would favor retaining a risk-based capital approach. The Panel urges that the C-M-S should study in more detail the consequences of this rule-change on the solvency of single schemes

2.12 Adjustments

2.12.1 Adjustment for efficiency

On page (pp. 84-87) of the FCTT's report, one can read a strong argument in favor of including 'efficiency adjustments' in the REF. The Panel agrees with the concerns raised by the FCTT that it is important to encourage efficiency that translates into lower costs. As stated by the Minister of Health, the ultimate objective of the reform is to pave the way for SHI, not just to clean up the present flaws in the industry. Cost will be the single most important factor in any move toward SHI.

The current fee-for-services environment creates cost distortions, which should be corrected by measures that support a shift towards a more efficient cost structure that stimulates competition, particularly between hospitals, such as reference pricing. The Panel has set eyes on a number of underlying problems, notably a well-documented fraud element. Costing, calculations of diagnosis-treatment pairs, and other adjustments need to be done on a rigorous and balanced basis. Also, benefits packages need to be reasonably standardized (see Sections 2.7.1 and 2.7.2) and competition between schemes needs to be based on prices. These are yet to be implemented. The panel is therefore skeptical that at the present juncture, self-regulated, market-driven competition alone will lower costs to the point which would make the contribution widely affordable, or substantially reduce the very large gap in costs between the public and private sectors in South Africa. This skepticism is based on an impression that medical schemes have been operating in an environment akin to oligopolistic. The Panel is therefore of the view that although the REF can make a major contribution to enhanced price competition through risk equalization (see Sections 2.5, 2.6, 2.7), all cost control cannot be left to the industry alone (see Section 3.4 below).

However including a flat-rate efficiency adjustment into the calculations of the REF may not be the best approach. First, its calculation would be hard to justify. What cost levels would be regarded as achievable? Second, it would reduce the amounts to be equalized through the REF and might therefore allow some scope for cream-skimming based on risk profiles rather than justified cost differences. To that extent, the rewards for efficiency would be weakened. The inclusion of efficiency adjustments within the REF could be revisited when more data is available about the achievement of efficiency targets by other measures taken outside it.

Recommendation 28:

The Panel endorses the need for cost control in any move to SHI. However it does not recommend the introduction of an across-the-board efficiency adjustment within the REF.

2.12.2 Adjustment for inflation & cost changes

For the success of the REF, the Panel deems necessary a stringent adjustment for inflation and cost changes. Adjustments for inflation and cost changes need to go hand in hand. This exercise needs to take into account prospective increases in utilization and changes in technology, particularly for the mix of goods and services included in the provision of the basic package (PMB). One problem with this is that none of the statistical indexes readily available from Statistics South Africa or research institutions reflects price development in the medical schemes sector adequately. Medical schemes can assess the real costs of services only retrospectively, while the contribution table that REF needs to issue should be inflated forward. Hence, an index that allows forward-projection of these costs needs to be developed. This index should ideally be based on a weighted average of salary-related and price-related information. The index needs to be subject to rigorous evaluation, based on a set of stringent criteria including validity and reliability. This index can be developed on the basis of existing longitudinal data from parts of the industry, but it needs to be constantly refined and tested.

Recommendation 29:

The Panel recommends that an index should be developed for determination of the contribution table. This index should take into account retrospective salary-related and price-related figures, which will be weighted and inflated forward. The Panel recommends that risk-specific costs included in the cells of the contribution table should be reviewed annually, at a fixed date, and shall then remain unchanged for the next year.

2.13 Stability considerations of the medical schemes

2.13.1 Minimum subscription period

Open enrolment (implying complete freedom for members to cancel their membership at any time) can result in free rider behavior, i.e. buying membership only in the months when you expect to have expenses higher than the premium, and can thereby increase the risk of insolvency for single schemes. It is our understanding that currently, monthly contracts are the norm in South Africa, which means that beneficiaries can leave a scheme without any prior notice. Medical schemes should be given time to adjust to the departure of customers. This can be done by requiring a minimum subscription period of 12 months, and a mandatory advance notice for cancellation of at least four weeks. Recalling the Panel's recommendation 14 to publish an annual brochure (See Section 2.7.3 above), a simultaneous introduction of the minimum subscription period together with the requirement to publish an annual brochure will ensure fairness both to schemes and to customers.

In consultation with the industry, the Council may wish to consider the advantages and disadvantages of standardizing the renewal/cancellation date, e.g. to 1 January of each year (which means that the first contract will usually be longer than twelve months). The Panel does not consider this standardization as essential for the introduction of the minimum subscription period, and its introduction should be retained only if the medical schemes do not see in this an undue obstacle.

Recommendation 30:

The Panel recommends introducing a minimum subscription period of twelve months for all contracts, with prior notice for cancellation of at least four weeks. The renewal/cancellation date should be standardized for the entire industry.

2.13.2 Exemption from minimum subscription period

The minimum subscription period and the advance notice would need to be relaxed in certain cases, e.g. a transfer from an open scheme to an employer-based closed scheme due to a change in employment, inability to pay the contribution due to loss of employment etc.

2.13.3 Role of brokers

The Panel is concerned about the practice of medical schemes to pay brokers for recruitment of beneficiaries, because this practice increases costs that are then loaded on all customers, and because brokers have an incentive to move people between schemes (so-called ‘churning’), which weakens stability of membership. The Panel considers that brokers should be allowed to offer service to customers, and those customers should pay for the service directly to the broker.

Recommendation 31:

The Panel recommends that medical schemes be forbidden to pay brokerage fees. This change should reduce contribution levels commensurately. We recommend that the Regulator monitor the market to ensure that this reduction in costs is passed on to customers.

2.14 Mandatory affiliation of schemes to the REF

Recommendation 32:

All medical schemes that are required to provide the PMB should also be required to participate in the REF.

Mandatory affiliation to the REF should also apply to all new medical schemes that might be accredited in the future. An exception to this rule should be made for existing “Bargaining Councils Schemes”, because they are not required to provide the PMB. However, all new Bargaining Council schemes should have to provide the PMB level of benefits and participate in REF.

2.15 Reserves and taxation

An interesting and unresolved issue arises how to record REF payments in the accounts of the medical schemes. A related issue is taxation rules applying to these payments, and the impact of REF payments on reserves.

Recommendation 33:

The C-M-S, together with the industry and the South African Board of Accountants elaborate a proposal for the best practice that should apply.

2.16 Institutional arrangements for the REF

2.16.1 Management and Supervisory Board

International experience suggests that the management team required to operate a REF is rather small. The C-M-S should therefore administer the REF and finance the administrative costs incurred by the REF. This may mean that the contribution collected by the Council might need to be marginally increased. There are self-evident advantages to a strong link between the C-M-S, the regulating body, and the REF, notably no duplication of certain services.

The Board of the REF should be composed of members of the Board of the C-M-S, to which other persons should be added to increase its capacity in certain areas of special pertinence to the REF.

Recommendation 34:

The Panel recommends that the REF should be administered by the C-M-S, and supervised by the Board of the Council.

2.16.2 Regulations

The creation of the REF should be set in legislation, and its operative rules should be laid down in the Regulations. It is important to allow for sufficient flexibility to introduce technical changes as required.

2.16.3 Auditing

Recommendation 35:

2.16.3.1 Of transactions between medical schemes and the REF

The existing external auditors of medical schemes should carry out the auditing requirements for REF. However, the C-M-S should be empowered to validate the audit, including requesting additional information. Because the audited returns will determine the amount that each scheme is entitled to from REF, the Panel suggests that the margin of materiality for audit of the REF payments should be lower than that fixed for general financial audit (e.g. a materiality level of 1%, compared to the traditional level of 10% applies to financial audits). The Council should consult the industry and the Auditor's trade association on the level of materiality to be determined.

