CIRCULAR

Reference:	Low Cost Benefit Option and Demarcation Products
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Circular 82 of 2019: Low Cost Benefit Option & Demarcation Products

This Circular serves to inform medical schemes and insurers that no additional exemptions will be granted for the creation of products for the low-income market segments, outside of the Medical Schemes Act, No. 131 of 1998.

This policy decision includes demarcation products, which were provisionally exempted, and have influenced the medical scheme environment. An analysis of demarcation products offered in the market is provided in Appendix A, further detailing the empirical evidence supporting this decision.

In addition, the Council for Medical Schemes' (CMS) projects and key activities going forward are highlighted in the report. These initiatives are geared towards achieving the mandate of CMS and fulfil the national health policy goals.

This report should be read in conjunction with Circular 80 of 2019 as well as Circular 18 of 2019.

Yours sincerely,

Dr Sipho Kabane
Chief Executive and Registrar
Council for Medical Schemes

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Abbreviations

CMS	Council for Medical Schemes
CPI	Consumer Price Inflation
NDoH	National Department of Health
FSB	Financial Services Board
LCBO	Low Cost Benefit Option
MSA	Medical Schemes Act
NHE	Non-Healthcare Expenditure
NHI	National Health Insurance
PAC	Principal member, Adult dependant, Child dependant
PMB	Prescribed Minimum Benefit
RCI	Risk Contribution Income
SAM	Solvency Assessment and Management framework
SCR	Solvency Capital Requirement
VAT	Value Added Tax

1. Policy Goals

South Africa has embarked on a journey to introduce universal health coverage for all citizens. To effectively deliver on this mandate, the private healthcare finance environment has to be carefully coordinated to ensure that it complements, rather than competes, with the long-term goals of delivering quality, affordable, accessible and equitable healthcare to the people of South Africa.

An important element to note is that the Medical Schemes Act indicates that the CMS has a mandate to control and coordinate medical schemes in a manner which is complementary with National Health Policy. This is consistent with the efforts of CMS to deliver on its primary mandate, which is to protect medical scheme beneficiaries.

Low-Cost Benefit Options (LCBOs) were developed to extend coverage to a wider proportion of the population by improving affordability of healthcare financing options, in a controlled environment.

2. Background

2.1 Medical Scheme Industry

In February 2015, Circular 9 of 2015, was published. This circular, titled *CMS Discussion on the Introduction of a Low-Cost Benefit Option (LCBO) Framework*, initiated discussions on the development of LCBOs in South Africa. This circular invited industry stakeholders to contribute to the development of guidelines based on the proposed framework. Key factors highlighted in this circular were risk pooling, benefit design, continuation of care, solvency protection, non-healthcare expenditure, marketing, underwriting, open enrolment, community rating, consumer protection and non-discrimination.

In May of the same year, Circular 37 of 2015, *Request for Proposal – Benefit Design and Pricing of a Low-Cost Benefit Option (LCBO)*, was published. This circular requested the industry to submit proposals on the benefit design and pricing that would form part of the minimum set of benefits that the CMS intended to incorporate into the framework.

This was later provided for in Circular 54 of 2015 (*Low-Cost benefit Options (LCBOs) Framework and Principles Approved, as well as guidelines for preparation of a business plan pursuant to an application for exemption to register a LCBO)*, and retracted in Circular 62 of 2015 (*Low-Cost Benefit Option (LCBO) Guidelines)*. More specifically, this circular set out the request for submissions regarding the proposed benefits and pricing of LCBOs and further engagement on the supporting mechanisms to ensure that the benefits of the proposed framework would achieve CMS' objective to stimulate the industry and promote access to quality and cost-effective healthcare.

2.2 Insurance Industry (Demarcation)

Demarcation regulations, more specifically described under the Long-term Insurance Act, 1998 (Act No. 52 of 1998), Section 72 and Short-term Insurance Act, 1998 (Act No.53 of 1998), Section 70, came into effect on 1 April 2017. They identified health and accident policy contracts that conducted the business of a medical scheme and remained insurance contracts outside the regulatory provisions of the Medical Schemes Act.

In 2016, the Ministry of Health published Demarcation Regulations in the Government Gazette 40515. This prohibited short-term and long-term insurers from providing financial services products which included primary healthcare insurance policies.

Transitional provisions in the Demarcation Regulations allowed time until January 2018 or upon renewal, for the amendment of health and accident policy contracts to become compliant with the Insurance Act. The Ministers of Health and Finance then realised that some health and accident policies could not be amended without regressing access to healthcare services and therefore agreed to a two-year exemption period while a guidance framework for a LCBO package was being developed.

On 15 March 2017, Circular 19 of 2017, was published to inform the industry that the CMS, in consultation with the National Department of Health (NDoH), National Treasury and the Financial Sector Conduct Authority (FSCA) (then the Financial Services Board), concluded the Exemption Framework, which served as a guideline to providers who wished to apply for exemption in terms of Section 8(h) of the Medical Schemes Act.

In 2017, 23 exemptions were granted, out of 40 applications. In 2018, two appeals were made in terms of Section 50 of the Medical Schemes Act to the Appeals Board, which upheld the decision of the CMS. One of these appeals led to an exemption application under the category of insurer, which was successful.

In 2019, the CMS received three exemption applications, which were declined by Council. Two of these are currently appealing the decision with the Appeal Board.

Circular 18 of 2019, *Status Update on the Demarcation Regulations and the Development of a Low-Cost Benefit Package*, was published to notify the industry that entities should submit renewal applications for extension until 31 March 2021.

Additionally, CMS issued a discussion document on 29 March 2019 entitled "*Development of Low-Cost Benefit Options within the Medical Schemes*". This report highlighted the challenges associated with introducing the envisioned LCBOs into the current socio-economic and regulatory landscape, in light of national healthcare goals. This report followed on the research shared in the discussion document by taking the most appropriate decision within the South African context.

3. Key Enabling Factors

The decision by the CMS and the NDoH to cease the issuance of exemptions was well considered, with cognisance of other ongoing strategic projects to support the provision of universal healthcare coverage, and in light of the macroeconomic and socioeconomic landscape that the country exists in.

Most importantly, this decision considered the mechanisms that drive the operational effectiveness and sustainability of medical schemes. These include, but are not limited, to risk pooling, mandatory coverage, eligibility criteria, underwriting, anti-selection requirements, risk assessments and financial sustainability, clinical input in product design and accessibility, amongst others.

3.1. Macroeconomic Indicators

Although South Africa has recently avoided a second recession in two years, the growth of the economy is weak and has had a tangible impact on ordinary South Africans. Investment levels have remained subdued and businesses have been directly impacted. Private sector activity is considered low and imports continue to exceed exports. The impact of labour strikes, issues with energy supply and weak agricultural production have also had a direct impact on the growth of the economy.

Even with the rebound in the second quarter of this year, economic growth is still forecasted to be lower than estimates from the first quarter. The World Bank has revised growth targets from 1.3% to 0.8% for the year, according to its October 2019 Africa's Pulse Report. National Treasury recently provided a slightly more optimistic perspective in the Economic Overview of the Budget Speech, estimating 2019 GDP growth at 1.5%. However, this was also revised downwards from 1.7% since the 2018 Medium Term Budget Policy Statement. Subsequently third quarter GDP results release by StatsSA indicate an economic decline of 0.6%.

These downward revisions are indicative of slow improvements in production and employment as a result of the poor investment growth which South Africa experienced in 2018, as well as the slowdown in real GDP growth experienced in the first quarter of 2019. Persistent policy uncertainty has exacerbated the low investor sentiment.

All of these factors affect the members of medical schemes and the policyholders of insurance products. They influence the ability of the people of South Africa to access healthcare.

3.2. Government and Employer Subsidies

The individuals targeted by the LCBOs are largely exempt from taxes due to their low-income level. Requiring them to pay for healthcare from their incomes defeats the purpose of tax exemptions and their access to state social security programs.

More broadly, empirical evidence has shown that tax subsidies and interest deductions often fail to deliver the intended impact on the often-targeted low-income households. Maboshe and Woolard (2018) investigated the distribution and impact of medical credits and interest deductions in South Africa which revealed that these were highly regressive and concentrated amongst the top three income deciles. This was expected, given the coverage of medical schemes. Due to increasing healthcare costs and therefore, medical scheme premiums in South Africa, efforts to expand coverage within the current legislative framework and healthcare environment in the past have been met with systemic challenges.

Although cash transfers were found to be highly progressive and well-targeted in the same study, South Africa does not have a specific cash transfer benefit targeted at healthcare. This is currently catered for by providing healthcare services in free or subsidised health facilities. Considering the complex nature of healthcare purchases, a cash transfer would not be deemed appropriate without significant system and regulatory changes, a clear detraction of focus from the ongoing developments towards National Health Insurance, which has a very similar, and more holistic goal.

Consequently, further subsidies targeted at low-income communities to purchase private sector healthcare finance products, are deemed to be inappropriate. Evidence provided in Appendix A further support that use of government and employer financial resources would mainly serve to benefit funders, and not the beneficiaries.

Since the policy initiatives driving healthcare and the need to consolidate funding mechanisms to rehabilitate the public healthcare environment and accelerate universal healthcare coverage, government funding is better suited towards these policy initiatives, as opposed to subsidising the private healthcare financing environment. This will also support the enrolment of South African residents onto the universal health coverage program when it is officially launched.

3.3. Financial Sustainability

The introduction of LCBOs, with the current PMB framework, creates a challenge for schemes in maintaining their solvency requirements as is currently stipulated by the Medical Schemes Act.

The continuation of the exemption process is seen to have created regulatory arbitrage opportunities which are not in the best interest of the members and policyholders of the products under consideration. Continuing to conduct business and offer financial products outside of the standard regulation would continue to encourage opportunistic product design.

The expansion of the risk-pool with LCBO membership is likely to undermine the existing risk pool or create fragmentation which may not be seen as equitable. This may encourage buy-downs across the industry, and threaten the financial sustainability of current options.

Additionally, there is limited scope to achieve income cross-subsidisation within a risk-pool of only low-income members, as is supported by current legislation.

