Review of the South African Market for Hospital Cash Plan Insurance

September 2012

FinMark Trust

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1. Executive Summary

Background to the South African health insurance market for low income earners[1]

The funding of health care in South Africa has a long and complex history. Private medical schemes operate as not for profit trusts and pool members' funds to purchase private health care goods and services. The Medical Schemes Act no. 131 of 1998 is the primary legislation governing medical schemes while the Council for Medical Schemes (CMS) is the delegated administrative body with jurisdiction over these schemes. The majority of the income-rated options as considered in this report provide for benefits at 100% of the scheme rate. As this is below the charging rate of many specialists, income rated options often make use of provider networks and designated service provider (DSP) agreements that facilitate payment in full as long as the member makes use of the applicable networks. Consequently, while medical schemes offer greater protection to members, they are also significantly more expensive and are thus inaccessible to the majority of the population, with only 16% of the population currently being members of these schemes.

In addition to health insurance products offered by medical schemes, long- and short-term insurers also offer health insurance products. Long- and short- term insurers are governed by the Long Term Insurance Act no. 52 of 1998 and Short Term Insurance Act no. 53 of 1998, respectively, and their primary administrative body is the Financial Services Board (FSB). The Insurance Acts do not permit them to be involved in the business of a medical scheme. An agreement reached in 2004 between the CMS, FSB and the Life Offices' Association (LOA), the then industry representative body for long-term insurers, saw the release of a demarcation document to provide clarity to all stakeholders on the definition of the "business of a medical scheme" as defined in the Medical Schemes Act. The aim of the demarcation agreement was to protect medical schemes and ensure that the core principles of solidarity and community rating in the medical schemes environment were not undermined by the risk-rated approach of health insurance products.

The provision of health insurance products by long and short-term insurers is relevant to the demarcation issue on two fronts:

1. In response to increasing prices charged by specialists for in hospital services, short-term insurers have developed Gap cover insurance policies which provide for the shortfalls between medical scheme benefits and rates charged by providers. Membership of Gap cover products is limited to members of medical schemes, thereby providing additional cover for

[1] Low income earners are defined for purposes of this report as the LSM 1-6 market and exclude the unemployed and people whose only income is social grants.

those that can afford medical scheme membership but providing no protection for low income earners that are not members of a medical scheme. Profit margins are relatively high, although this has reduced recently as doctors and patients become more acquainted and aware of Gap cover benefits.

The CMS considered Gap cover products to be non-compliant with the demarcation and in 2006 challenged the validity of these products in court. They considered the fact that Gap cover products offered benefits that were directly related to the cost of treatment to mean that insurers offering these products were conducting the business of a medical scheme. The CMS was concerned that these products encouraged buy-down behaviour by enticing younger healthier members to select cheaper medical scheme options and then to "top up" with insurance products to provide more comprehensive cover. This option is not available to all medical scheme members due to the risk rating and underwriting policies of these products and as such could lead to a de-stabilisation of the medical schemes industry by reducing the cross-subsidies from younger to older members or from healthier to sicker members. Although the lower court ruled in favour of the CMS, the Supreme Court of Appeal in 2008 ruled in favour of the insurer based on the interpretation of the medical schemes Act.

2. In addition to Gap cover products, both long- and short-term insurers offer Hospital Cash Plans (HCPs). HCPs are mainly aimed at that part of the market that does not belong to medical schemes and are dependent on public health care services. Public health care services are billed according to a means test and the tariffs for each income category are set out in the Uniform Patient Fee Schedule (UPFS). Only certain groups (unemployed, those receiving social grants) receive free care while those in higher income categories pay proportionally higher fees with those earning in excess of R6,000 per month (individual income) being charged in full. The result is that charges can be significant for low income earners. These costs, together with the related costs of a health event such as transport, accommodation and lost income, can result in significant out of pocket expenditure.

   Under HCPs, premiums are dependent on age and cover level. While hospitalisation is generally the trigger for payout, compensation is unrelated to the cost of the health services but is instead a lump sum benefit based on number of days hospitalised and in some cases type of care. HCPs generally provide cover of between R250 per day and R5,000 per day for premiums of between R100 and R450-R850, respectively. Some HCPs also contain add-ons like disability insurance, cash-back and the like. Given that the payout under HCPs is unrelated to the cost of care, insurers are unable to confirm how these payouts are spent (on covering direct health expenses, on indirect expenses like transport or convalescence, or as a

windfall). It is possible that they are used in many cases to defray the costs of health care, most likely at a public facility.

