



ACTUARIAL SOCIETY
S O U T H A F R I C A

Loss-making / self-supporting options and section 33(2)(b) of the Act

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WHY BOTHER

DECAF

Community rating



Open enrolment

PMBs



Revised PMBs

PMB reimbursement

Income cross-subsidies

Risk equalisation

LCBOs

RBC

Mandatory cover

Inter-scheme Risk Equalisation

Between schemes

Intra-scheme Risk Equalisation

Between options



MUTUALITY AND SOLIDARITY IN HEALTHCARE IN SOUTH AFRICA

By HD McLeod

ABSTRACT

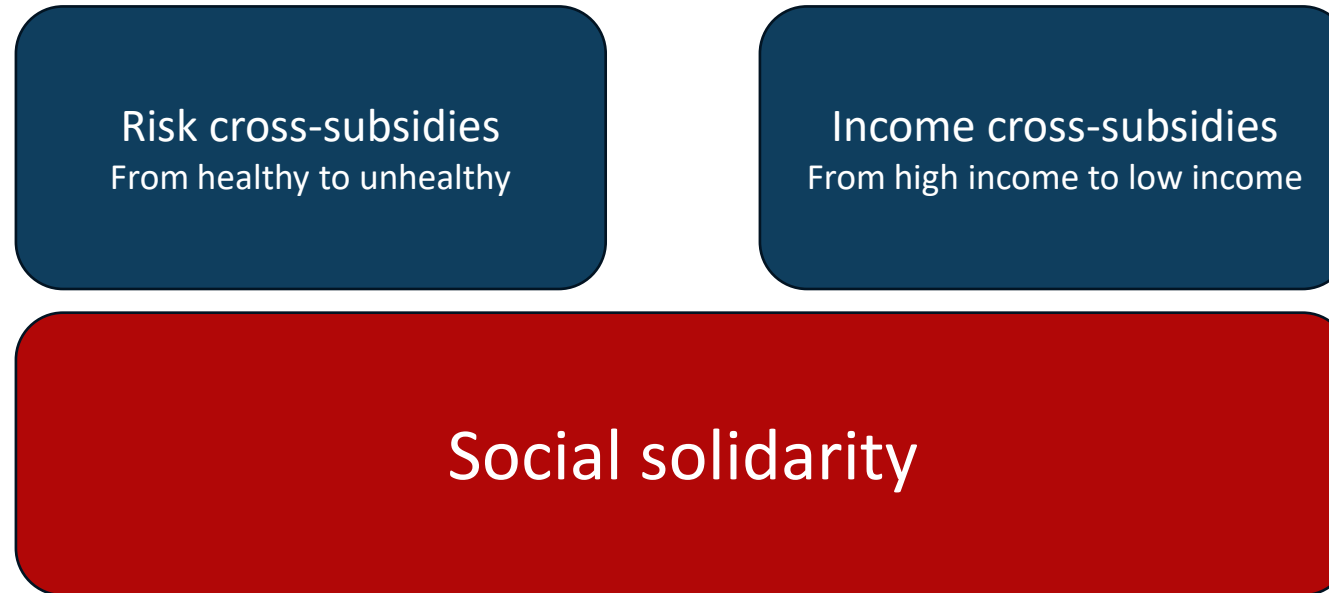
This paper uses Wilkie's definitions of mutuality and solidarity to review the history of private healthcare in South Africa. The vision for a future unified national healthcare system is given and the phases of reform are outlined. The first phase of reforms has been completed and these are contextualised in terms of a return to solidarity principles. The elements of a planned social health-insurance system are described and it is shown how income cross-subsidies will further entrench the principles of solidarity. In the past, healthcare actuaries largely supported mutuality principles. The implications for the actuarial profession are suggested.