Empirical evidence from other jurisdictions indicate that voluntary membership creates less scope for income and risk cross-subsidisation, coupled with cherry-picking and upward cost spirals. High-risk members of low-income groups are likely likely to sign up for LCBOs in the absence of mandatory membership. However, compulsory membership within the current (open) medical scheme landscape would pose additional administrative strain, particularly with expanding systems and capital investment.

3.4. Administrative Issues

Private medical scheme products which make use of public healthcare facilities indicates a need to invest efforts in delivering NHI faster, as opposed to continuing the current arrangements. This current benefit design flaw is currently proliferating within private medical schemes.

The need for an increase in monitoring the financial and claims performance of these products may result in an increased administrative burden for medical schemes and regulators, as has been experienced with the current legislative framework.

One should also not underestimate the challenges associated with negotiations between medical schemes and their administrators and private healthcare providers to bring down the cost of healthcare passed onto the members. Any additional negotiations required to develop products suitable for this segment of the market are likely to create additional challenges across the value chain with service providers.

Additionally, this has created a challenge within the regulatory environment itself. The administrative burden associated with regulating by exemption across two regulatory bodies detracts from the main issues which must

be addressed for us to develop the products needed in the market, which includes strengthening the regulatory environment to encourage innovation, financial sustainability, accountability and transparency.

4. Policy Alignment and Sequencing

CMS has been working on several strategic projects in parallel to one another to stabilise the medical scheme environment. These include, amongst others, the PMB Review (and the development of the base benefit package as recommended by the Health Market Inquiry (HMI) report), Benefit Standardisation, revising the Risk-Based Solvency requirements and a framework for potential Scheme Consolidation.

Due consideration has been made of the supporting legislation of the healthcare industry, as well as the HMI Report which was released in September 2019 (detailed further in section 5.1 below).

Ensuring that roll-out of these projects is sequenced appropriately, in accordance with national health policy goals, is of paramount importance. This is also to minimise the disruption of the market.

The first of these matters that should be addressed is that of LCBO and Demarcation products, in tandem with the PMB review process.

In the absence of a completed PMB review process, further developments towards LCBOs creates a policy conflict and possibly further regulatory arbitrage which may impede efforts to roll out NHI effectively. A key recommendation from the HMI was the suggestion of a comprehensive base package across all schemes. In the absence of this package, allowing schemes to develop their own (possibly very different) LCBO options further exacerbates information asymmetry and poor comparability of these financial products.

Several stakeholders have expressed interest in the Umbrella Fund. This is another option which CMS is exploring, in tandem to Scheme Consolidation, to potentially improve financial sustainability in the industry and encourage innovation around more affordable product design.

4.1. Health Market Inquiry

The Competition Commission initiated the HMI on 29 November 2013, and the final report was issued on 30 September 2019. This inquiry was into the state of competition in the private healthcare sector. The main funding stakeholders the inquiry focused on were medical schemes, medical scheme administrators and brokers. Framed under the Theory of Harm 1, this inquiry investigated the market power and distortions in healthcare financing.

An additional Theory of Harm to consider in light of the product development of healthcare financing products for the low-income market is Theory of Harm 6, the regulatory framework.

The healthcare funding market is characterised by benefit option proliferation, rising costs, reduced access and insufficient competition on innovation, patient outcomes, provider contracting and rising contributions (or premiums in the case of insurance products).

The complexity of medical scheme benefits is a key impediment to medical scheme members being able to make informed comparisons when selecting a benefit option. The incomplete regulatory framework was also cited as

one of the reasons for product proliferation, high differentiation, lack of standardisation and poor comparability of benefit options.

The report indicated that the members' inability to compare benefit options meant that schemes had little incentive to innovate and contract effectively for the benefit of members. Additionally, the inability of members to decipher details of benefit options means that members cannot effectively make use of their benefits, and that medical schemes unfairly benefit from the lack of understanding of their consumers.

Several recommendations were noted which have been incorporated into the strategy for stabilising the funding market.

The report suggested the introduction of a comprehensive standardised base benefit option across all schemes, coupled with greater increased transparency and appropriate risk-adjustment mechanisms. This base benefit option would be compulsory to all scheme members and cover a combination of primary care, out-of-hospital and catastrophic expenditure. Medical schemes would then be required to innovate around supplementary cover.

The need for a standardised base benefit package is clear. This base package will be based on the PMBs which are currently under review and will be announced soon, once their costing and prioritisation is completed. This package will cater to primary care benefits and integrated care coordination

With regards to the funders market, two additional key findings from the HMI were that funders are neither accountable to beneficiaries nor beneficiary-centric.

The findings from the HMI have informed the decision by CMS to cease the exemption process in benefit design and instead focus on improving the regulatory environment for healthcare funders to better serve the low-income market.

4.2. Option Standardisation and Simplification

One of the findings of the HMI Final Report is that beneficiaries are not at the centre of the health funding market. In the future, the health funding market will be required to be more transparent regarding benefit option offerings.

CMS has conducted a benefit option classification exercise. The purpose of the exercise was to distinguish between different risk types by controlling for differences in benefit designs' health service consumption bundles (see fig 1). Additionally, the exercise attempted to assess whether similar health service consumption bundles attract similar risk profiles.

Risk profiles are characterised or described by financial results and demographic indicators of benefit options among open and restricted schemes. A key result of the exercise was that similar health service consumption bundles are not homogenous in underlying financial and demographic indicators. This raises additional concerns that beneficiaries are finding it difficult to distinguish between benefit designs. This is further complicated by the proliferation of benefit options.

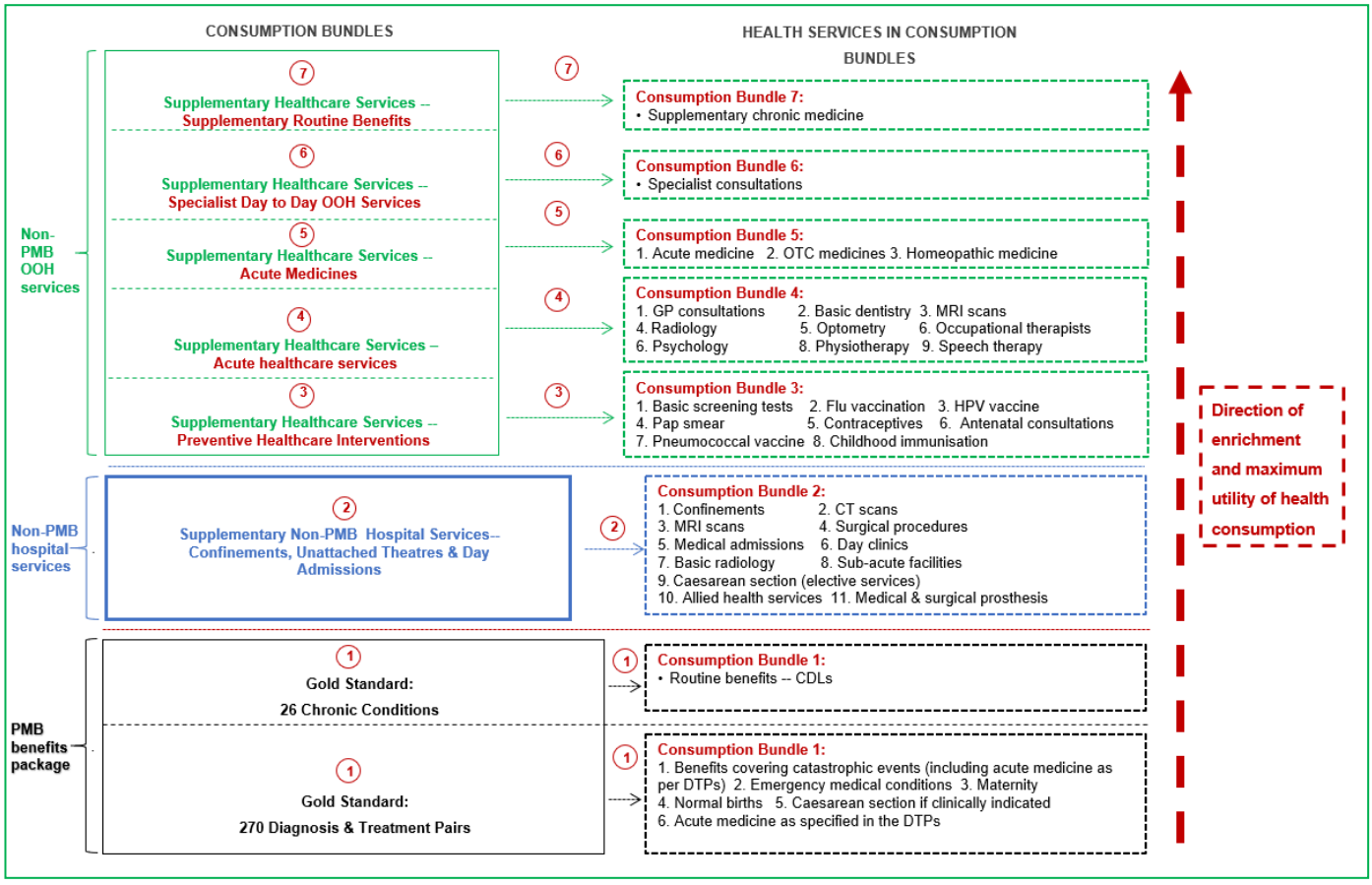
The benefit option classification exercise has identified three groups of benefit options. CMS intends to follow up this exercise with a market segmentation survey, to collect more data from medical scheme beneficiaries. The survey will be based on questions directly related to members' benefit option choices. Supplementing actuarial data with missing behavioural information will assist in understanding benefit option characteristics that are

common for specific benefit designs. This will assist the CMS to implement a benefit standardisation framework that allows for simpler decision making by the members of medical schemes. (Please click here to follow the link to the published research brief on option standardisation).

With consultative and collaborative governance processes, standardised model rules can be implemented and incorporated into the scheme rules registration process. Once benefit options are standardised, consumers may be able to optimise their benefit option decisions regarding available healthcare consumption bundles (choice menus). A standardised benefit option regime will assist beneficiaries to reduce benefit option proliferation through not selecting inefficient options.

A simplified overview of the healthcare consumption bundle framework utilised in this analysis is provided below.

Figure 1: Benefit design in current regulatory environment



4.3. Scheme Consolidation

On 19 October 2018 the Council for Medical Schemes (CMS) published Circular 42 inviting stakeholders within the industry to comment on the proposed framework for medical schemes consolidation.