2.16.3.2 Of the REF

The State Auditor General should audit the accounts of the REF separately from those of the C-M-S. It should be recalled that the funds under management of the REF belong to the beneficiaries of the medical schemes industry. Therefore, the Auditor General should make available to the public a summary of the annual audit.

2.16.4 Data validation, errors and omissions

Recommendation 36 :

Auditing procedures should be put in place to correct errors in the calculation of transfers between the REF and medical schemes.

If unknowing errors are found, the C-M-S should determine if the corrections are significant enough to justify recalculation of transfers for previous quarters. If a recalculation should occur, this should be reconciled to date of transfers, with some base interest rate (e.g. Johannesburg inter-bank rate).

If deliberate errors are found, the C-M-S should impose penalties; and in particularly severe cases, the Council should consider whether the penal responsibility of the Directors of the medical scheme should be engaged.

2.16.5 Independence of periodic reviews

Recommendation 37:

The Panel reiterates its call to the Board of the REF to ascertain the independence of ongoing reviews of the risk factors, weights applied to each risk factor, cost of the PMB and the operational terms of the REF (Recommendation 24; see Section 2.9.4 above).

2.16.6 Prospective or retrospective assessment

Recommendation 38:

The FCTT makes a convincing case in favor of prospective assessment (page 29 of the FCTT report). The Panel agrees that prospective assessment is probably more responsive to the needs of the medical schemes, and recommends that this should be applied.

2.16.7 Timing of calculations

Recommendation 39:

The medical schemes should forward to the Council the required data within 30 days of the end of each quarter; and the REF should complete transfers to single schemes 30 days thereafter. Contribution tables should be published sufficiently in advance to allow the medical schemes to determine their pricing strategy.

2.16.8 Periodicity of payment from REF to the schemes

Recommendation 40:

The REF should make quarterly payments to medical schemes. This periodicity enhances the schemes' certainty of the effects of REF on their financial position. It is also consistent with current arrangements whereby schemes make returns to the C-M-S on a quarterly basis. The annual adjustment for inflation and cost changes described in Section 2.12.2, and Recommendation 29, should not interfere with quarterly payments from the REF to the schemes, based on retrospective changes in the schemes' beneficiary compositions.

However, quarterly returns could increase administration costs for single schemes and for REF itself; therefore collection mechanisms should be as efficient as possible.

3 Income-related cross subsidies: SHI

In this chapter we discuss implementation of Social Health Insurance (SHI) in South Africa. The main milestones discussed are the introduction of an income-related contribution to the REF, mandatory payment of the contribution, cost-containment measures and options to enlarge the pool and to provide protection to low-income persons and those in the informal economy.

3.1 Definition

In the South African context, Social Health Insurance (SHI) means:

- Risk-related cross subsidies
- Income-related contribution levels; and
- Mandatory regime of payment and affiliation

The most important risk-related cross subsidization measure already implemented by all medical schemes is the application of community rating. The significant differences in the cost of the PMB package across the medical schemes have accelerated the decision to improve risk-related cross subsidies by the introduction of the REF. The previous chapter has provided a detailed discussion of the Panel's recommendations on this issue. The other two components of SHI mentioned above are not yet implemented at all.

3.2 Income-related contribution levels

As stated earlier in Section 2.8.10, and as mentioned by the FCTT in its report, income is not the most suitable factor for risk equalization, and has thus not been retained by the Panel as one of the risk adjusting factors (See Recommendation 16).

On the other hand, international experience confirms that income rating which is applied on the majority of the population is a more equitable method to finance healthcare than flat-rate contribution, regardless of the absolute level of the contribution or the level applied to income rating. And one of the defining components of SHI is the introduction of income rating. This is why the Panel recommended, in Section 2.5, to entrust SARS with the collection of the industry REF community-rate for PMB, in order to put in place a system that will be compatible with the future implementation of income rating.

The Panel is in principle favorable to the introduction of income rating as part of SHI. However, unemployment rates are very high in South Africa at present [estimated by one source at around 41 per cent, with very low employment in the informal sector (unlike the pattern prevalent in most developing countries where paucity of formal sector jobs drives a large informal sector rather than high levels of open unemployment)⁸]. A related problem is the extreme prevalence of persons "without income", estimated at around 63 percent of the

⁸ Geeta Gandhi Kingston and John Knight, 2004: *Unemployment in South Africa: The Nature of the Beast*, Oxford, [World Development](#) University of Oxford, UK Vol. 32, No. 3, pp. 391–408

population⁹. In this reality, a proposal to introduce mandatory and universal income rating to fund the entire South African healthcare system is impractical.

The SCTT recommended the following steps toward enhancing income-related affiliation to medical schemes:

- A flat rate government subsidy, equal to the cost of providing a PMB package in the public sector, and payable for all new entrants into the open medical schemes. Under the proposal, in order to ensure that this measure is cost neutral, the flat rate subsidy for new members should be funded by a corresponding reduction in the Health Department budget.
- An income-related earmarked tax (“levy”) to be paid by all members of medical schemes, collected by employers as deductions at source from employees’ salaries, and transferred to the REF for redistribution to the medical schemes according to their risk profiles. This income-based levy should fund the difference between the costs of delivery of PMB in the private and public sectors (SCTT-report page 43). The purpose of this levy would be to redistribute the cost of the contribution across income groups, so that lower-income persons can join a medical scheme.
- Existing health-related tax deductions would remain unchanged.

These proposals call for the following observations:

Firstly, it is difficult to see how the Health Department’s budget could be reduced in real terms, when the Department would continue to be responsible for primary care to the four million persons who would buy essentially the PMB package only (which does not include primary care at present). Incidentally, the amount of estimated savings of the Department of Health is calculated based on average costs rather than marginal costs. Therefore, the Panel considers the estimated savings to be overstated.

Secondly, according to the proposal of SCTT (page 48 of their report) the levy should be imposed on all employees, regardless of their own membership status with a medical scheme. In view of the high unemployment level, and difficulty to reach persons working in the informal economy, the panel doubts that it is currently possible to collect any amount from much more than 10-15 percent of the top earners. A more precise estimate of the number of persons who would pay and of the revenue should be performed. These 10-15 percent top-earners are for the most part the beneficiaries of those open schemes that have concentrated on a high-income market. There is no certitude that the proceeds will reach low-income beneficiaries or exclusively those schemes targeting lower-income people. Therefore, the Panel developed some suggestions in section 3.5 to introduce income-related cross-subsidies to increase risk pooling among poor households.

Thirdly, by introducing both risk-related cross-subsidies and income-related cross-subsidies at the time of implementing the REF, there is a real risk that the population will be confused about the purpose of the REF, between risk equalization and income redistribution. This

⁹ October 1999 Household Survey StatsSA, which includes information on participation in a medical scheme and served as the basis to estimate the additional coverage under SHI. Some of the harder employment data originates from the Labour Force Survey, which does not include questions on healthcare cover. Therefore, differences are bound to exist.

speaks against entrusting the REF with responsibility for income redistribution in the first years.

Fourthly, the SCTT proposal would immediately involve a substantial and continuing public subsidy. The Panel is of the view that the REF can and should be self-funded. Therefore, allocating direct public subsidies for this is currently unnecessary.

Fifthly, the SCTT proposes that the income-based levy should only fund the difference between the costs of delivery of PMB in the private and public sectors (SCTT-report page 43). However, this creates a structural shortfall for the REF, because the payments out of the REF are related to the costs of PMB in the private sector. The Panel is of the opinion that the REF should be structurally self-funded. Therefore, to prevent a structural shortfall the Panel recommends that the contributions to the REF should fund the costs of the PMB in the private sector (and not only the cost difference between the private and public sectors), as was recommended in section 2.5.