Community rating

Section 29(1)(n) – premiums to vary only based on family size and income



Social solidarity is enshrined and embodied in the Act



Community rating

Section 29(1)(n) – premiums to vary only based on family size and income



Section 33(2)

CHAPTER 6 BENEFIT OPTIONS

33. Approval and withdrawal of benefit options.—(1) A medical scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.

(2) The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option—

(a) includes the prescribed benefits;

(b) shall be self-supporting in terms of membership and financial performance;

(c) is financially sound; and

(d) will not jeopardise the financial soundness of any existing benefit option within the medical scheme.



Intention of the legislature?

Section 29(1)(n)

Community rating
And income-rated contributions

Regulation 4(2)

Freedom of movement
between options

Section 33(2)

Self-“supporting” options

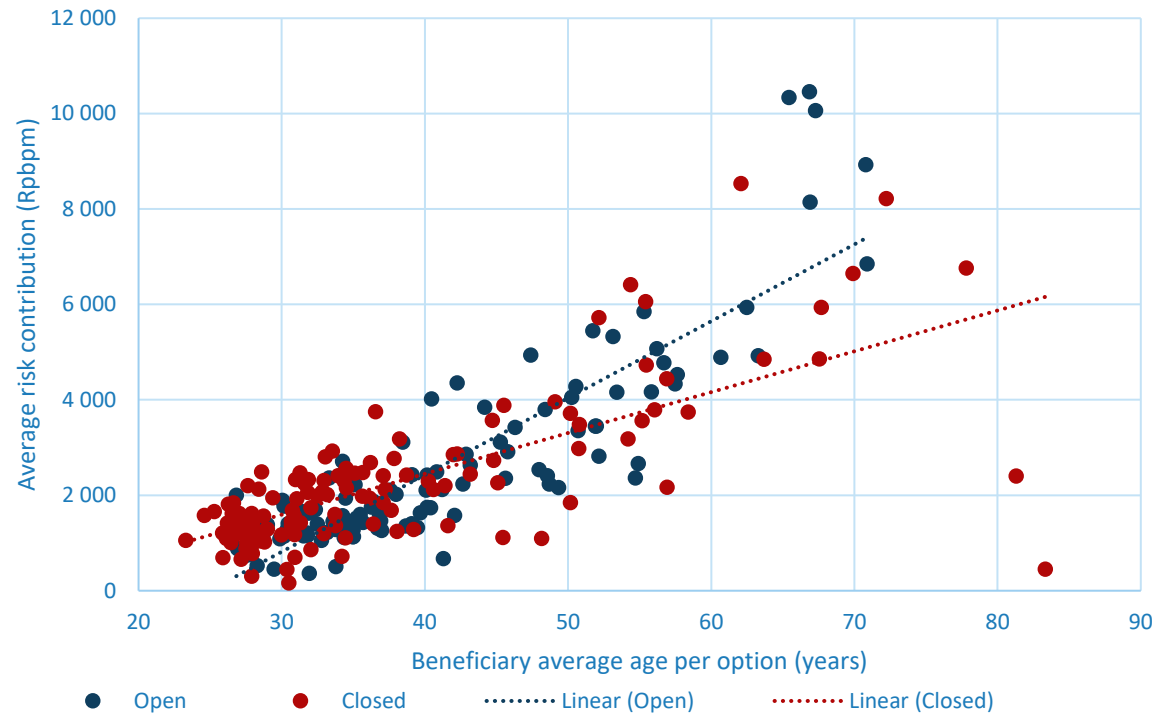
Legislature assumed that risk is one of many factors that will determine your choice of option.
For example, risk aversion was anticipated to play an equal role (“worried healthy”).

After 25 years under the new Act, it is clear with hindsight that option choice is progressively done only based on risk.