The following were key objectives of Circular 42:

- Reducing the excessive fragmentation of risk pools.
- Address risk rating
- Strengthening cross-subsidies, and hence social solidarity.

- Standardise and simplifying benefit options.

On 30 March 2019, CMS published a subsequent circular (Circular 28 of 2019) where it made it clear that the simple metric of scheme membership size would not be sufficient to inform consolidation of medical schemes.

A key deviation of this process from that which was initially proposed (schemes with less than 6000 members) is to take a multi-criteria approach in developing a framework which schemes that intend on consolidating can utilize to do so in a sustainable manner.

Stakeholder engagements will be critical to ensure that the outputs are useful for schemes to strengthen the industry. Medical schemes will be engaged closely in 2020 to provide input into the development of this framework, in light of the current shifts in the industry.

4.4. Prescribed Minimum Benefits

Since their launch, the Prescribed Minimum Benefits have been at the heart of affordability and clinical adequacy debates within the healthcare industry.

PMBs, in and of themselves, are critical to ensure that there is a social security floor within the private healthcare market. As indicated in the HMI report, they are an essential component of universal health coverage and the most successful mechanism to prevent catastrophic health expenditure. However, several components of the healthcare environment prevent the effective implementation of PMBs and the PMBs themselves require revision.

The NDoH has indicated that the PMBs must be reflective of the primary healthcare needs of the country. Additionally, the Low-Income Medical Scheme (LIMS) task team suggested the revision of the benefit package to offer primary healthcare which is a subset of the broader PMB package.

In response to the comments made by stakeholders across the industry and the healthcare needs of the nation, the Council for Medical Schemes has been undergoing an extensive review process of the benefit composition and pricing of the PMBs which medical schemes must offer its members under all packages. This process began with the publication of Circular 83 of 2016.

The proposed PHC package for the medical scheme industry is informed by and several existing legislative and policy directives in South Africa. The key documents are as follows:

- The constitution of the Republic of South Africa
- The National Health Act (No 61 of 2003)
- The Mental Health Act (No 17 of 2002)
- The National Development plan
- National Mental Health Policy Framework and Strategic Plan, 2013 – 2020
- The National Department of Health Strategic Goals
- National HIV testing services, 2016
- National infection prevention and control policy & strategy, 2007
- National Policy Framework and Strategy on Palliative Care 2017 -2022
- The Framework and Strategy for Disability and Rehabilitation Services in South Africa 2015

The key principles in developing the revised PHC package are health needs, right to access health care services, financial risk protection, affordability and sustainability, clinical- and cost- effectiveness as well as efficiency.

The combination of experts and key policy directives have culminated in the drafting of a PHC package which addresses the primary healthcare needs of the nation, whilst addressing the concerns raised in the past.

The proposed PHC will consist the following:

- Preventive services
- Maternal and Neonatal services
- Mental health services
- Oral and Eye Health Services
- Radiology and Pathology Services
- Allied health services
- Palliative services
- Medical and Surgical procedure
- Essential drugs,
- Devices and Consumables

Further details of the package are contained in Circular 79 of 2019.

The Council for Medical Schemes considers the proposed PHC package as a more direct and efficient manner in which to bring affordable and quality healthcare financing packages to residents of South Africa, as opposed to the current low-cost benefit options and demarcation products on the market.

Additionally, the PMB Review process is seen to satisfy several of the recommendations mentioned in the HMI report.

The combination of the single, stand-alone, standardised, obligatory "base" benefit package is a key driver in informing the decision to bring low cost benefit options and demarcation products to an end at this national health policy juncture.

5. Actions Going Forward

There will be no additional exemptions granted for healthcare financing products within the medical scheme and healthcare insurance environments. All products which do not comply with the Medical Schemes Act must be wound down before March 2021. Products which do not comply with the Medical Schemes Act after March 2021 will be deemed to be illegal. The organisations which currently have exemptions are invited to approach the Council for Medical Schemes to identify the best way forward to wind down these tranches of business.

6. Conclusion

It is essential to refer to the legal history and societal context which brought medical schemes into existence and to which the Council for Medical Schemes is bound, as specified in the Medical Schemes Act, No. 131 of 1998.

Universal health coverage is the ultimate goal of the creation and current existence of medical schemes. South Africa finds itself at a critical juncture within healthcare, particularly as we have engaged in an extensive investigation of the challenges facing the healthcare environment in the HMI. The opportunity to rectify past mistakes and to move forward decisively positions us favourably to support the mandate which predicates our very existence.

The current exemption framework and the products which have entered the market under this exemption process do no align with the social solidarity principles of healthcare.

It is neither efficient nor progressive for us to continue to regulate by exemption and we must collectively make the necessary regulatory and strategic shifts to transform the industry and drive national healthcare policy within the bounds of the Medical Schemes Act.

As we consider the healthcare needs of the nation, in light of the findings from the HMI and the ongoing plans towards NHI, focusing the efforts to implement the recommendations already provided would be in the best interest of the industry and members.

The needs of the low-income population remain a priority for CMS and NDoH. This decision is in light of creating a more sustainable solution which fits into the new healthcare regime we are building together as stakeholders across the healthcare value chain.

The Council for Medical Schemes calls on all stakeholders to support the healthcare industry as it moves towards providing affordable, accessible, equitable quality healthcare for all.

Registered medical schemes and insurers remain key factors in the healthcare financing environment. The sustainability of regulated entities impacting the healthcare finance environment remains a priority for the CMS and the NDoH.

CMS invites parties to share their views and suggestions.

Please share all comments with LCBO@medicalschemes.com.

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Appendix A – Analysis of Design and Performance of Demarcation Products

Purpose of the analysis

This appendix serves the purpose of providing insight into analysis performed on information submitted by Demarcation product providers to the Council for Medical Schemes (CMS), and considers the implications of these products being governed by a regulatory framework which differs from that relating to medical schemes. In particular, the impact on the medical scheme risk pool is considered together with the performance of these products in respect of fulfilling their expected purpose and providing value to policyholders.

This appendix should be read in conjunction with the full circular, and provides supporting analysis in respect of the CMS's decision that no additional exemptions will be granted with respect to the creation of products for low income market segments, outside of the Medical Schemes Act, No. 131 of 1998.

The information considered for the purpose of the content of this appendix was submitted as part of the renewal application process for exemption in order to provide primary care health insurance products while the CMS finalises a Low-Cost Benefit Option (LCBO) framework. The health insurance data received was in a non-standardised format, with many providers providing incomplete or no data at all. The ability to produce conclusive analytics is limited given these data constraints, and the high-level observations noted in this circular should be considered against the above limitations. However, the analysis conducted does give key insights in terms of the performance of the exempt products. Where applicable, the approach adopted and the data used is detailed for each relevant analysis. The CMS will formally engage providers to provide complete and accurate data in a standardised format.

Information submitted as part of the exemption application process

In order to qualify for potential exemption, a number of requirements were outlined in respect of the insurance products, specifically:

- Benefit design
- Marketing and communication of benefits
- Discrimination towards policyholders
- Underwriting policies
- Complaints processes
- Service provider contracting
- Financial soundness
- Insurance licensing

Information was collected to assess the level of compliance with the requirements above.

In addition, the following information was to accompany any exemption application:

- Names of all brokers and administrators, or other persons, with whom the insurer has contracted, who provides marketing and/or ongoing services to clients

- Detailed breakdown of non-healthcare expenditure and figures

The information provided by the exempted insurers has been analysed in order to consider the appropriateness of these products for the policyholder base, with specific reference to the different experience that would be evident within a medical scheme context.

Despite the requirements regarding the provision of supporting information, the information provided by the exempted insurers has been in many cases incomplete or of poor quality. As a result, the analyses performed and conclusions drawn rely heavily on the limited information available.

The Sections below provide various analyses in respect of these exempted insurance products and the exempted entities offering these products. The availability of relevant information is addressed specifically within each relevant context.

Financial statement analysis – review of product value

Financial statements submitted by the exempt insurers were used for the purpose of analysing the value provided by these insurers to their policyholders.

Viable financial statements for the purpose of this analysis were available in respect of nine exempt insurers. These included annual financial statements in eight cases as well as a nine-month income statement in one case.

The most recently available financial statements were analysed, which included year-ends ranging from 31 December 2017 to 31 December 2018.

The non-healthcare expenses were assumed to generally include all expenses not related to benefit funding. These expenses therefore included the likes of operating and administration costs, commission costs and the cost of acquisition of contracts.

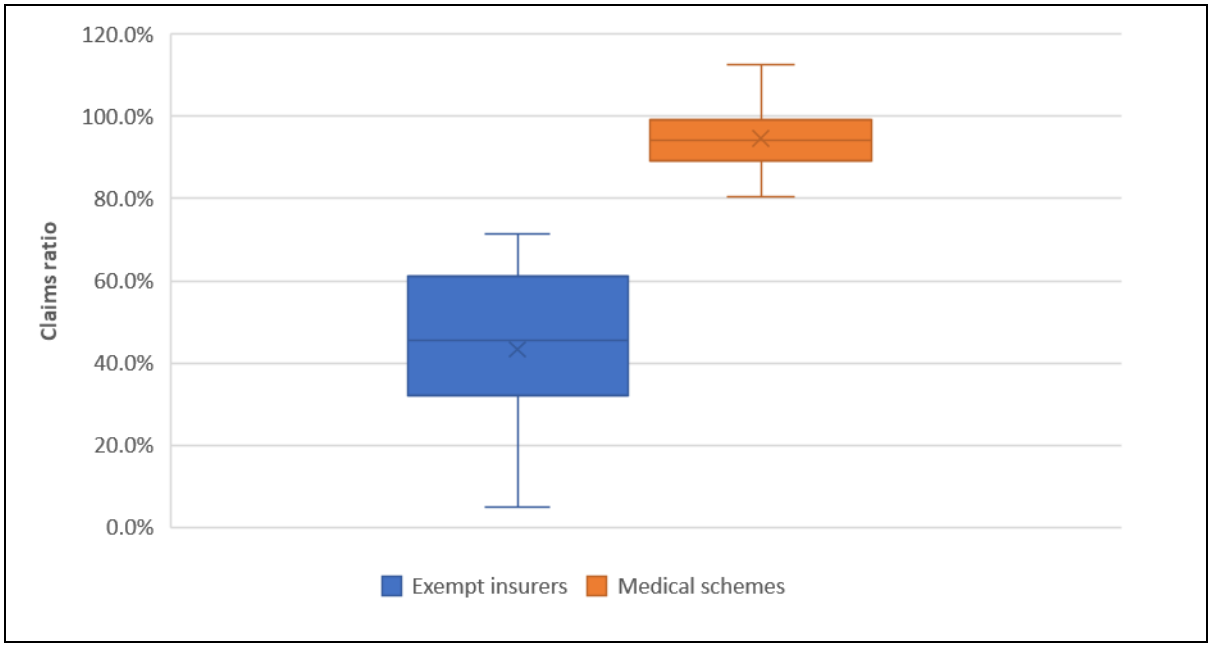
Box and whisker plots have been used to analyse the range of financial experience evident within the financial statements submitted by the exempted insurers.