Finally, taking into account that the SCTT advises not to change the current tax expenditures subsidies, from which the rich benefit more than the poor, The Panel recommends to explore future possibilities to make the mandatory contributions to the REF income-related. Because the direct payment from the consumer to the medical scheme (i.e. the scheme-specific community-rated premium for PMB+) is a relatively low amount of money, income-related contributions to the REF would make medical scheme membership more affordable for the lower/middle income people who do not benefit from the current tax expenditures subsidies. In this way the REF could gradually become the core of SHI, with mandatory income-related cross-subsidies being reflected in the payments into the REF and risk-related cross-subsidies being reflected in the payments out of the REF.

Recommendation 41:

The Panel cannot endorse the set of proposals of the SCTT. On the other hand, the Panel recommends that the Ministry of Health and the C-M-S continue to explore possibilities to introduce income-related contributions to the REF and other income-related cross subsidies related to access to healthcare, notably of lower income persons.

3.3 Mandatory regime of payment and affiliation

Mandatory payment of a contribution is prevalent in most developed countries, and is the second condition (additional to determining the contribution relative to income) underlying full implementation of SHI.

The reason why mandatory contribution is so important is that it enlarges the insurance pool, it reduces adverse selection (i.e. the low risks choose not to insure or contribute), it reduces variations in risk between the medical schemes and is therefore an urgent matter. Although strictly speaking one could argue that mandatory payment of the contribution is unrelated to the introduction of the REF, the Panel thinks otherwise. In previous sections of this report the Panel had occasion to reason and recommend several measures that go hand in hand with mandatory payment of the contribution. Firstly, we recommend immediate application of mandatory payment of contributions to the REF by high-income earners, regardless of whether they are currently beneficiaries in a medical scheme. Secondly, we recommend gradual widening of this measure to middle and lower-income groups as well as to all

beneficiaries of medical schemes. Thirdly, we recommend applying a minimum subscription period in medical schemes, with only limited possibility to withdraw from membership. Fourthly, we postulated inclusion of primary care, and standardization of benefits packages, with a view to improving the fit between the products offered by medical schemes and the needs and capacity-to-pay of all income groups. Fifth related measure that we recommend is the mandatory affiliation of schemes to REF. Sixth recommendation postulates that SARS should collect mandatory payments, with a view to introducing, in the future, income-related mandatory payments. As stated above, these income-related payments should be considered in relation to the tax expenditures subsidies. And the seventh recommendation, related directly to mandatory payment of contributions to REF by consumers, is the proposal that the Council together with the industry, publish each year a brochure with full details of prices and composition of services, as well as providers delivering those services, so that the public can exercise its right not only to join a medical scheme, but also to benefit from price and service competition between schemes offering the identical BBP and standardized SBP.

These measures need to be seen as a whole: admittedly, they fall short of mandatory income-related contributions, which is the goal for SHI. However, these measures move the system forward considerably compared to the present reality, and set the stage for much more equity between schemes and beneficiaries, while also opening avenues for a considerable widening of access to the medical schemes for people who at present are excluded de facto from membership.

3.4 Who is responsible for cost containment & efficiency?

Cost will be a major factor in the acceptance of any mandated SHI. The SCTT Report cited a survey of members of a lower-income medical scheme who expressed willingness to contribute but felt impeded by their ability to pay. Affordability is bound to be a major issue. Amongst those who had left, 93% cited affordability as the main reason and 50% of those who changed schemes did so in order to pay a lower contribution. Work by the FCTT estimated that for conditions covered by the PMB, costs in the private sector were between 78% and 100% higher than in the public system, depending on the estimation methodology used. Such large differences raise many questions. This should be the subject for ongoing research and study.

The present cost structure in the private sector is of particular concern when one contemplates extending coverage, with a view to implementing SHI, through existing schemes. Transferring a large number of people from a combination of out-of-pocket payments and dependence on the public sector to an insured environment will inevitably increase their expectations to access the same level of services that is provided today by the private medical schemes. Mandatory contribution levels based on the PMB will also raise expectations of people to access all relevant service. The insurers and the service providers may also see the additional Social Health Insurance membership as a captive market. Finally, there is the obvious economic fact that if demand for services increases without a similar increase in health care resources, prices will rise.

There are a number of responses, some of which – capitation, preferred provider arrangements etc. – are already employed to a certain extent in the private sector. However international experience has shown that the industry can rarely self-regulate cost containment, and

government has a major supporting and regulatory role to play. This will be even more necessary if payment of a contribution is mandated.

Recommendation 42:

The Panel recommends that the C-M-S establishes a Working Party to propose cost containment measures in the South African setting. This Working party should include representatives from the Treasury and the health insurance industry, and should be requested to submit specific proposal for cost estimates, coordination of benefits and cost containment within the industry.

3.5 Subsidies to enlarge the pool: Save-for-Health Accounts

The South African government encourages affiliation to, and discourages withdrawals from medical schemes through tax deductions of part of the cost of the contribution, Out-of-Pocket Spending (OOPS), and deposits into Medical Savings Accounts (MSA). These deductions are taken up only by those employers and employees who pay taxes and have deductible costs and are affiliated with a medical scheme. This group of beneficiaries represents a minority of the population, estimated by the SCTT at 1.3 million taxpayers, and the revenue loss in respect of this provision is estimated at R2 bn (p. 45 of the report). This tax incentive is relative to the level of deductible costs, which is positively correlated to income; hence it is regressive. In the long term, it should be replaced by progressive taxation.

The regressive character of MSA can be mitigated even without a full reform of the system of tax benefits. If the policy underlying these subsidies aims at encouraging savings and spending on health, then there is no logical need to limit access to these subsidies to people who are affiliated with a medical scheme. In fact, low-income persons who are unlikely to join a medical scheme would need more help in defraying out-of-pocket health expenditures, and should be encouraged to engage in health-related savings. Therefore, the Panel thinks that it would be desirable to design a pro-poor, subsidized health-related savings product that would be offered notably through existing informal risk-pooling mechanisms.

The number of people who participate in informal insurance arrangements in South Africa, such as Stokvels and approximately 100,000 burial societies, is estimated to be over eight million. An estimated R5 billion is invested in these arrangements every year. About 35 percent of the fully banked South Africans maintain membership in a burial society. The burial societies usually sell a death benefit, which is now also sold by several life insurers. But unlike life insurers, the Stokvels and the burial societies are communal institutions more than they are commercial ones. These informal pooling/insurance arrangements have an ongoing relationship with about 8 million people, a number that is not only very high but remarkably similar to the estimated number of persons slated for inclusion in the medical schemes for low-income earners in the formal sector, mainly civil servants, under the “initial new SHI” and the “second New SHI” (8.127 million) (see p. 11 of the FCTT report). These organizations offer an excellent entry point to market a subsidized health-savings product that responds to the needs of the group and is sold through an existing leadership-structure. Success in selling such a product would enhance the willingness and ability of the poor to pay for healthcare, and the government’s policy would be well served.

For this reason, the Panel recommends directing a government subsidy to enable low-income persons who save for health to benefit from similar advantages that are already accorded to

high-income earners through tax deductions. In order to distinguish it from the MSA, we propose calling this product by a different name, e.g. “Save for Health Account” (SHA).

SHA would further three objectives: first, subsidize OOPS of low- or no-income groups. Secondly, encourage the voluntary affiliation of low- or no-income persons in a risk pool on a longer term basis. Thirdly, help the government to build inroads into informal insurance arrangements, with a view to developing a different kind of offer of health-related products.