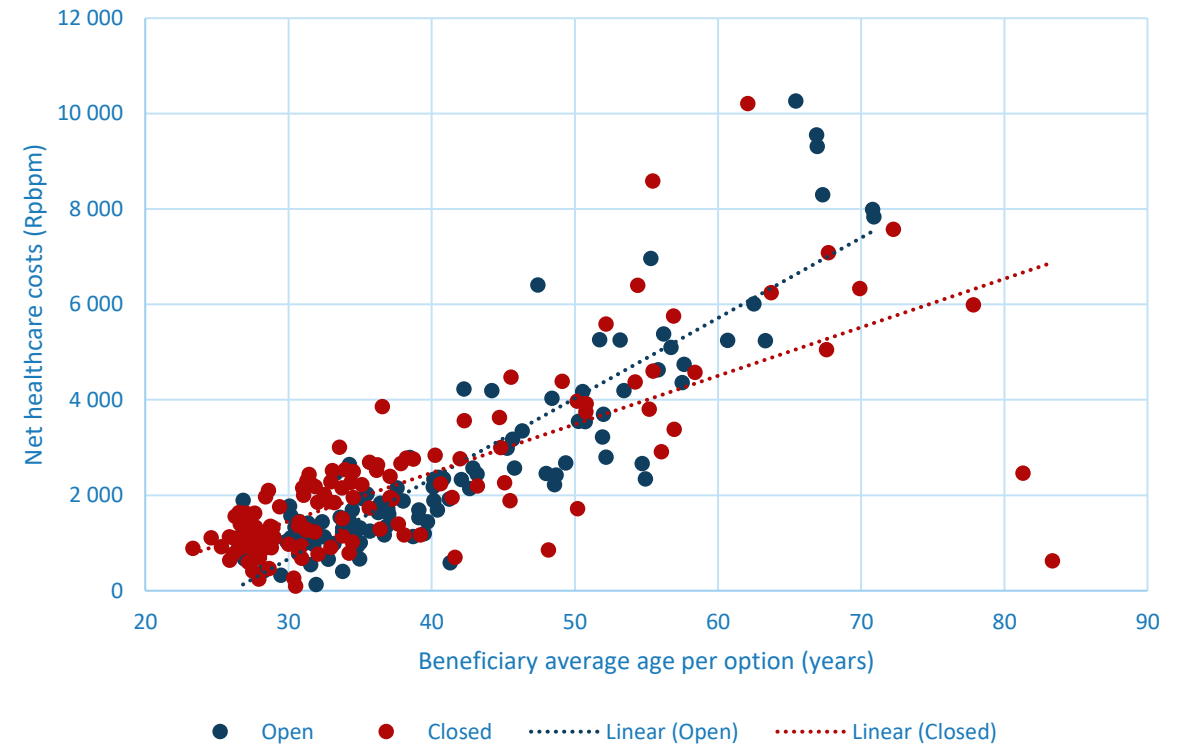


Significant age vs cost differentiation across options

Average age vs risk contributions

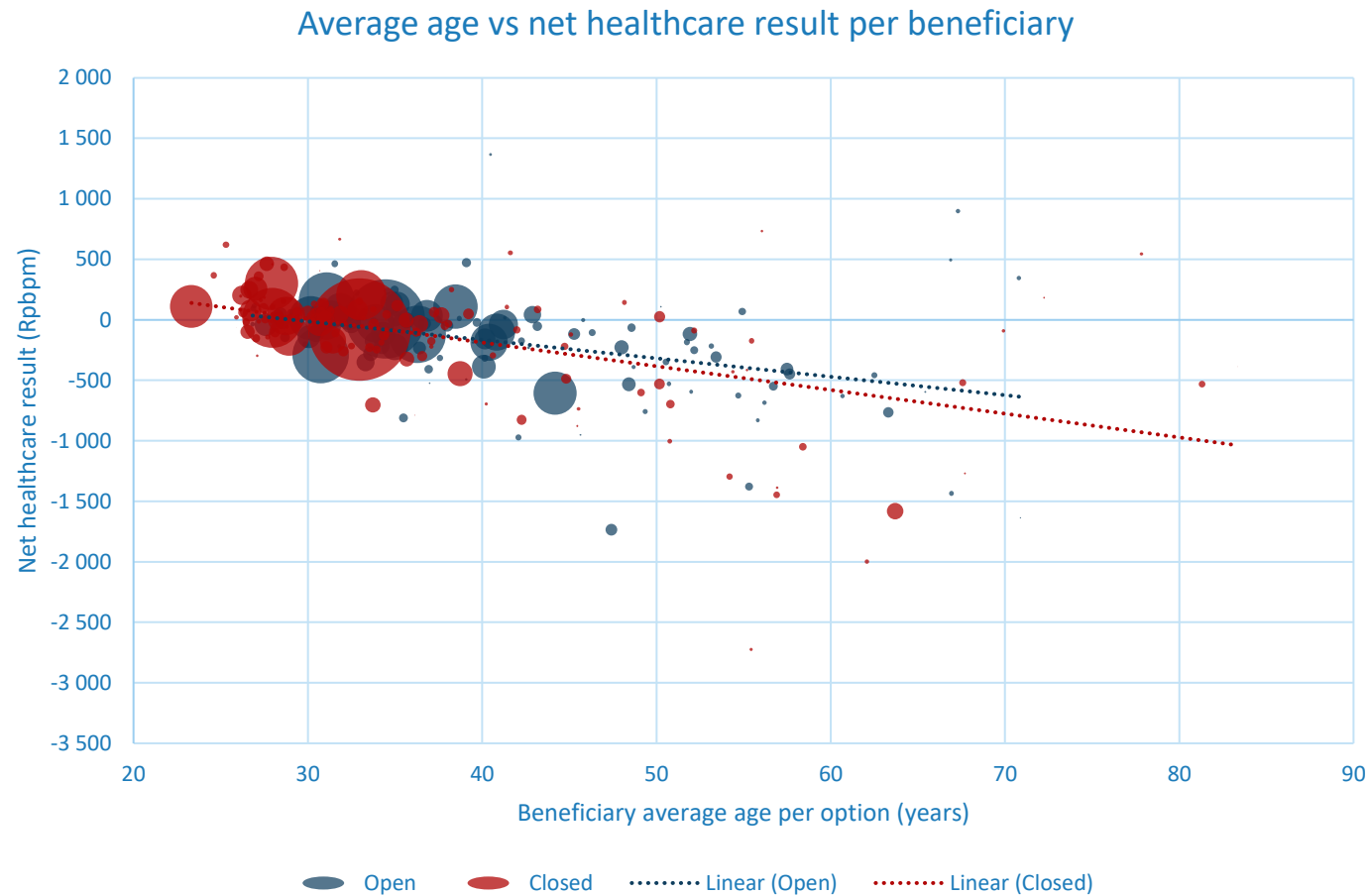


Average age vs net healthcare cost

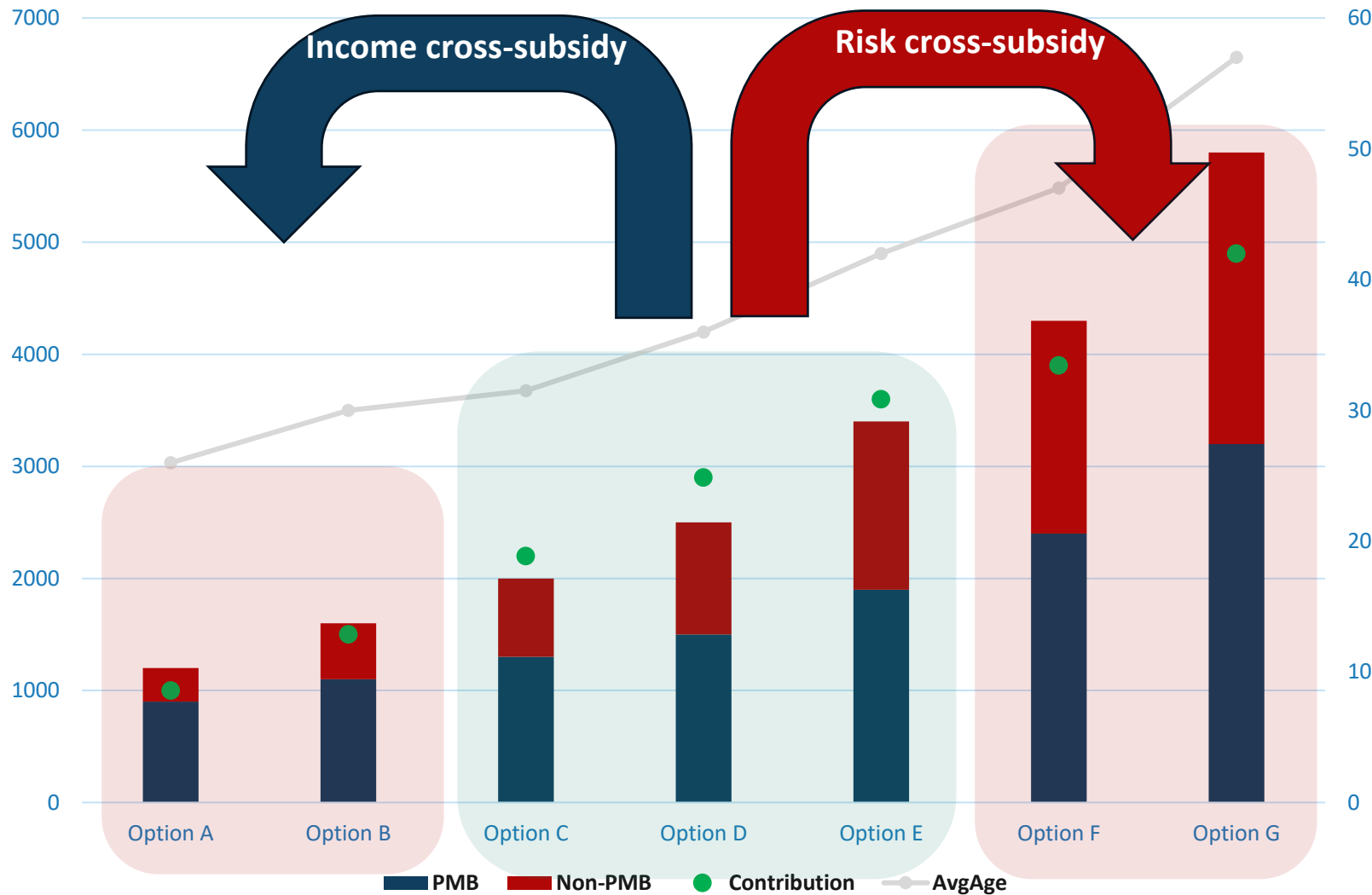




Older options are smaller, more expensive, and loss-making



Typical multi-option scheme (generalisation)



Commonly observed:

- Loss-making low-end options
due to income cross-subsidy
- Loss-making comprehensive options
due to risk cross subsidy

Fundamentally incompatible
with a literal interpretation of
section 33(2)(b)

Typical multi-option scheme (generalisation)



Spirit of the Act

Non-discrimination
Section 29(1)(n)
Regulation 4(2)

INCOMPATIBLE

Letter of the Act

Section 33(2)
Active indirect discrimination

The legislature never anticipated that members would select options based on risk profile

The legislature anticipated that income bands rather than targeted low-income options would be used as a means of facilitating income cross-subsidies