In order to interpret a box and whisker plot, the following should be noted:

- The box captures 50% of the observed experience (ie the 25th to 75th percentile)
- The line within the box displays the median
- The top and bottom of the lines extending from the box display the maximum and minimum observations (excluding outliers)

The box and whisker plot below provides the spread of the claims ratios [1](i.e. benefit costs divided by premium income) observed for the exempted insurers relative to that evident within the medical scheme industry.

Figure 2: Spread of claims ratios (exempted entities vs medical schemes)



The table below compares the median claims ratios for the exempted insurers and medical schemes.

Table 1: Median claims ratios (exempted entities vs medical schemes)

Insurance group	Median claims ratio
Exempt insurers	45.5%
Medical schemes	94.3%

The chart and table above demonstrate that the claims ratios within the medical schemes environment significantly exceeds those within the exempt insurer financial structures. If outliers are ignored, the maximum claims ratio within the exempt insurers is lower than the minimum claims ratio within the medical scheme industry.

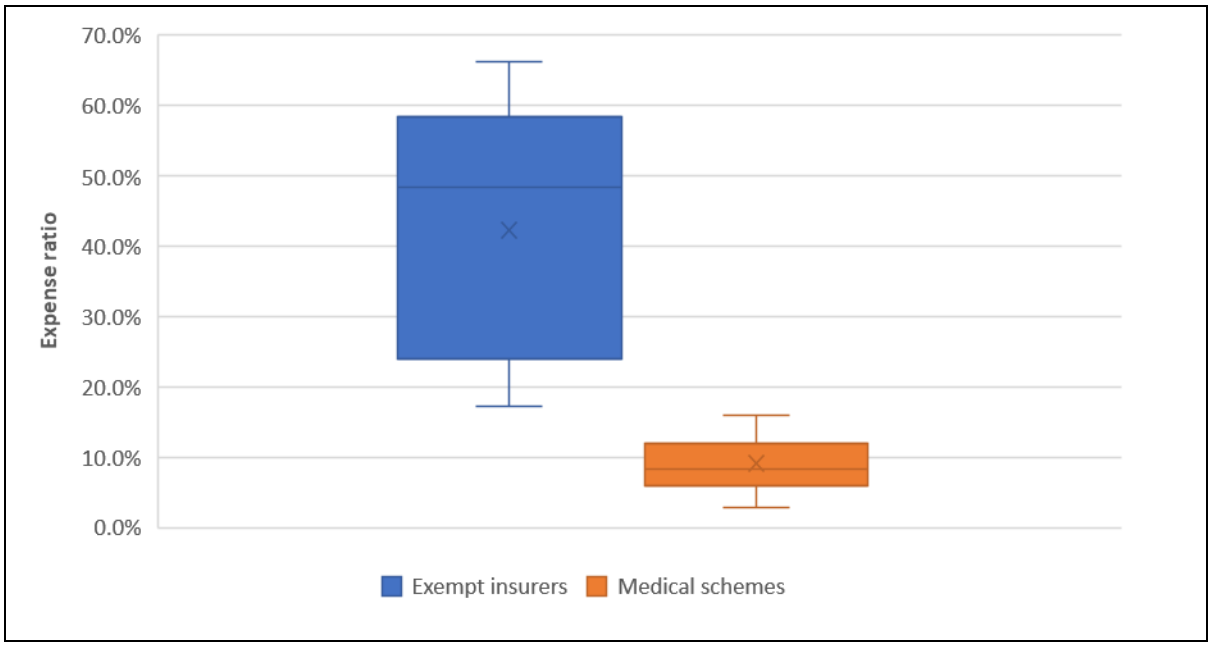
If it is assumed that the demarcation products operate on a similar financial model as evident from the total exempt insurer financial results, this implies that policyholders purchasing demarcation products are enjoying significantly lower value than the average member in the medical scheme environment, as a significantly lower portion of the premium is being used to purchase healthcare benefits.

The lower value is driven by a combination of higher expense ratios as well as profit margins, which are able to be extracted by the exempt insurers given that they are regulated by the Short-Term and Long-Term Insurance Acts rather than by the Medical Schemes Act.

[1] Medical scheme claims ratios have only considered risk claims relative to risk premiums. The exempt insurer claims ratios include total premiums and benefits paid (ie not net of reinsurance arrangements)

The chart below provides the spread of the non-healthcare expense ratios (i.e. non-benefit related expenses, such as administration costs, marketing expenditure and commission, divided by premium income) observed for the exempted insurers relative to that evident within the medical scheme industry.

Figure 3: Spread of non-healthcare expense ratios (exempted entities vs medical schemes)



The table below compares the median non-healthcare expense ratios for the exempted insurers and medical schemes.

Table 2: Median non-healthcare expense ratios (exempted entities vs medical schemes)

Insurance group	Median non-healthcare expense ratio
Exempt insurers	48.4%
Medical schemes	8.4%

The chart and table above demonstrate that a significantly larger proportion of premium/contribution increase is being used for non-benefit related expenses within the exempt insurers than is the case within medical schemes.

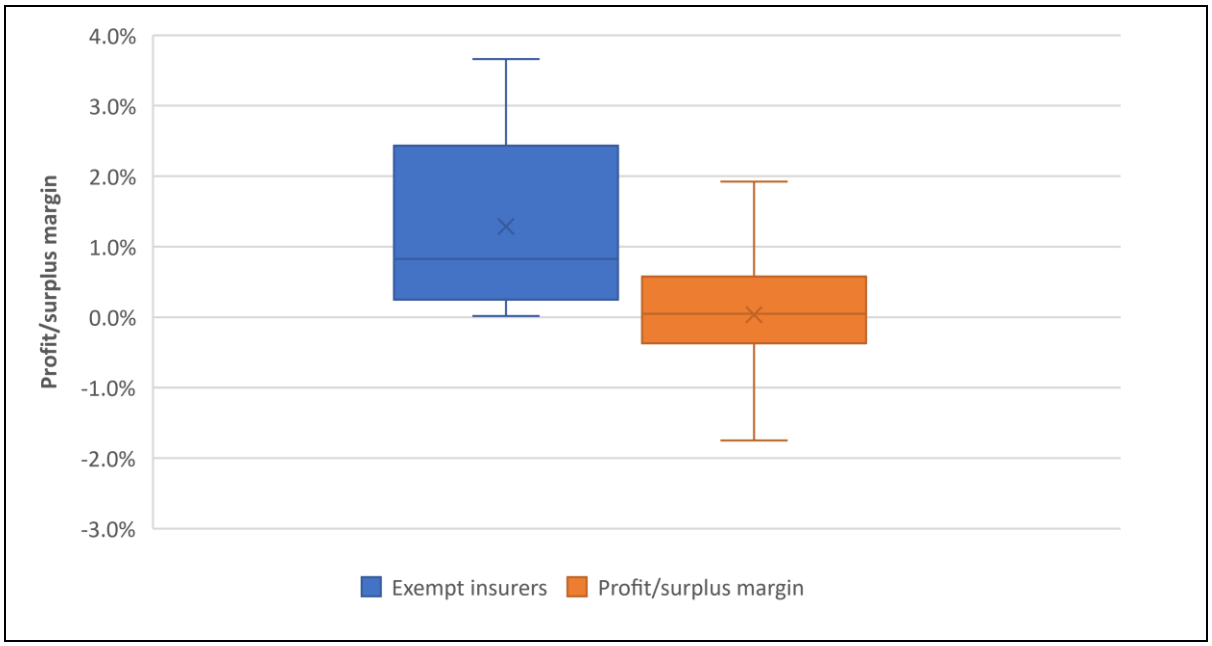
The median non-healthcare expense ratio for the exempt insurers is in fact almost six times that of the medical schemes. If outliers are ignored, the maximum non-healthcare expense ratio within medical schemes is lower than the minimum non-healthcare expense ratio within the exempt insurers.

A more detailed analysis for the expense structures evident within the Demarcation products is discussed below.

In addition to significantly higher non-benefit related expenses, profit is also able to be extracted by the exempt insurers, whereas this is not the case for not-for-profit medical schemes where members benefit from retained surplus.

The chart below provides the spread of the profit margins (i.e. profit before tax divided by premium income) observed for the exempted insurers, compared to the surplus margins (i.e. net surplus divided by risk contribution income) for medical schemes.

Figure 4: Spread of exempted entities' profit margins vs medical scheme surplus margins



The median profit margin for exempt insurers is 8.3%. Should this be an indicator of the profit extracted through the Demarcation products, this implies that the average policyholder is contributing 8.3% of their premiums towards profit, which in contrast would go towards additional benefits and value within a medical scheme context. This disparity is evident in the chart above in that the average surplus for medical schemes is approximately 0%, given the non-profit earning nature of these entities.