The SHA should offer different levels of yield according to the use: OOPS will enjoy a subsidy similar to the notional average tax benefit that is realized by present holders of MSA. A higher yield would be given to those who agree to use their balance in the SHA toward payment of a contribution in a pooled arrangement. The government would provide the subsidy to this group in the form of the yield on SHA. Receipt of such subsidy would be linked to an obligation to remain in the pool for a minimum length of time, and payment of the subsidy would flow directly into the pooling scheme. This would encourage health related savings, the development of health related pooling mechanisms within the informal sector, and possibly also a basis for the creation of medical schemes, which would be acceptable to lowest income earners and to people in the informal sector. The detailed design of the SHA requires more information on how the poor spend money for health, and on prevailing attitudes to risk, pooling and solidarity within the group. Arrangements for flows of funds and account management also need to be designed.

Recommendation 43:

The Panel recommends that the C-M-S develop a Save-for-Health Account programme, which will offer a government subsidy to encourage willingness to pay for healthcare among low-income persons. The Panel recommends appointing a special Task Team to elaborate the detailed proposal, composed of experts in designing and quantifying a health insurance product, who should consult with informal insurance groups as well as other stakeholders. The Save-for-Health Account programme should be launched as soon as possible after the establishment of the REF.

3.6 “Social Reinsurance” for low-income informal schemes

The Panel has devoted most of its attention to the conditions under which the REF will succeed in improving the competition within the existing healthcare industry. However, a systemic view of SHI cannot ignore the population which at present is not slated for membership in medical schemes. Following the guideline of the Minister and the Registrar, the Panel acknowledges the need to address longer-term risks associated with economic inequality within South African society. A sensible design of solutions for the longer-term requires that the government would lead in prompting a change of vision among the poor who, unable to meet the cost of private medical schemes today, fail to understand how being insured can help them deal with their major risks. According to recent web-based information¹⁰, only 38 percent of South African adults use an insurance product (life, burial,

¹⁰ Prepared by FinMark Trust, an independent NGO promoting institutional development aiming to increase access to financial services by the un- and under-banked of southern Africa
http://www.finmarktrust.org.za/aboutus/Brochures/onlinebrochure.htm#in_executing

health or other short-term), compared to 44 percent engaged in savings and 57 percent who take credit. The significantly lower rate of access to insurance among low-income households must be analyzed against the backdrop of ways in which they frame their strategy to cope with risks.

For the majority of people in low-income households, family, social, economic and cultural ties are an integral part of risk mitigation strategies. The reference group, defined by some form of shared “destiny” (area-based, trade-based, faith-based, gender-based, ethnicity-based etc. but normally not risk-based or based on income levels) accepts to share responsibility for the consequences of an adverse event befalling any of its members. As low-income groups rely on their shared financial and material means to deal with risks, decisions are often taken by the group. Not surprisingly, these groups often frame their actions around realized risks rather than potential ones. If people do not appreciate the larger potential risks, they will not take steps to deal with them. This is why poor households might prefer paying OOPS in connection with a risk that has occurred, over paying the contribution of an insured person who is not acutely distressed.

Lessons from microfinance show that the poor are unlikely to engage with formal institutions even if they can afford to, because of psychological framing. The institutions to which the poor have access normally, and which they know and trust, are community-based informal insurance arrangements. If the government wishes to extend formal coverage to the poor through the existing construct of membership in medical schemes, it is bound to face resistance to any measure requiring the poor to pay part of the cost, no matter how small. Low-income groups must feel comfortable that the institutions that deal with the larger potential risks will be responsive to their needs, and can be trusted to deliver results. Failing this, the poor (like any other group) will most likely not agree to pay.

The Panel is of the view that poor households must be offered more efficient insurance solutions than available to them at present to reduce and manage their health risks, and at the same time, that the government cannot be expected to carry the full cost of such insurance. The Panel recommends that the government define a new paradigm of ‘provision and supervision’: community-based schemes will be charged with the provision of insurance, and the government will bestow the supervision and the support. The government may wish to implement its support role directly or by delegating others to act on its behalf.

The main strengths of community-based groups are (i) their ability to forge acceptance of a limited benefits package (which could be narrower than the PMB/BBP which applies to formal schemes and to the REF but which may be better adjusted to context-specific priorities); (ii) their capacity to collect payments at low transaction costs, thereby adapting to the priority of the poor to pay small amounts frequently rather than a single bigger amount more rarely; and (iii) their ability to intervene with members to reduce deviant behavior (e.g. free riding and adverse selection). Analysis of the operation of microinsurance schemes in other countries has shown that they enhance both access to healthcare and equity among the insured, compared to the uninsured living in comparable circumstances.

The main weaknesses of such groups are essentially three-fold: claims-related risks, administrative risks and investment risks. From the claims point of view, the biggest risk factors are the prevalence of controllable infectious diseases related to low living standards,

the increase in age-related morbidity and growing prevalence rates of HIV/AIDS. These determine the solvency requirements. On the operational side, the biggest risks relate to low technical capacity to manage risks and the inefficient or inappropriate use of funds. The investment risks are that reserves will yield poor returns.

All three problem areas can be fixed. The cost of subsidizing the support mechanism to these schemes is lower, and the ‘provision and supervision’ paradigm probably also more efficient than open-ended direct service delivery by the government. However, opting for such a policy requires the government to develop missing components of the support mechanism. For example, at present, just as poor people cannot easily access formal insurance, community-based health financing schemes have no access to reinsurance or to technical assistance. Commercial reinsurers saw no profit in a market that is characterized by low premiums, badly identified risks, and widely variable management capacity of the communities-as-insurers. As a result, private reinsurance companies have never designed a product for this market. The first plan specifically designed to provide reinsurance for community health schemes has been conceptualized under the name of “Social Reinsurance”¹¹, or *Social Re*. This concept combines the provision of technical assistance for improved administration with the provision of seed capital for sustainable and solvent operation. Once stabilized notably through social reinsurance, informal sector health plans could in principle join the REF, probably through some federated form linking several small community-based schemes. Whether this concept can fit the reality of South Africa is a matter that should be weighed by the Ministry of Health and the C-M-S, and the Panel recommends that it should be done in the context of implementing the REF, to abate concerns about equity.

Recommendation 44:

The Panel recommends that the Ministry of Health and the C-M-S should appoint a Task Team to review opportunities and constraints of improving equity and extending access to healthcare in the informal sector, notably through support for community-based pooling schemes. The Panel recommends that this should be done in the context of implementing the REF, to abate concerns about equity. The ultimate objective should be to elaborate a feasible proposal to sustain, both financially and operationally, schemes which service the poor, including informal schemes. The Task Team should report on its findings to a broad-based consultation with stakeholders, government agencies and civil society (including pertinent NGOs).

¹¹ Dror DM, Preker AS (Editors): Social Reinsurance: A New Approach to Sustainable Community Health Financing, (Washington), World Bank & ILO, 2002, xvii+518 pp.

4 Recapitulation of Recommendations

In this chapter we recapitulate the Panel's recommendations, explained in detail in the previous chapters.

The recommendations formulated in earlier sections of this report are grouped here under different headings and in a different sequence, for ease of thematic perusal. The reader is invited to consult the reasoned explanations provided in the body of the report.

As stated in this report's introduction, the Panel formulated its recommendations with the view that they would be considered as a whole, and assessed in the wider context set down by the Ministry of Health and the C-M-S.

For the same reason, the Panel included a few recommendations to address the needs of low-income populations who at present are unlikely to join the medical schemes. Concern for the advancement of the political paradigm of "better life for all", rather than a REF-related technical need per se, motivated the Panel to include these recommendations in the sequencing and timing for action on these recommendations.

4.1 Risk-related cross subsidies

Recommendation 1: Introduction of risk equalization across South African medical schemes

The International Review Panel regards the introduction of risk equalization across the medical schemes in South Africa as an essential prerequisite for the introduction of SHI, as a vital mechanism to improve fair competition between medical schemes under open enrolment, and as a means toward the efficient implementation of PMB as the basis for coverage and community-rating as the basis for the contribution.