Implication of literal “surplus-making” interpretation

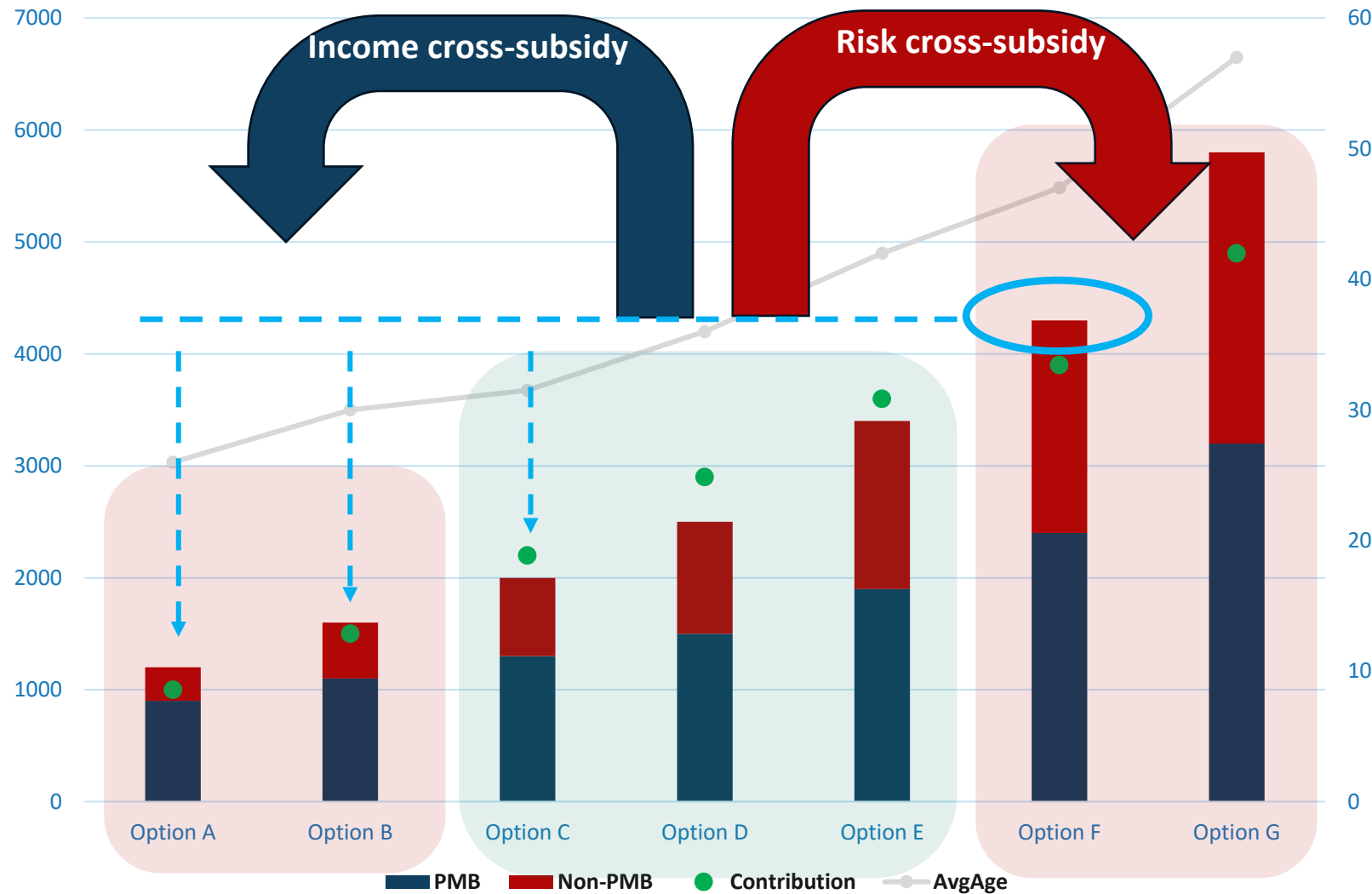
Literal enforcement of 33(2) to imply “self-supporting” must require “surplus-making” is leading to **discrimination based on state of health**

High risk patients (chronic, oncology, dialysis, etc) are required to share risks with other similarly high risk patients

This due to the legislature having failed to foresee that members will select options mainly based on their state of health

What is needed is not an amendment of the Act or Regulations, but a reconsideration of the interpretation of the existing requirements