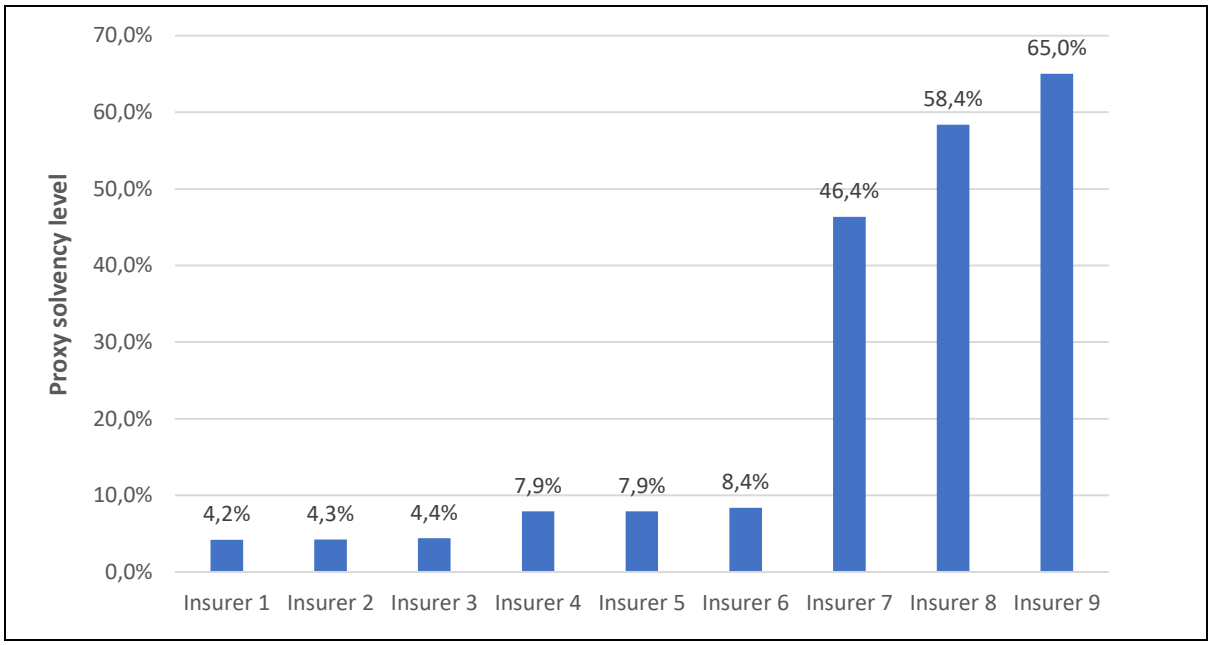
Financial sustainability of exempted entities

According to the Medical Schemes Act 131 of 1998, a medical scheme must maintain accumulated funds expressed as a percentage of gross annual contribution of at least 25%. This is assumed to be the level of reserves which provide security to members as it ensures that medical schemes have sufficient funds to cover catastrophic claims experience.

Reserve requirements for short and long-term health insurers are calculated differently to that of medicals schemes, needing to comply with the Solvency Assessment and Management framework ('SAM'). Thus, this section should be interpreted with caution. SAM outlines the Solvency Capital Requirement, which it defines as the amount of capital required to survive a 1-in-200 year loss event. The calculation of this requirement takes into account the various risks faced by the insurers.

Where possible, the financial statements submitted by exempted insurers were reviewed in order to assess the financial sustainability of these entities. Using total equity as a proportion of premium income as a broad approximation of a medical scheme solvency calculation, the graph below details the spread of the most recently available "solvency" levels of these exempted insurers.

Figure 5: Proxy solvency levels – exempted entities



The graph above demonstrates that the exempted insurers display a large variety in proxy solvency levels. However, two thirds of the insurers exhibit proxy solvency levels lower than 10%, which is very low relative to the current medical scheme solvency requirement of 25% of contribution income.

Only 9% of medical schemes exhibit solvency lower than 25% in 2018, and only one scheme exhibited solvency lower than 10%.

Despite some of the low implied proxy solvency levels for the exempted insurers, all exempted insurers that submitted their most recently available solvency capital requirement ('SCR') ratios submitted to the Financial Sector Conduct Authority (previously known as the FSB) displayed reserve levels in excess of the required SCR, which is calculated to ensure a 99.5% confidence of surviving potential losses over the course of a year. This includes two exempted insurers with a proxy solvency level of 4.4% and 7.9%.

The above indicates that reserving requirements within an insurance context may result in lower levels of required reserves relative to medical schemes, such that medical scheme members enjoy a greater level of protection from financial ruin compared to an insurance provider.

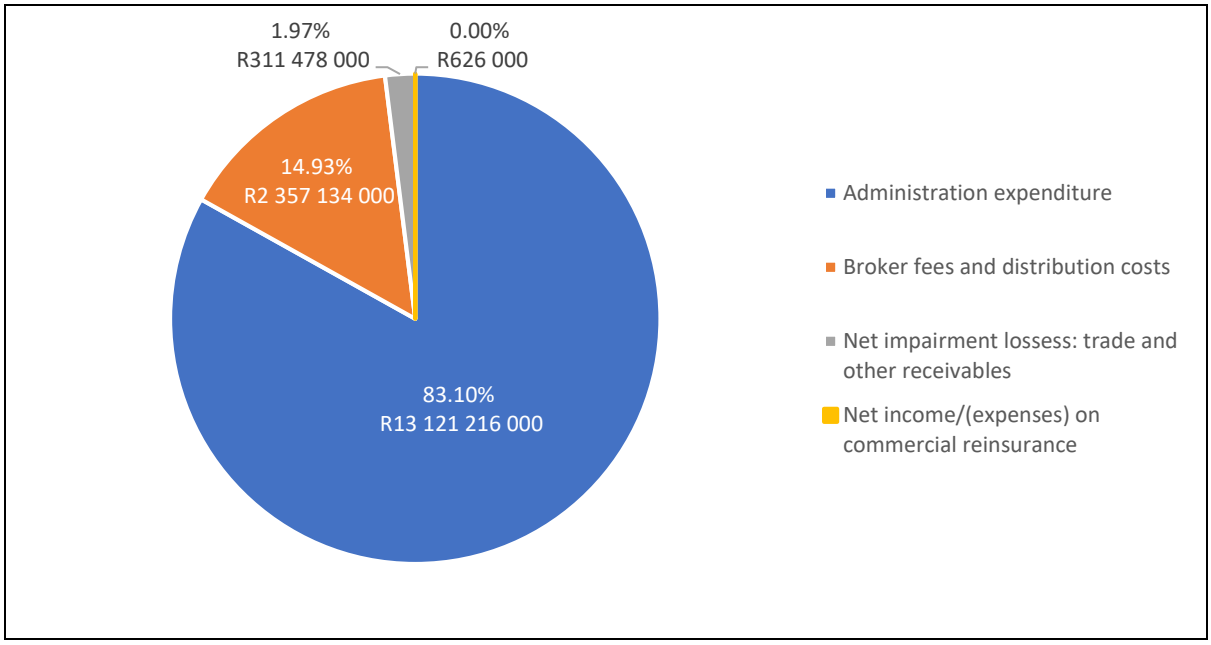
Exempted product expense structures

Non-healthcare expenses ('NHE') consist of all expenses of a scheme or insurer that are not allocated towards the funding and payment of healthcare related claims. These expenses can include broker commission fees, administration costs, fixed expenses, managed care fees, etc.

All information regarding NHE of medical schemes was extracted from the relevant annual reports and annexures published by the Council for Medical Schemes. The NHE expenditure analysed for health insurers was retrieved from the limited information provided by these insurers, provided as part of their demarcation exemption submissions to the Council in March 2019. Of the 18 insurers, only 10 had provided sufficient information for this analysis, but the information was not-standardised and the ability to provide conclusive analyses limited. For example, certain insurers only provided information on their broker commission structure, whilst others included detailed information per product and per NHE category.

The graph below shows the proportional split of NHE for the main NHE categories within medical schemes in 2018. Using the average results for five exempted insurers where sufficient information was available for this purpose, the split between 'administration expenditure' and 'broker fees and distribution costs' was 49.1:50.9. Table 4 shows a detailed split for one exempted insurer.

Figure 6: Non-healthcare expenditure medical schemes 2018



Contributions and cost increases in the medical scheme environment are overseen by the CMS, and remain under scrutiny as the CMS aims to restrict the impact of high increases on members. Proposed cost and contribution increases are also reviewed by the CMS on an annual basis. A circular is published annually by the CMS which provides guidelines for benefit design and contribution pricing of medical schemes for the upcoming year. This circular includes, amongst other things, the maximum increase for NHE. Circular 45 of 2017 stated that "non-healthcare expenditure increases for 2018 should **not** be greater than the CPI projections for 2018." The CPI projection for 2018, as detailed in this circular, was 5.7%. The overall increase in NHE from 2017 to 2018 was 4.4% per member per month, indicating the considerable efforts from schemes to control costs.

Broker fees (including commission and distribution) are the second largest NHE expenditure by medical schemes, with R48.87 per member per month spent on these fees in 2018 overall and 14.93% of NHE. Broker commission accounts for 95% of these fees, whilst R2.34 per member per month was spent on the distribution portion in 2018. The Medical Schemes Act limits the commission payable to brokers by medical schemes as per Regulation 28(2) of the Act. As published in Circular 4 of 2019, the fees payable to brokers have been set to the minimum of either 3% plus value added tax (VAT) of the payable gross contribution, or R94.77 plus VAT. Overall, the medical schemes industry spent 1.2% of its gross contribution income on broker commission.

Less than half of the exempted insurers analysed adhere to Regulation 28(2) of the Act. The remainder have more favourable commission structures that incentivise brokers above the medical scheme levels. Commission as high as 20% of the retail premium is offered to brokers by certain insurers which puts medical schemes at a competitive disadvantage from a sales perspective. Broker commission furthermore accounts for over 66% of certain insurers' NHE.

The table below provides the proportion of risk contribution income ('RCI') allocated to non-healthcare expenses ('NHE') in 2017 and 2018 for the medical scheme industry. This is shown for the open, restricted and overall industry.

Table 3: Non-healthcare expenses as a proportion of risk contribution income

Medical scheme industry	**NHE as a percentage of RCI**	
	2017	**2018**
Open medical scheme industry	11.56%	11.52%
Restricted medical scheme industry	6.26%	5.95%
Overall medical scheme industry	**9.23%**	**9.08%**

An analysis of available health insurance product information on a per product basis revealed that non-healthcare expenditure, which includes marketing and distributions costs, administrations fees, broker commission fees, binder fees, etc. ranges from 9.4% to 72.6% of the retail premium. However, only two health insurers were identified with products whose NHE portion was 9.4% of their retail premium. The average proportion of NHE is 37.4% of the retail premium of all health insurance products considered in this analysis. NHE as a proportion of risk contributions for medical scheme options range from 2.7% to 37.1%. The medical scheme with the highest overall NHE spends below 16% of its total risk contributions on NHE, whereas the NHE of health insurers is generally a fixed percentage of the retail premium per option and can be as high as 72.6%.