Recommendation 34: Administration and supervision of the REF

The Panel recommends that the REF should be administered by the C-M-S, and supervised by the Board of the Council.

Recommendation 2: Introduce REF on 1 January 2005

The Panel strongly recommends introducing risk equalization as soon as technically possible; the target date of 1 January 2005 that has been proposed by the REFTG is endorsed by the Panel.

Recommendation 3: The basis for risk equalization

The Panel recommends that, with a view to implementing SHI through the medical schemes, all medical schemes should face the same (equalized) basic risk, representing the coverage for an essential healthcare package to all their beneficiaries.

Recommendation 4: Reference to the PMB in the formula for risk equalization

The Panel regards the PMB package as a reasonable basis for risk equalization, but recommends that the present composition should be reviewed from time to time, with a view to changing the services that may be deemed essential (see Section 2.9.5 of the Report).

Recommendation 32: Mandatory affiliation of medical schemes to the REF

All medical schemes that are required to provide the PMB should also be required to participate in the REF.

Mandatory affiliation to the REF should also apply to all new medical schemes that might be accredited in the future. An exception to this rule should be made for existing “Bargaining Councils Schemes”, because they are not required to provide the PMB. However, all new Bargaining Council schemes should have to provide the PMB level of benefits and participate in REF.

Recommendation 22: Underlying data source for REF

In implementing the REF in 2005, the calculation of weights attached to the risk factors should be based on 2003 claims data.

Recommendation 16: Risk factors retained for REF

The Panel recommends inclusion of the following factors for risk equalization:

Age - using age ranges: 0, 1-4, 5-9, 10-14... 75-79, 80-84, 85+. The age band of 75+ years should be split into three separate age bands, and that definition of birth year should be standardized to mean “age in years on 1 January”.

Gender – based upon interactions with age.

CDL – should be phased in as a factor for REF calculations, with a weight of 10% in the first instance. An additional maternity / pregnancy indicator column should be added to the CDL. A beneficiary should be recorded as belonging to the maternity category if she had an episode of maternity utilization in the last year prior to the returns.

Recommendation 23: Age bands for the REF

The age band of 75 years and above should be split into three separate age bands of 75-79, 80-84 and 85+ years. We understand that this information is not routinely recorded by schemes for these age bands, but we suggest record that information is in the future. This is because of the variation in the usage profile for health services of these two sub-groups.

Recommendation 19: Methodology for calculation of REF contribution rates

The Panel recommends running a model on a single dataset to select risk factors; this is said in relation to the “stepwise methodology” used to select the risk factors as described in section 5.3. (i) of the FCTT Report.

Recommendation 20: Goodness of Fit of underlying REF Model

An alternative approach to assessing the predictive ability of a given model is suggested. The data provided by the medical schemes could be split at random into two subsets (but not necessarily of equal amounts). One dataset would then be used to define the appropriate weights to be applied to the risk factors. The second dataset would be used to calculate the expected expenditure claims given the risk factors and weights attached to these. A comparison of expected expenditures to actual expenditures will then be possible. This would provide a useful out-of-sample assessment of the predictive power of the risk equalization model to complement measures of fit provided through R-squared and mean-squared error statistics.

Recommendation 18: Analysis of data

Given the potentially huge number of observations available for statistical analysis when all schemes contribute data, the REFTG may wish to consider analyzing a sub-set of observations selected at random, provided that the sample size provides sufficient coverage of all categories of the risk factors being considered.

Recommendation 38: Apply Prospective assessment

Contribution tables should be published sufficiently in advance to allow the medical schemes to determine their pricing strategy. In this regard, The FCTT makes a convincing case in favor of prospective assessment (page 29 of the FCTT report). The Panel agrees that prospective assessment is probably more responsive to the needs of the medical schemes, and therefore endorses the proposal of the FCTT.

Recommendation 28: Adjustment for efficiency

The Panel endorses the need for cost control in any move to SHI. However it does not recommend any across-the-board efficiency adjustment within the REF.

Recommendation 31: Brokerage fees

The Panel recommends that medical schemes be forbidden to pay brokerage fees. This change should reduce contribution levels commensurately. We recommend that the Regulator monitor the market to ensure that this reduction in costs is passed on to customers.

Recommendation 12: SBP should not be included in REF

The Panel recommends that medical schemes that sell SBP should not be entitled to receive any payment from the REF for this business.

Recommendation 24: Review of the REF

The risk factors used for equalization, the weights to be attached to these, and the costs entered into the contribution table should be updated periodically.

The periodic updates will ensure that risk equalization is based upon the most appropriate set of risk factors (reviewed every three years), that the weights reflect latest risk-factor to utilization patterns (reviewed every year in the first instance and subsequently every two years. However, an annual review of major fluctuations in costs may be required to ascertain whether a further review of weights is required) and that most appropriate cost of providing the PMB package is properly reflected in the contribution table (updated annually, with a medical inflation factor used as basis for change).

Recommendation 17: Future risk factors

Future assessments of appropriate risk factors and the weights to be attached to these should ideally be based on data on all beneficiaries from all schemes participating in the REF. If this is not possible, there is a possibility that risk equalization could be contaminated by biases brought about through use of an unrepresentative sample of data. This risk should be assessed, both in relation to the choice of risk factors and to their weights.

Recommendation 37: Independence of reviews

The Panel reiterates its call to the Board of the REF to ascertain the independence of ongoing reviews of the risk factors, weights applied to each risk factor, cost of the PMB and the operational terms of the REF (Recommendation 24; see Section 2.9.4 above).

Recommendation 25: Role of Primary Care and Outpatient Drugs

The Panel sees strong arguments in favor of the expansion of the basic package to include primary care and outpatient drugs, and deems these as necessary prerequisites on the way towards SHI. While refraining from formulating concrete suggestions as to scope and timing, the Panel recommends that work should continue on how these steps can be introduced, notably in the risk equalization formula.

Recommendation 13: Future risk equalization of SBP

As an alternative/additional way to the previous recommendation, some form of risk equalization may be applied to (some of) the SBP (with modality 2 flow of funds) to prevent risk selection.

Recommendation 15: Late-joiner penalty

The Panel recommends that the medical schemes be disallowed to charge late-joiner penalties from persons buying the BBP, but allowed to decide whether or not they will charge this penalty from persons buying one or more SBP; such a late-joiner penalty would have to be part of the contribution payable, which will respect the overriding rule that the total amount payable is within the contribution rate band approved for the package(s). No late-joiner penalty should be required for SBP from persons with SBP and who switch medical scheme, because this penalty might reduce the possibility for the high-risk persons to switch medical scheme for the BBP.

Recommendation 21: Independent validation of REF

The process of future reviews of (i) the appropriate risk factors to be used for risk equalization, and (ii) the weights to be attached to each factor needs to be independent of the administrators, schemes, and providers. It should be open to scrutiny, and independent validation should be envisaged.

Recommendation 29: Indexing contribution table

The Panel recommends that an index should be developed for determination of the contribution table. This index should take into account retrospective salary-related and price-related figures, which will be weighted and inflated forward. The Panel recommends that risk-specific costs included in the cells of the contribution table should be reviewed annually, at a fixed date, and shall then remain unchanged for the next year.

Recommendation 26: Insolvency of REF

The Panel recommends that further modeling needs to be undertaken to determine the likelihood of the REF becoming insolvent. In the short term, if a deficit scenario were to occur for the newly launched REF, there would be a need for short term bridging capital to cover the deficit. The Panel suggests that any such deficit should be financed by a loan from the National Treasury, or if this is impossible, by a loan from a commercial financial institution or existing medical schemes. The deficit should be covered by an increase of subsequent payments from the beneficiaries.