The effectiveness of HCPs in meeting the cost of health care

The purpose of this paper is to analyse the effectiveness of HCPs in meeting the cost of health care for low income-earners. There are estimated to be between 1 million and 1.5 million policies in effect, with total lives covered estimated to be 27% of those covered under medical schemes, or 2.4 million people. The majority of policyholders are in the LSM[2] 4-7 brackets[3], and more than 55% of HCP beneficiaries are concentrated between the ages of 20 - 40 years. There are between 30 and 40 insurers providing HCPs, versus 99 medical schemes and between 15 and 20 Gap cover providers. While the benefits of a HCP are not comparable to those of a medical scheme, low-income South Africans would likely have no alternative product which they could access due to affordability constraints.

HCP products are less expensive than the cheapest open income-rated medical schemes for most ages and cover levels. The reason for the relative affordability of HCPs is that they have significantly lower benefit levels. HCPs also apply relatively light underwriting conditions, this due to the relative expense of underwriting at such low premium levels.

Our analysis in this paper illustrates that HCPs are able to offer some form of protection against both direct and indirect costs to low income (less than R 6,000 per month) earners that make use of public facilities even at benefit levels as low as R 500 or R 1,000 per day. At income levels as low as R 3,000 per day the higher relative state subsidy would imply that these products would be even more beneficial.

Suppliers' perspective

From a medical schemes perspective, one of the key concerns regarding the HCP market is the risks posed to medical schemes, but while HCPs are significantly less expensive, even high benefit cover levels of R 3,000 to R 5,000 do not come close to covering private sector hospital costs in the same manner as medical scheme products do. Considering that the majority of HCP policyholders also have lower levels of cover (70% to 80% of the market are believed to fall below R 1000 per day), the

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[2] LSM refers to the Living Standards Measure as developed by the South African Advertising Research Foundation (SAARF) and is the most widely used tool for categorising the South African population.

[3] According to the FinScope South Africa survey 2012, the average personal monthly income for the LSM 4 category is R975 and that for LSM 7 is R4080, implying that the current user base would be people earning roughly in these bands. Note, however, that the LSM categorisation is not drawn up on an income basis, but reflects various socio-economic variables including asset ownership and geographical spread.

current marketing and disclosure requirements as well as the required up front lump sum deposits required for an uncovered individuals to attend a private facility, it is highly unlikely that the average HCP product offering in this market would be able to draw members away from medical schemes.

As for HCP writers, the market is relatively large and rapidly growing with an estimated 50,000 new policies sold every month. Products seem to be profitable with risk costs assumed to be between 20% to 35% of the total premium and, while lapse rates and initial expenses can be high (20% - 30% first year lapses), this is not out of the ordinary compared to other short term insurance products. Underwriting costs and fraud represent a challenge to this industry and, with limited sharing of information and institutional market data available, this is likely to remain a key concern.

The future of HCPs

As a direct (if delayed) response to the aforementioned court case, on the 2nd of March 2012 the National Department of Health in conjunction with the CMS and FSB released a discussion document for public comment outlining a proposed revised demarcation between medical schemes and health insurance providers. The proposed revised demarcation sets out the changes to the Long Term Insurance Act and Short Term Insurance Act that would directly impact all existing health insurance products. In particular, the demarcation provides that the benefits of health insurance products cannot be related to the cost of treatment (this is not a change per se but rather a re-emphasis and clarification) and that daily HCP benefits are to be capped at 70% of daily income (net of tax) of the policyholder. It further provides for underwriting for health insurance products.

While the majority of HCPs provide benefits that are unrelated to the cost of care and thus would not be significantly impacted by the first requirement, Gap cover products certainly would be. More worrying for low income earners, is the negative effect the cap on daily cash benefits to 70% of the policyholder's income will have on the value that these products are able to offer. While it appears that an attempt is being made to reclassify HCPs as income replacement with the proposed cap being introduced to prevent fraud, our analysis shows that at a monthly salary of under R3,000, the cap would limit daily benefits to a maximum of R105 while at income levels of between R3,001 and R6,000 the cap would limit daily benefits to a maximum of R210. The effect is that these products will be unable to defray the costs of either direct or indirect medical expenses for hospitalisation at state facilities, making them unattractive to low income earners. Further, in order to provide daily cover of over R2,000, a person would need to earn over R57,100 per month while for daily cover of R5,000 income of R142,850 per month would be required. People in these income brackets would be able to afford medical cover, so that there would be little market for HCPs at either the low or higher income levels.

The proposed National Health Insurance (NHI) may also reduce the need for HCPs in that one of the proposals is that patients will not be required to pay for services at the point of treatment. While this is subject to debate, if there are no user fees this would significantly decrease the potential out of pocket burden faced by patients, and in turn decrease the need for HCPs. Similarly, if no co-payments are required for health care services, the need for Gap cover products is limited. The shape that NHI will take is still unclear and rollout may be protracted.