Medical schemes and health insurers generally compete for the low-income earning market. Therefore, the low-cost options on medical schemes are most comparable in terms of price and target market to that of health insurance products. The average NHE portion for low-cost options[2] in the open medical scheme market (on a member-weighted basis) makes up 14.8% of risk contributions, or R186.29 per member per month. This is higher than the overall open industry average of 11.6%, but still lower than the average NHE as a percentage of retail

[2] Low-cost options considered in this analysis were those options on open medical schemes with the lowest gross contribution income per member per month in 2018

premium of health insurers of 37.4%. Health insurers on average pay R278.90[3] towards NHE per member per month.

The table below provides an example of the NHE distribution as a percentage of the principal member retail premium of one of the health insurers included in this analysis.

Table 4: NHE as a proportion of retail premium

NHE item	Average proportion of retail premium
Administration costs	69.4%
Commission fees	1.0%
Binder fees	0.6%
Third-party services fees	1.6%
Total NHE as a proportion of retail premium	**72.6%**

For this specific insurance product, 72.6% of a principal member's premium is allocated towards payment of expenses. Other categories of NHE may include marketing, distribution and cell fees. Third-party service provider fees are usually related to risk-transfer arrangements with emergency service providers. However, administration costs, marketing and distribution and commission fees were the primary NHE categories for the majority of insurers, with administration and commission fees being the greatest expense. This further implies a greater level of disproportion towards relevant healthcare expenses as this only accounts for less that 30% of the retail premium.

With legislative factors such as payment of PMBs in full, and a regulatory minimum solvency requirement, medical schemes face the challenge to keep NHE as low as possible to keep contributions fair and competitive whilst also ensuring the financial sustainability of the scheme and value for money for its members. Medical insurers, on the other hand, are freed from regulatory requirements such as PMBs. However, it would appear that members of health insurers are receiving poorer value for money with as much as 72.6% of their premiums going toward NHE and only claiming as little as 5% of their paid premium. The reverse is evident in the medical scheme industry where NHE is only approximately 9% of a member's payable contributions and at least 80% goes toward the payment of healthcare costs.

An analysis of the non-claims related expenditure of medical schemes versus health insurers appears to reveal the inappropriate distribution of premiums by health insurers. Expenditure weighs far heavier toward NHE in the health insurance environment as opposed to medical schemes who spend the vast majority of its contribution income on healthcare expenditure, as one should expect.

Benefit design and affordability of exempted products

The premium levels for the Demarcation products were analysed based on the information contained in marketing brochures provided by the exempted insurers.

[3] This is based on the information available for exempted insurers, and where not enough information was available regarding membership profiles, a family structure consisting of one adult dependant and one child dependant was assumed.

In many cases marketing brochures were not provided or did not include premium levels. This is partly due to premium levels in certain cases being negotiated on an employer by employer basis. This differentiation again highlights the risk rating applied by the health insurers relative to medical schemes, promoting member cherry-picking.

In order to improve the value of premium comparisons, the Demarcation products were divided into four categories for analysis purposes, as follows:

- Day-to-day – These products do not include any inpatient benefits
- Hospital – These products include solely inpatient benefits and do not include outpatient benefits
- Comprehensive – These products include a combination of inpatient and outpatient benefits
- Limited – These products include a small number of select benefits (an example includes products that exclusively provide dental benefits)

The types of benefits provided within each category unfortunately still differ significantly in certain cases. As an example, hospital benefits may only include limited benefits for accidental hospitalisation in certain cases, but in other cases may provide relatively comprehensive benefits.

The inconsistency in benefit design, and lack of regulation with respect to a comparable benefit package places policyholders at risk. Many policyholders may not understand the implications of the benefit differences, and may not fully comprehend the risk they face with regards to potential healthcare cost shortfalls.

In addition, detailed benefit definitions are often not available or publicised, again placing current and prospective policyholders at risk. As an example, it is often unclear what is implied by “accidental hospitalisation”.

In summary, there is a definite lack of transparency with regards to the benefits offered by the Demarcation products.

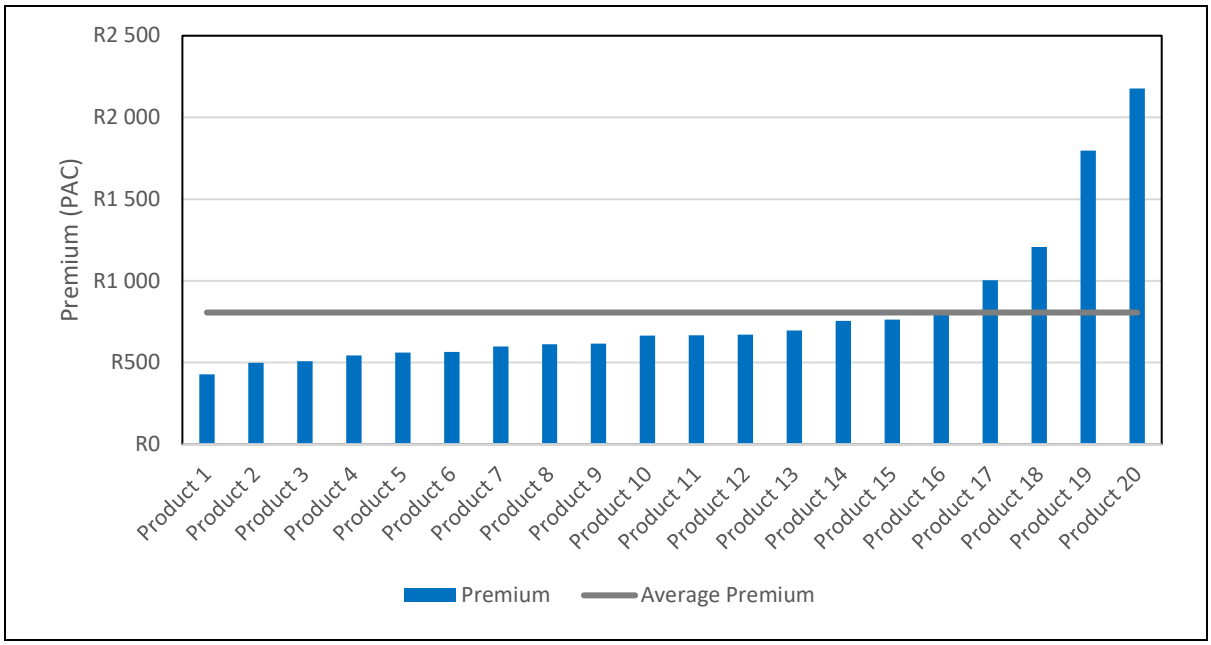
The majority of marketing brochures provided were 2019 brochures. Where only 2018 brochures were available, the 2018 premium rates were inflated by 7% to convert them into 2019 terms for purposes of this analysis.

Where premiums were age rated, the lower premium rates (excluding loadings due to older age) were considered.

For the following analysis we have considered the family contributions, where a family consists of a principal member, adult dependant and child dependant i.e. PAC family structure.

The graph below shows the premiums for the Day-to-Day insurance products considered.

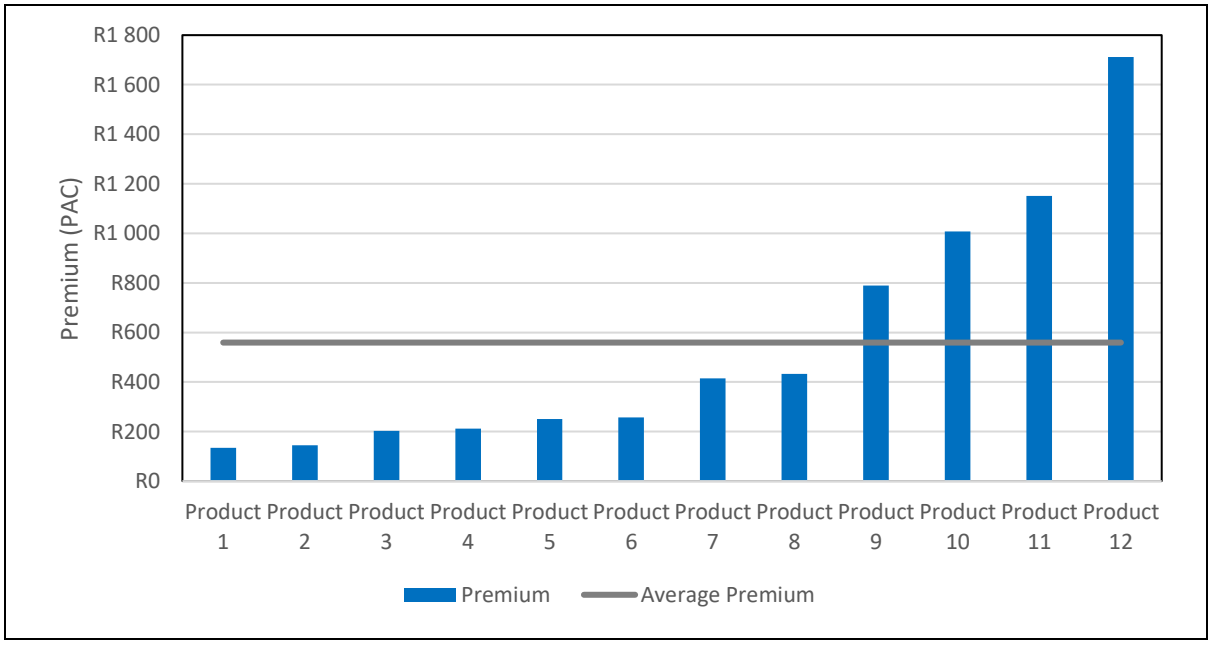
Figure 7: Spread of day-to-day product PAC premiums



The monthly family premiums for the Day-to-Day insurance products considered range from **R427** to **R2,177**. On average a family is paying **R806** per month for a Day-to-Day insurance product in 2019.

The graph below shows the premiums for the hospital insurance products considered.