Recommendation 33: Impact of REF payments on taxation and reserves

The C-M-S, together with the industry and the South African Board of Accountants should elaborate guidelines for best practice in accounting for REF payment for the purpose of reserves and taxation

Recommendation 27: Change in solvency conditions for schemes

After the introduction of REF, solvency requirements of medical schemes should in principle be calculated based upon both the volume of business written by each medical scheme, as measured by written contributions (i.e. the sum of payments received by the medical scheme from both the consumer and the REF on a written accounting basis) and the cost of benefits each scheme has to pay (i.e. claims incurred). In the longer term, the Panel would favor retaining a risk-based capital approach. The Panel urges that the C-M-S should study in more detail the consequences of this rule-change on the solvency of single schemes.

Recommendation 39: Periodicity of reporting to the REF

The medical schemes should forward to the Council the required data within 30 days of the end of each quarter; and the REF should complete transfers to single schemes 30 days thereafter.

Recommendation 40: Periodicity of payments of REF to the medical schemes

The Panel considers that REF should make quarterly payments to medical schemes. This periodicity enhances the schemes' certainty of the effects of REF on their financial position. It is also consistent with current arrangements whereby schemes make returns to the C-M-S on a quarterly basis. The annual adjustment for inflation and cost changes described in Section 2.12.2, and Recommendation 29, should not interfere with quarterly payments from the REF to the schemes, based on retrospective changes in the schemes' beneficiary compositions. However, quarterly returns could increase administration costs for single schemes and for REF itself; therefore collection mechanisms should be as efficient as possible.

Recommendation 35: Audit

A. of transactions between medical schemes and the REF

The existing external auditors of medical schemes should carry out the auditing requirements for REF. However, the C-M-S should be empowered to validate the audit, including requesting additional information. Because the audited returns will determine the amount that each scheme is entitled to from REF, the Panel suggests that the margin of materiality for audit of the REF payments should be lower than that fixed for general financial audit (e.g. a materiality level of 1%, compared to the traditional level of 10% applies to financial audits). The Council should consult the industry and the Auditor's trade association on the level of materiality to be determined.

B. Of the REF

The State Auditor General should audit the accounts of the REF separately from those of the C-M-S. It should be recalled that the funds under management of the REF belong to the beneficiaries of the medical schemes industry. Therefore, the Auditor General should make available to the public a summary of the annual audit.

Recommendation 36: Correcting errors and omissions

Auditing procedures should be put in place to correct errors in the calculation of transfers between the REF and medical schemes.

If unknowing errors are found, the C-M-S should determine if the corrections are significant enough to justify recalculation of transfers for previous quarters. If a recalculation should occur, this should be reconciled to date of transfers, with some base interest rate (e.g. Johannesburg inter-bank rate).

If deliberate errors are found, the C-M-S should impose penalties; and in particularly severe cases, the Council should consider whether the penal responsibility of the Directors of the medical scheme should be engaged.

Recommendation 42: Cost containment measures

The Panel recommends that the C-M-S should appoint a Working Party, with representatives from the Treasury, the health insurance industry and consumer organizations, with mandate to submit specific proposal for cost estimates, coordination of benefits and cost containment within the healthcare industry in the South African setting.

4.2 Income-related cross subsidies

Recommendation 6: Mandatory payment of the industry community-rate for PMB

The Panel recommends that payment of the 'industry community-rate for PMB' to the REF should be mandatory; and that implementation of compulsory payment of contribution should be gradual. The application of this measure to the highest income group (say, the 10 percent with the highest income) should coincide with the implementation of the REF. Mandatory payment of contribution should then be gradually applied to other income brackets, as well as other persons who enter the group of those covered by a medical scheme.

Recommendation 7: SARS should collect the mandatory payment to the REF

The Panel strongly recommends that the SARS should collect the mandatory payments on behalf of REF, since SARS is the only institution that can establish the income of individuals. SARS should transfer the total amount collected directly to the REF.

Recommendation 5: Apply modality 1 flow-of-funds

The Panel recommends that the flow of funds into- and out of the REF should be according to modality 1, from inception.

Recommendation 8: Introduce a Basic Benefits Package

The Panel recommends that all medical schemes should be required to offer a standardized "Basic Benefits Package" (BBP) under open enrollment and at a scheme-specific community-rated contribution.

Recommendation 9: The BBP should include primary care

The Panel recommends that the BBP should include PMB conditions and primary care, i.e. 'all the care that is usually delivered by primary care physicians'.

Recommendation 10: Standardize supplementary benefits packages (SBP)

The Panel recommends that the C-M-S initiate a process of standardization of supplementary benefits packages (SBP). SBP will be sold under open enrolment in combination with contribution rate bands. The C-M-S will determine the factor X applicable for contribution rate banding for each SBP.

Recommendation 11: Periodic review of SBP

The Panel recommends reviewing the operating of the SBP on a regular basis.

Recommendation 41: The proposals of SCTT

The Panel cannot endorse the set of proposals of the SCTT. On the other hand, the Panel recommends that the Ministry of Health and the C-M-S continue to explore future possibilities to introduce income-related contributions to the REF and other income-related cross subsidies related to access to healthcare.

Family size

The Panel agrees that this factor should not be used as a factor for equalization. However, while there is no commercial reason to include family size as an equalization factor, one could envisage that the government, in any effort to mandate SHI for lower income people, will consider support for large families as being a significant social factor. Therefore, family size may become policy-relevant in an SHI situation.

4.3 Mandatory cover

Recommendation 32: Mandatory affiliation of medical schemes to the REF

All medical schemes that are required to provide the PMB should also be required to participate in the REF.

Mandatory affiliation to the REF should also apply to all new medical schemes that might be accredited in the future. An exception to this rule should be made for existing “Bargaining Councils Schemes”, because they are not required to provide the PMB. However, all new Bargaining Council schemes should have to provide the PMB level of benefits and participate in REF.

Recommendation 6: Mandatory payment of the industry community-rate for PMB

The Panel recommends that payment of the ‘industry community-rate for PMB’ (hereafter “the contribution”) to the REF should be mandatory; and that implementation of compulsory payment of the contribution should be gradual. The application of this measure to the highest income group (say, the 10 percent with the highest income) should coincide with the implementation of the REF. Mandatory payment of the contribution should then be gradually applied to other income brackets, as well as other persons who enter the group of beneficiaries of a medical scheme.

Recommendation 7: SARS should collect the mandatory payment to the REF

The Panel recommends that the SARS should collect the mandatory contribution from beneficiaries on behalf of REF, and transfer the total amount collected directly to the REF, since SARS is the only institution that can establish the income of individuals.

Recommendation 30: Minimum subscription period

The Panel recommends introducing a minimum subscription period of twelve months for all contracts, with prior notice for cancellation of at least four weeks. The renewal/cancellation date should be standardized for the entire industry.

Recommendation 14: Publish comparable prices of BBP and SBP

The Panel recommends publishing an annual brochure with information on the component of the BBP and the standardized SBP, qualifying conditions that may apply and their cost (including region/province specific differences as relevant). The brochure should also include a simple reply-card that members will use to announce switches in affiliation from one medical scheme to another. This measure should be implemented together with the Panel’s recommendation to introduce a minimum subscription period.

4.4 Pro-poor measures

Recommendation 43: Subsidize health-related savings of the poor

The Panel recommends that the C-M-S develop a “Save-for-Health Account” programme, which will offer a government subsidy to encourage willingness to pay for healthcare among low-income persons. The Council should appoint a special Task Team to elaborate the detailed proposal, if possible at the time the Council announces the establishment of the REF. The Task Team should include experts in designing and quantifying a health insurance product, who should consult with civil society groups in the formal and informal sectors. The “Save-for-Health Account” programme should be launched as soon as possible after the establishment of the REF.

Recommendation 44: Prepare financial infrastructure for informal sector schemes

The Panel recommends that the Ministry of Health and the C-M-S should appoint a Task Team to review opportunities and constraints of improving equity and extending access to healthcare through informal sector pooling schemes. The Panel recommends that this should be done in the context of implementing the REF, to abate concerns about equity. The ultimate objective should be to elaborate a feasible proposal to sustain, both financially and operationally, informal sector community schemes which service the poor. The Task Team should report on its findings to a broad-based consultation with stakeholders, government agencies and civil society (including pertinent NGOs).

4.5 Sequence, phasing and timing

4.5.1 Operations

In line with the Panel's Recommendation 34, the institutional structure of the REF should be the first item of business, and it should be dealt with as soon as practical, so as to ensure a coherent chain of responsibility.

The Administrator of REF will then have to establish the work-flows. Without attempting to provide a full list of activities, the Panel draws attention to the need to address, early-on, the topics which are the subject of Recommendations 2, 32, 6, 38, 7, 8, 30, 14, and 27.

4.5.2 Research, development and other follow up

The Panel had occasion to flag the need for research, development and follow-up activities related to the wide topic on which the Panel was invited to offer its opinions. The passages in the report calling for such work are recalled here, for ease of perusal and reference:

PMB: ...bearing in mind that PMB is not sold as a stand-alone package, the imperfect quality of data about utilization and the Panel's reservations regarding the comprehensiveness of the PMB catalogue (including the difficulty that from an insurance perspective it is somewhat meaningless if it refers to pathologies rather than to treatment), the Panel recommends to revisit and review the composition of the PMB...

BBP: When sufficient data are available, the BBP should become the common package on which the REF-contribution table is based.

SBP: (i): The Panel recommends that the operating of the SBP is reviewed on a regular basis. (ii) If it is established that SBP increase risk selection significantly, one might consider applying some form of risk equalization to (some of) these packages.

Age factor: Further investigation into the observed differences in expenditures by gender among babies should be done to consider gender-age inequality among this sub-group.

Geographic differences: If the C-M-S considers that region-specific differences in contribution levels are undesirable, it would have to elaborate a mechanism outside the REF to equalize prices. Further consideration should also be given to epidemiological evidence of differences in healthcare needs between geographic areas, which might translate into different CDL profiles.

Future risk factors: Future assessments of appropriate risk factors and the weights to be attached to these should ideally be based on data on all beneficiaries from all schemes participating in the REF...

The data model: (i) The Panel recommends running a model on a single dataset to select risk factors. (ii) Given the potentially huge number of observations available for statistical analysis when all schemes contribute data, the REFTG may wish to consider analyzing a subset of observations selected at random, provided that the sample size provides sufficient coverage of all categories of the risk factors being considered (iii) An alternative approach is suggested: The data provided by the medical schemes could be split at random into two subsets (but not necessarily of equal amounts). One dataset would then be used to define the

appropriate weights to be applied to the risk factors. The second dataset would be used to calculate the expected expenditure claims given the risk factors and weights attached to these. A comparison of expected expenditures to actual expenditures will then be possible. This would provide a useful out-of-sample assessment of the predictive power of the risk equalization model to complement measures of fit provided through R-squared and mean-squared error statistics.

Solvency of the REF: Further modeling needs to be undertaken to determine the likelihood of the REF becoming insolvent.

Adjustment for inflation and cost changes: None of the statistical indexes readily available (from Statistics South Africa or research institutions) reflects price development in the medical schemes sector adequately... Hence, an index should be developed for determination of the contribution table. This index should take into account retrospective salary-related and price-related figures, which will be weighted and inflated forward.

Standardize renewal date: In consultation with the industry, the Council may wish to consider the advantages and disadvantages of standardizing the renewal/cancellation date, e.g. to 1 January of each year (which means that the first contract will usually be longer than twelve months).

Reflecting REF transactions in the accounts: The C-M-S, together with the industry and the South African Institute of Chartered Accountants should elaborate a 'best practice' proposal for reflecting REF payments in the accounts of the medical schemes.

Introducing income related contributions: the Ministry of Health and the C-M-S should continue to explore possibilities to introduce income-related contributions to the REF and other income-related cross subsidies related to access to healthcare, notably of lower income persons.

Cost containment measures: The C-M-S should establish a Working Party to propose cost containment measures. This Working party should include representatives from the Treasury and the health insurance industry, and should be requested to submit specific proposal for cost estimates, coordination of benefits and cost containment within the industry.

Subsidize health savings of the poor: The Ministry of Health and the C-M-S should appoint a special Task Team to elaborate the detailed proposal for the launch of a "Save-for-Health Account" programme.

'Provision and supervision' of community-based health insurance: The Ministry of Health and the C-M-S should appoint a Task Team to review opportunities and constraints of improving equity and extending access to healthcare in the informal sector, notably through support for community-based pooling schemes. The Panel recommends that this should be done in the context of implementing the REF, to abate concerns about equity. The ultimate objective should be to elaborate a feasible proposal to sustain, both financially and operationally, schemes which service the poor, including informal ones. The Task Team should report on its findings to a broad-based consultation with stakeholders, government agencies and civil society (including pertinent NGOs).

Appendix A: Figures

Figure 1:

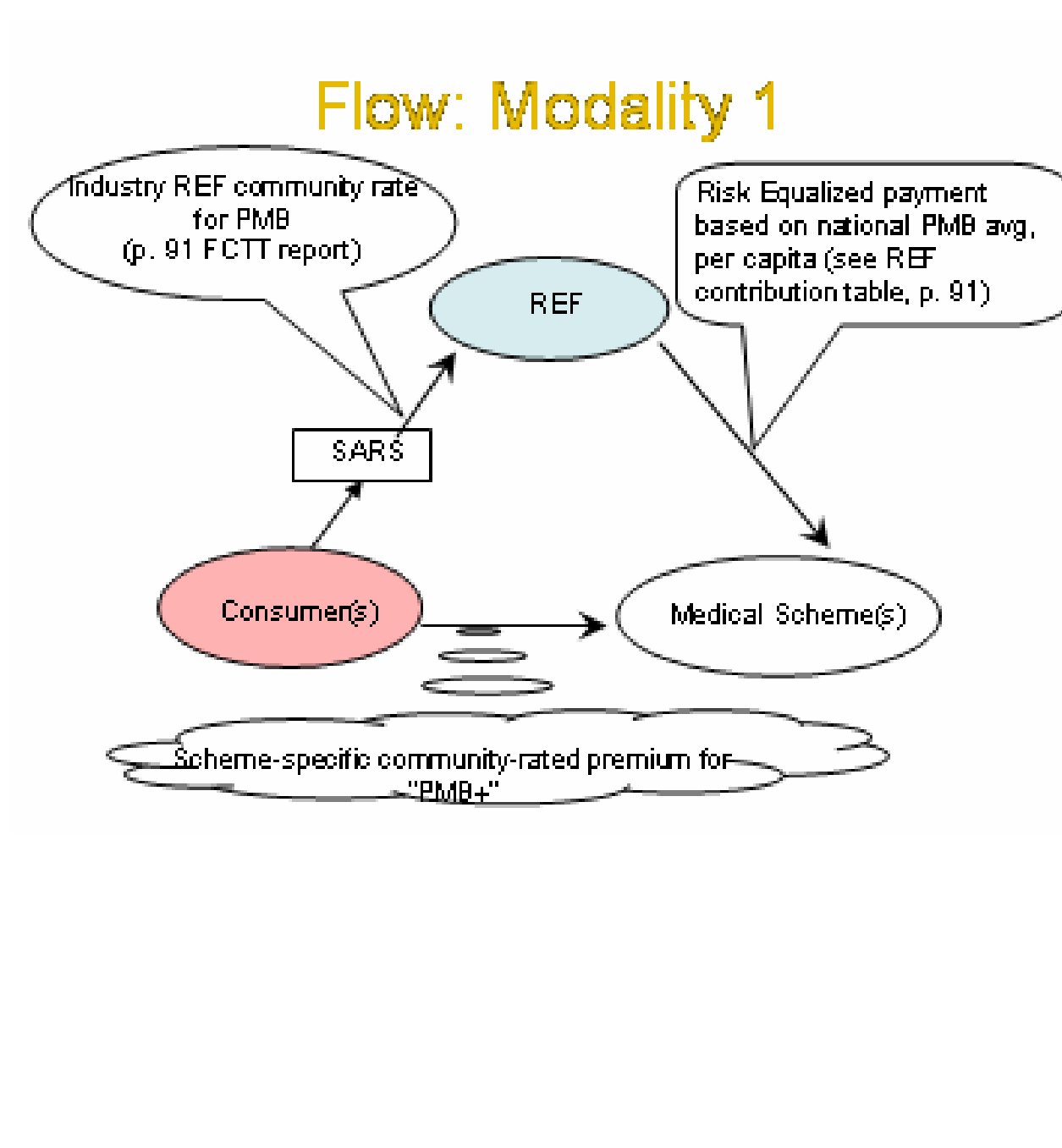


Figure 2:

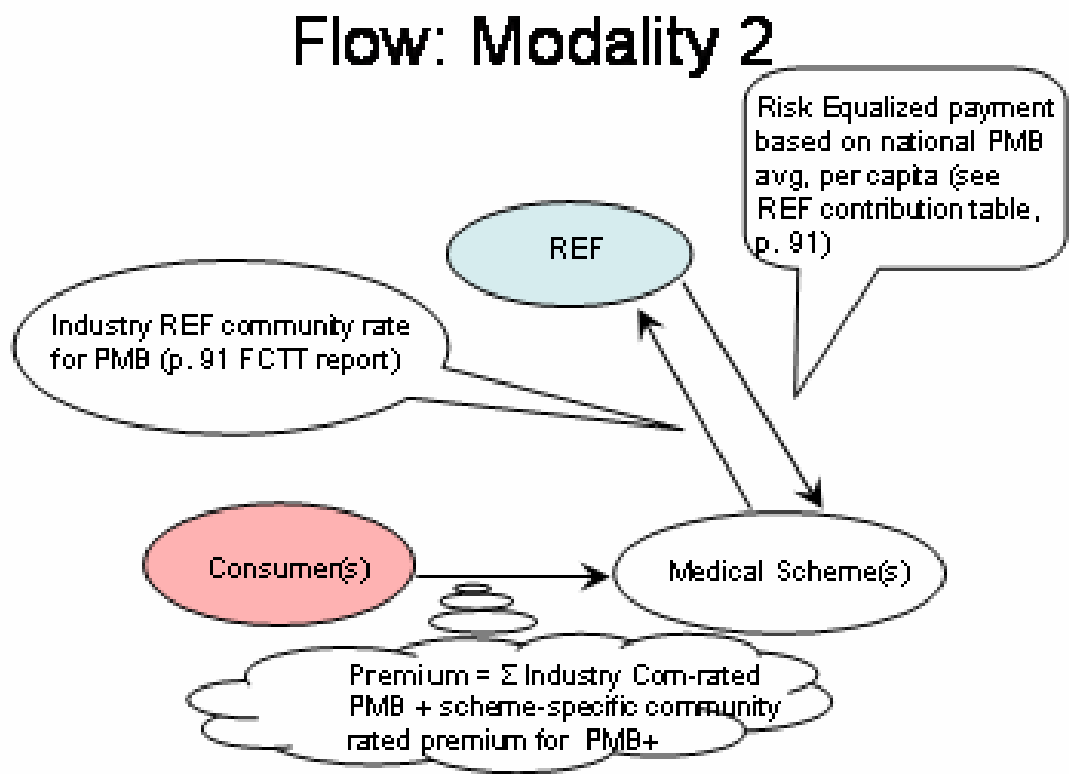
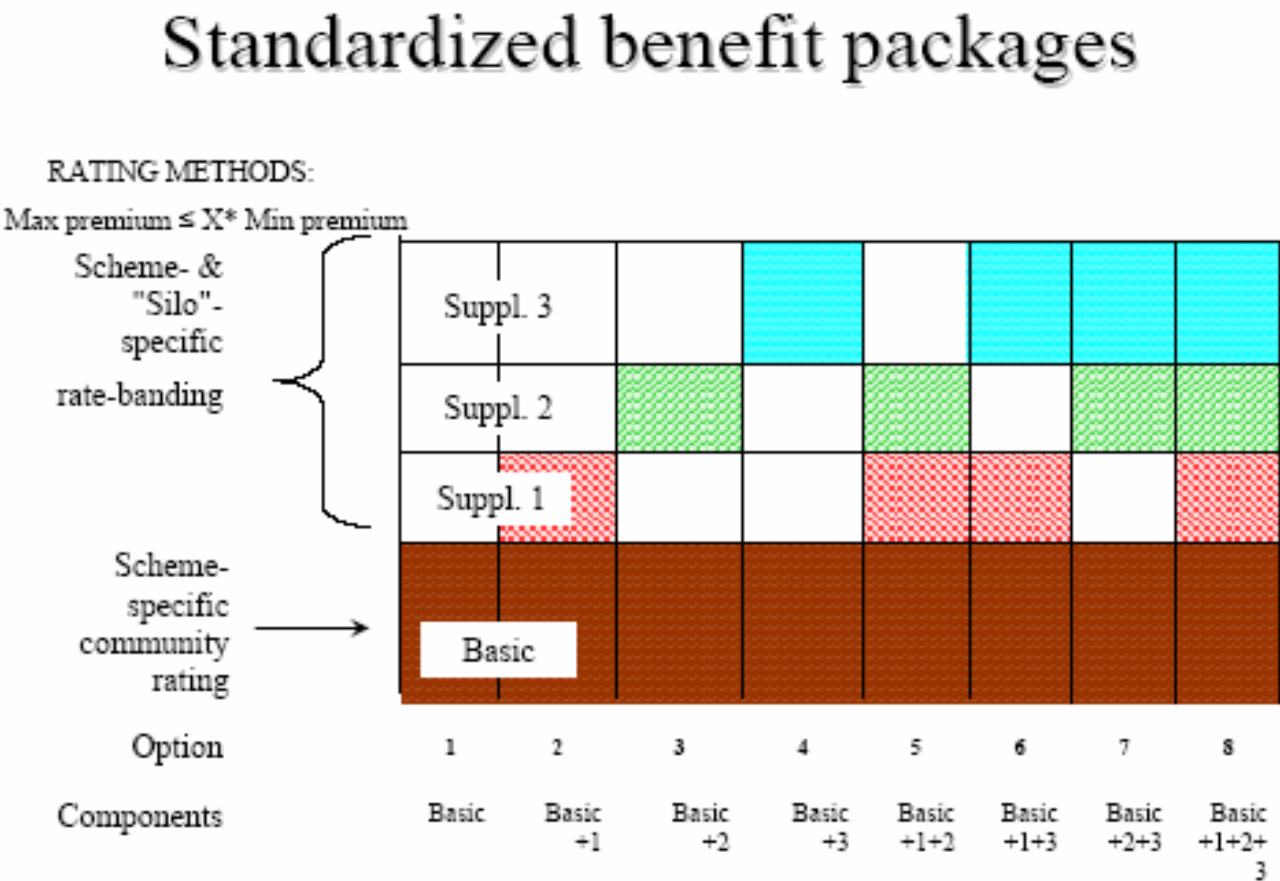


Figure 3:



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