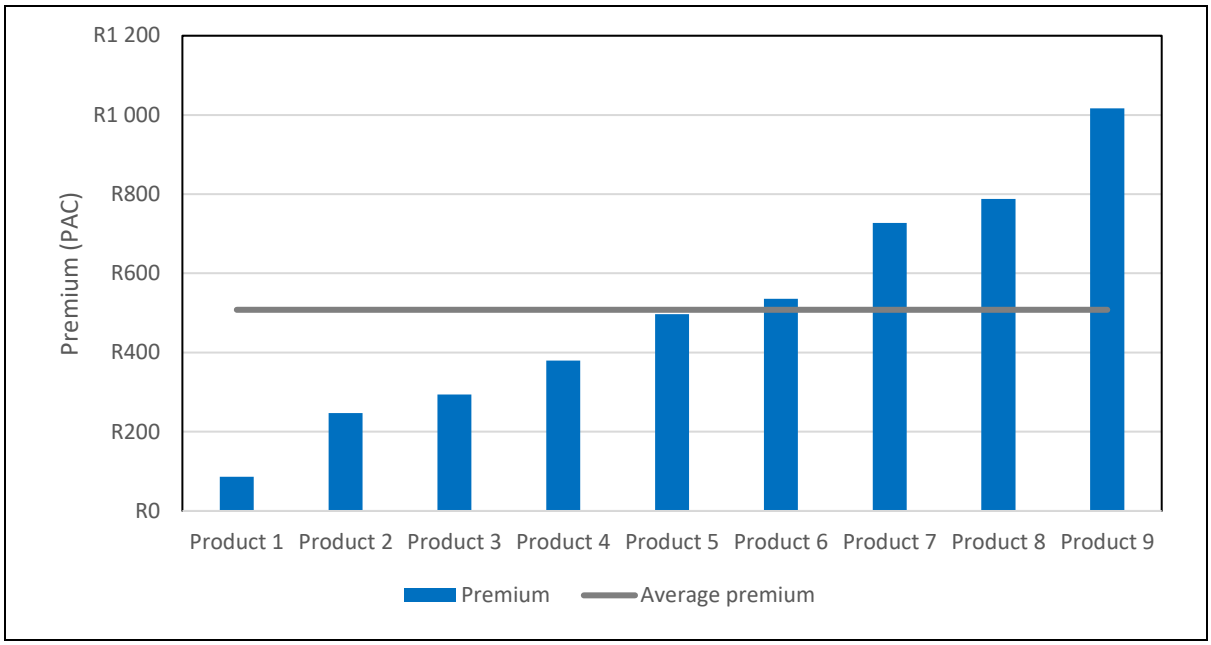
Figure 8: Spread of hospital product PAC premiums



The monthly family premiums for hospital insurance products range from **R134** to **R1,712** per month. On average a family is paying **R559** per month for a hospital insurance product in 2019.

The graph below shows the premiums for the limited insurance products considered.

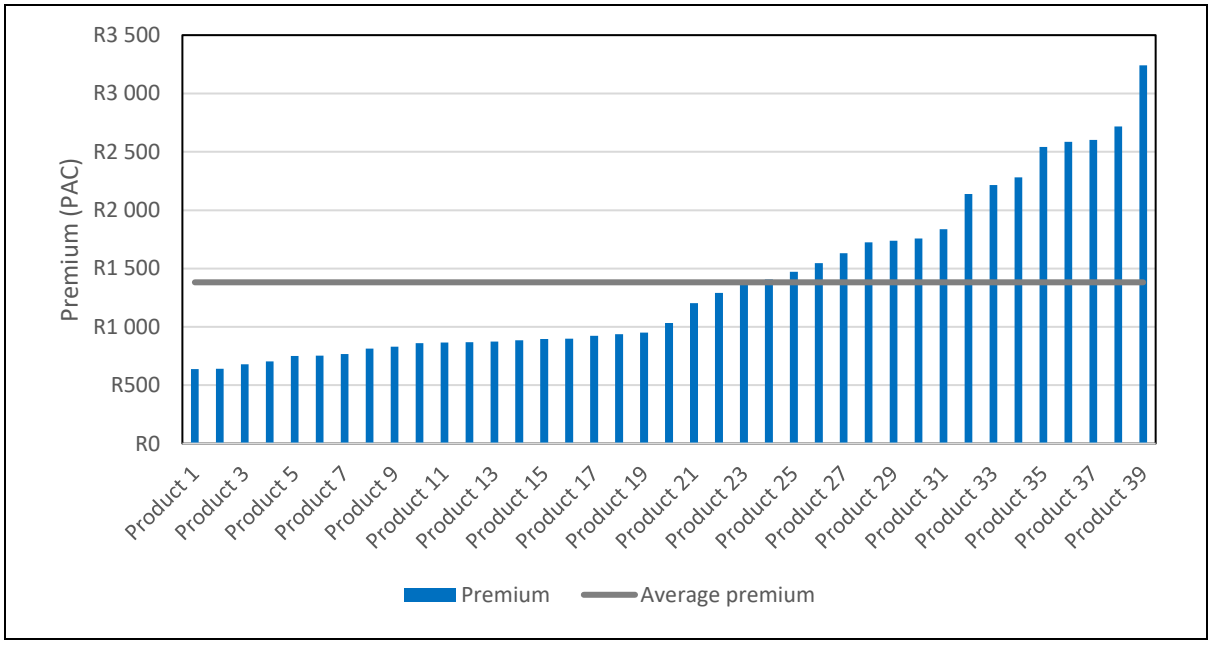
Figure 9: Spread of limited insurance product PAC premiums



The monthly family premiums for the limited insurance products considered range from **R86** to **R1,017**. On average a family is paying **R508** per month for a limited insurance product.

The graph below shows the premiums for the comprehensive insurance products considered.

Figure 10: Spread of comprehensive insurance product PAC premiums



The monthly family premiums for the comprehensive insurance products considered range from **R638** to **R3,242**.

The table below provides further information related to the spread of premium levels of these comprehensive insurance products.

Table 5: Family premium spread statistics for comprehensive demarcation products

Summary statistic	Result (comprehensive product PAC premiums)
25th percentile	R861
Median	R1,034
Average	R1,382
75th percentile	R1,756

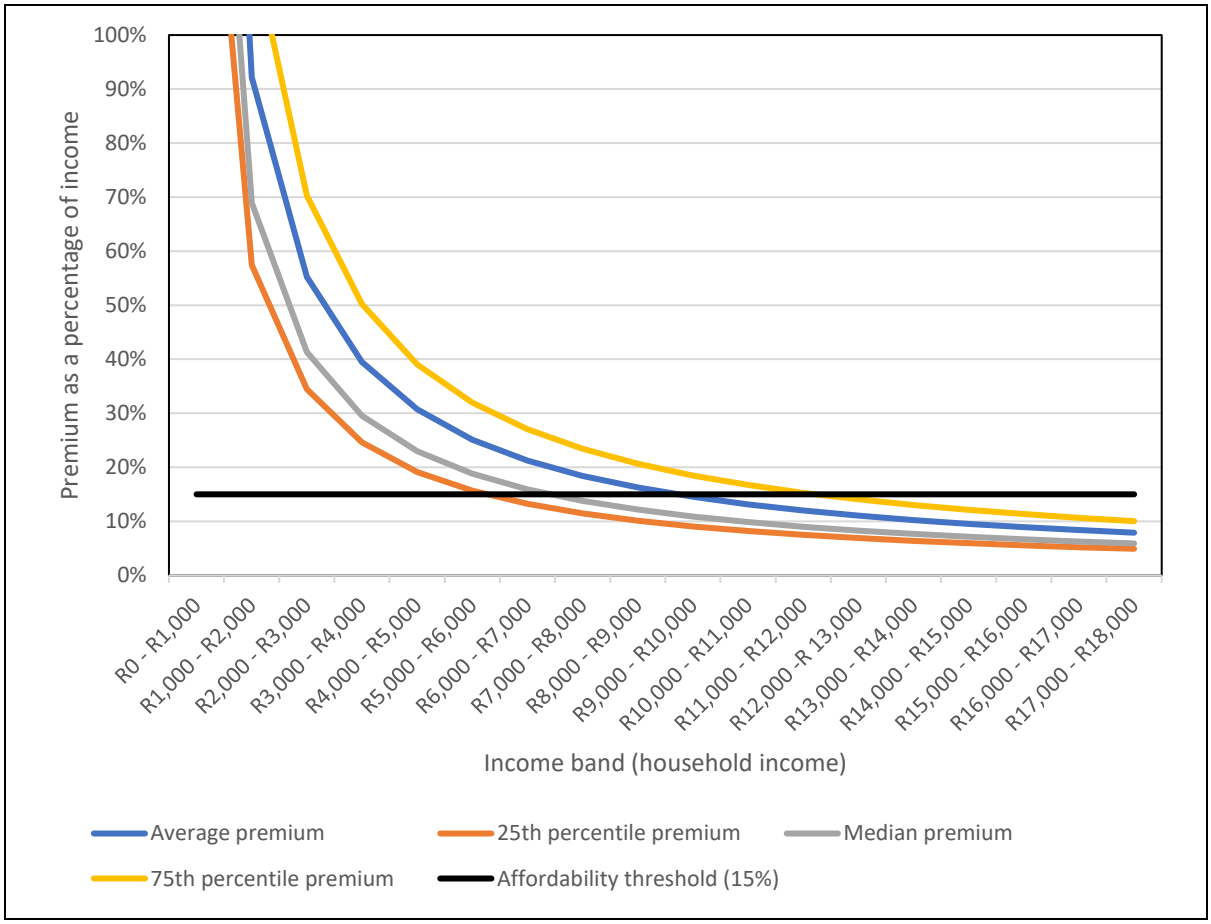
On average a family is paying **R1,382** per month for a comprehensive insurance product.

If it is assumed that approximately 45% of the premium is directed to the payment of healthcare benefits, as considered above in the analysis of exempted insurer income statements, this would result in R622 monthly being used to fund for healthcare benefits.

Given that, as an example, a GP consultation is expected to cost almost R400, this premium therefore approximately provides for only one GP consultation per beneficiary every second month. This further demonstrates the lack of value inherent in the benefits provided by the Demarcation products.

The graph below shows the PAC premium for the comprehensive insurance products vs. income.

Figure 11: Comprehensive product premiums vs. income



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It is evident from the above graph that for many of the lower income levels the average premium as a percentage of income is high. This demonstrates that for low income families these products are not particularly affordable.

It has previously been proposed that these low-cost insurance products be designed and targeted at those earning below the income tax threshold. The current average premium of R1,382 for a comprehensive insurance product represents 21% of the current income tax threshold level of R6,583 per month. Given that, based research, 15%[4] is considered a reasonable threshold level representing the maximum proportion of income individuals are able and willing to contribute to healthcare provision, this is considered to be unaffordable. Furthermore, affordability is further constrained where additional dependants are added to cover by often single earning household incomes.

The average premium is seen to be above the threshold affordability level of 15% of income for all incomes below R9,000.

Having analysed the contribution levels for the current scheme low-cost options on the ten largest open medical schemes based on a monthly household income at the tax threshold level, the average contribution for a PAC family in 2019 is approximately R3,000.

Given that Demarcation products do not need to provide for PMBs, they have therefore been in a position to offer a cheaper alternative. However, given the underwriting, risk rating and sales approaches of these insurers, and the lesser importance that healthier individuals would place on less extensive catastrophic cover, this has placed the medical scheme risk pool under threat given that the younger and healthier low-income earners have been more likely to exit the medical scheme risk pool in favour of these insurance product alternatives.

In addition, these products still appear to not fully solve the problem of adequately extending cover to low income earners.

The 75th percentile premium rate is considered a more appropriate indication of an average premium level where a reasonable level of hospitalisation and catastrophic cover is provided. The 75th premium percentile monthly premium of R1,756 is only below the affordability threshold of 15% of income where the monthly income level exceeds R11,700.

It was estimated in 2016 that medical scheme membership only becomes significantly prevalent at household income levels above R15,000 per month[5]. If CPI growth is applied to this figure, this represents approximately R17,200 in 2019.

Based on consideration of the comprehensive insurance product premiums, these products may be seen to partially enhance access to cover for those earning between R9,000 and R17,200. However, the most vulnerable who earn at lower levels remain unable to reasonably afford cover. These products in their current form therefore do not appear to successfully deliver on their promise to adequately extend cover to low-income earners.

[4] The WHO defines catastrophic health expenditure (CHE) in the case where health expenditure exceeds 40% of non-subsistence income. Threshold levels, resulting in CHE, have been set at various levels ranging from 5% to 25% of total income. 15% is considered a reasonable median value within the ranges of thresholds proposed.

[5] Erasmus D, etal (2016) Challenges and opportunities for health finance in South Africa: a supply and regulatory perspective. Prepared for FinMark Trust by Insight Actuaries and Consultants

In line with the NHI strategy, it may be considered more appropriate that these members access health cover via the State rather than accessing non-comprehensive cover via these insurance products that remain unaffordable, and yet further constrain their economic potential.

Underwriting and risk rating approaches

Underwriting in the health insurance context refers to the application of waiting periods and other penalties on members before they are able to claim for services. Underwriting is used by both medical schemes and health insurance providers to mitigate unfair claiming behaviours such as anti-selection. However, there are strict rules regarding the type and duration of waiting periods that are imposed on medical scheme members, whereas health insurers have more discretion on the extent to which underwriting is imposed, as well as the type of member to which this applies.

Medical scheme underwriting

There are two types of waiting periods that can be imposed upon medical scheme members:

- General waiting period of up to three months
- Condition-specific waiting period of up to 12 months.

A general waiting period may be imposed when a member joins a medical scheme for the first time; is moving between medical schemes or has had a break in cover. A waiting period cannot be imposed in respect of Prescribed Minimum Benefits ('PMBs') unless there has been a break in cover of more than 90 days.

Waiting periods do not apply to children who are born during the period of membership, a member moving between options on the same medical scheme, or members who transfer to a new medical scheme involuntarily (e.g. an employer changing the medical scheme of their employees).

Condition specific waiting periods may only be imposed if the applicant belonged to a previous medical scheme for less than 2 years.

Medical schemes may waive waiting periods under certain circumstances such as for a large employer group joining the scheme – particularly if membership if compulsory.

Health insurance product underwriting

Waiting periods applied within the health insurance market often vary according to the size and profile of the group, with individuals subject to stricter underwriting that may affect their premium.

Similar to medical schemes, health insurers also implement general and condition specific waiting periods. However, these may vary in length and the extent of cover limits. A review of waiting periods for the health insurers currently exempt from the medical schemes act showed considerable variation in the waiting periods applied.

These are summarised in Table 6 below.

General waiting periods vary between 1 and 3 months, chronic medication 6 and 12 months, maternity between 9 and 12 months and casualty between 3 and 12 months. Although waiting periods should be limited to 12 months

according to exemption conditions, certain health insurers still impose waiting periods of up to 24 months. In addition, certain key conditions such as heart attacks and strokes are excluded completely.

Table 6: Examples of exempt product waiting periods

Applicable services	**Duration**
Acute medication	1 month
Emergency casualty	1 month
Specialist consultations	1 month
General waiting period	1 to 3 months
Basic dentistry	1 to 3 months
Pathology	1 to 3 months
Radiology	1 to 3 months
Doctor consultations	3 months
Emergency dentistry	3 months
Casualty illness	3 months
Hospitalisation	3 months
Pharmacy visits	3 months
Prescribed medication	3 months
Specialised dentistry	3 to 6 months
Myringotomy, adenoidectomy, tonsillectomy, hysterectomy	10 months
Optometry	1 to 12 months
Chronic medication	6 to 12 months
Maternity	9 to 12 months
Cancer	12 months
Casualty accident	12 months
Dread disease	12 months
Gall bladder	12 months
Hysterectomy	12 months
Pre-exiting conditions	12 months
Chronic conditions	24 months

The demarcation regulations stipulate that a general waiting period may not be longer than 3 months and that if a member is replacing a health insurance policy with another similar policy within 90 days, no condition specific waiting period may be imposed for a condition where such a waiting period was already served on the previous policy.

Despite the length of waiting periods applied within the exempted products being similar to that which can be applied in a medical scheme context, there is more flexibility within the context of health insurance products to

apply waiting periods in a greater range of circumstances, and concerningly to the detriment of potentially vulnerable policyholders.

Risk rating vs. community rating

Medical schemes must adhere to the principals of community rating and open enrolment. Open enrolment guarantees that every member wishing to join a medical scheme may do so, while community rating ensures that they will not be discriminated against based on their age, gender or health status. These principles allow for cross-subsidisation between younger and healthier members and older and sicker members, ensuring social solidarity and the protection of a vulnerable sub-population needing access to healthcare.

Health insurers are permitted to offer risk-adjusted premiums. Historically these could be based on age as well as health status, which led to cherry-picking of younger, healthier members and the exclusion of members who needed healthcare services. Following the demarcation regulations, pricing may be age-rated but there may not be any discrimination based on health status.

Prior to the implementation of the demarcation regulations in 2017, many insurers terminated member policies at the age of 65. This practice is no longer allowed, but insurers may charge higher premiums for older members who join. Medical Schemes may also charge higher premiums to late joiners, but prior coverage is taken into account. The late joiner penalties applied to Medical Schemes are shown below, which are also used by several health insurers.

Table 7: Medical scheme late-joiner penalty structure

Years without cover	Penalty
1 to 4	5% of contribution
5 to 14	25% of contribution
15 to 24	50% of contribution
25+	75% of contribution

Several health insurers load premiums when members join after a certain age, regardless of previous cover. Loading is at the discretion of the provider, and the levels and types of loadings are not readily available based on the information provided by the majority of health insurers. Loadings information that was provided ranged from 40% - 48% of contributions for members joining after the age of 65.

The continued ability of the exempted insurers to age rate premiums jeopardises the medical scheme risk pool by incentivising younger (and by implication generally healthier) members to purchase exempted health insurance products rather than medical scheme products. As a result, vulnerable older (and by implication less healthy) members struggle to afford the cover and may therefore be excluded from accessing healthcare cover.

Further to the above, health insurers differentiate premiums by employer groups and individuals, providing discounts to employer groups based on their size and whether membership is mandatory or voluntary. Individual policyholders are prejudiced by these prohibitive pricing structures and given that their claims tend to be higher when compared to a group, the social solidarity principles are biased given their exclusion from participating in the health insurance product range.

Conclusion

The analysis of information provided by those entities currently granted exemptions to offer low-cost Demarcation products has provided justification for this decision through demonstrating that these products are performing poorly in respect of the value provided to policyholders, and are not aligned with the social solidarity principles of healthcare in the same manner as is desired and as is required within the medical scheme industry.

In many cases unfortunately, the information that should have been provided by exempted entities was lacking or of poor quality. This highlights the relatively low levels of regulatory oversight that has been in place in respect of the Demarcation products. This is worrisome in the context of health benefits for a vulnerable lower income group, where there has been limited ability to ensure that the appropriate social solidarity principles are in place.

Where information was available, in many cases the policyholders of these products are receiving less than half of their premiums back in respect of payment of healthcare claims. This is driven primarily by relatively expensive non-healthcare expense models, including costs in respect of commission that significantly exceed those allowed within a medical scheme context. In addition, these products are sold by profit-earning entities which results in an additional source of value extraction.

The risk rating and underwriting approaches employed by the exempted entities, together with the ability to incentivise brokers through attractive commission levels, has allowed the exempted products to cherry-pick young and healthy members from the medical scheme risk pool while, in some cases, making access to care difficult for the most vulnerable population groups.

This has been driven by, for example, the rating of premiums by age, which reduces the cross-subsidy from younger healthier policyholders to the older policyholders most in need of care. Price differentiation between employer groups and individual members further prejudices unemployed members seeking cover. This approach is contrary to the social solidarity principles evident within a medical scheme context and the plans towards National Health Insurance.

The needs of the low-income population remain a priority for CMS and NDoH, and the effectiveness of any health insurance solutions targeted at this group is therefore of critical importance. An analysis of the premium levels for these Demarcation products, that should be filling the need of providing health benefits to these low-income groups, demonstrated that there remains an affordability concern, whereby these products do not fully deliver on their promise of being an affordable alternative.

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