Unintended consequences of risk segregation

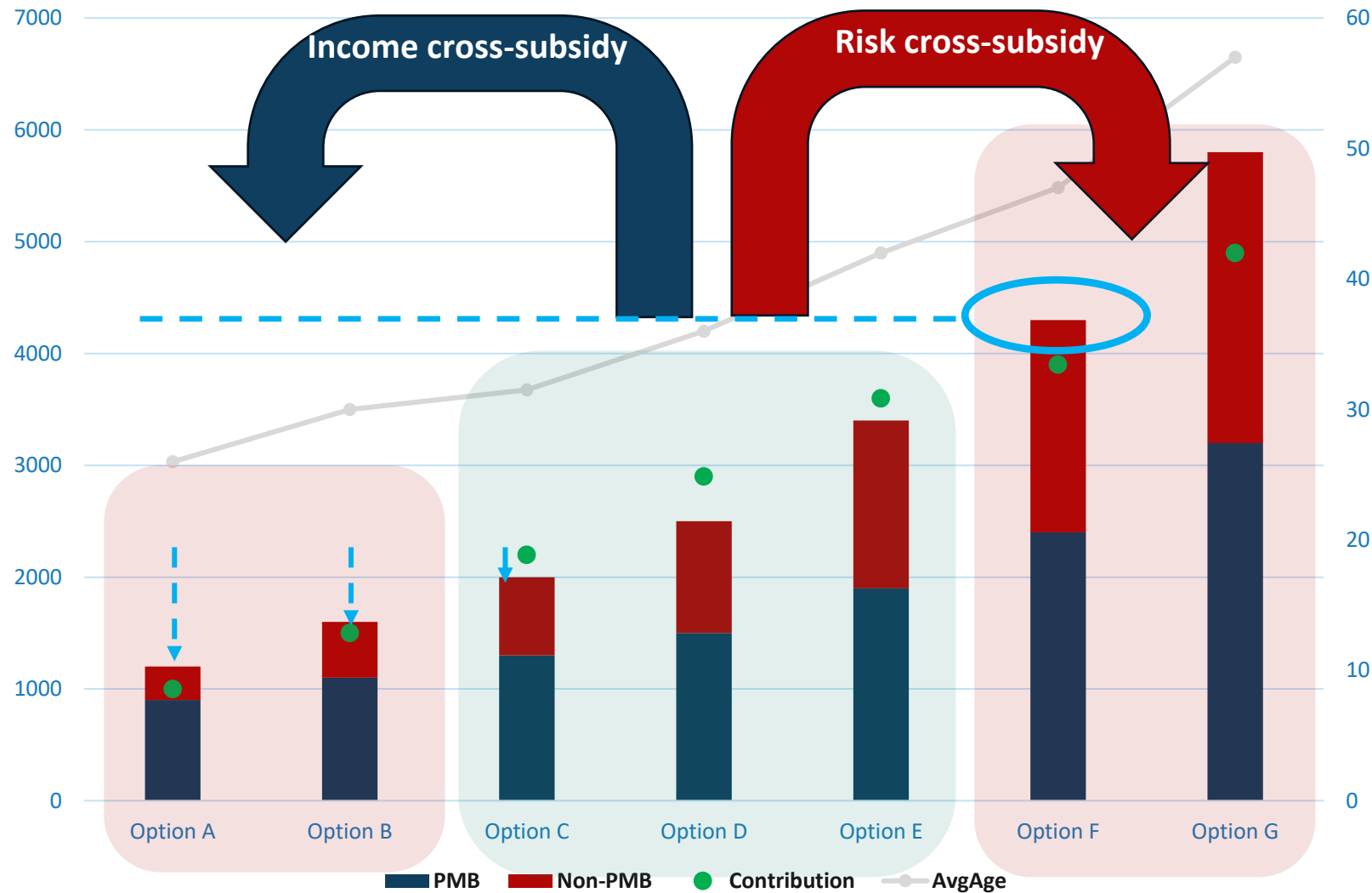


Informed and rational consumer in option F should downgrade to A/B/C/D and pay the difference out of pocket

This could compromise the sustainability of eg option C and its ability to attract good risk and continue to cross-subsidise, ironically, option F

This position is exacerbated if option F must increase its contributions to make surpluses

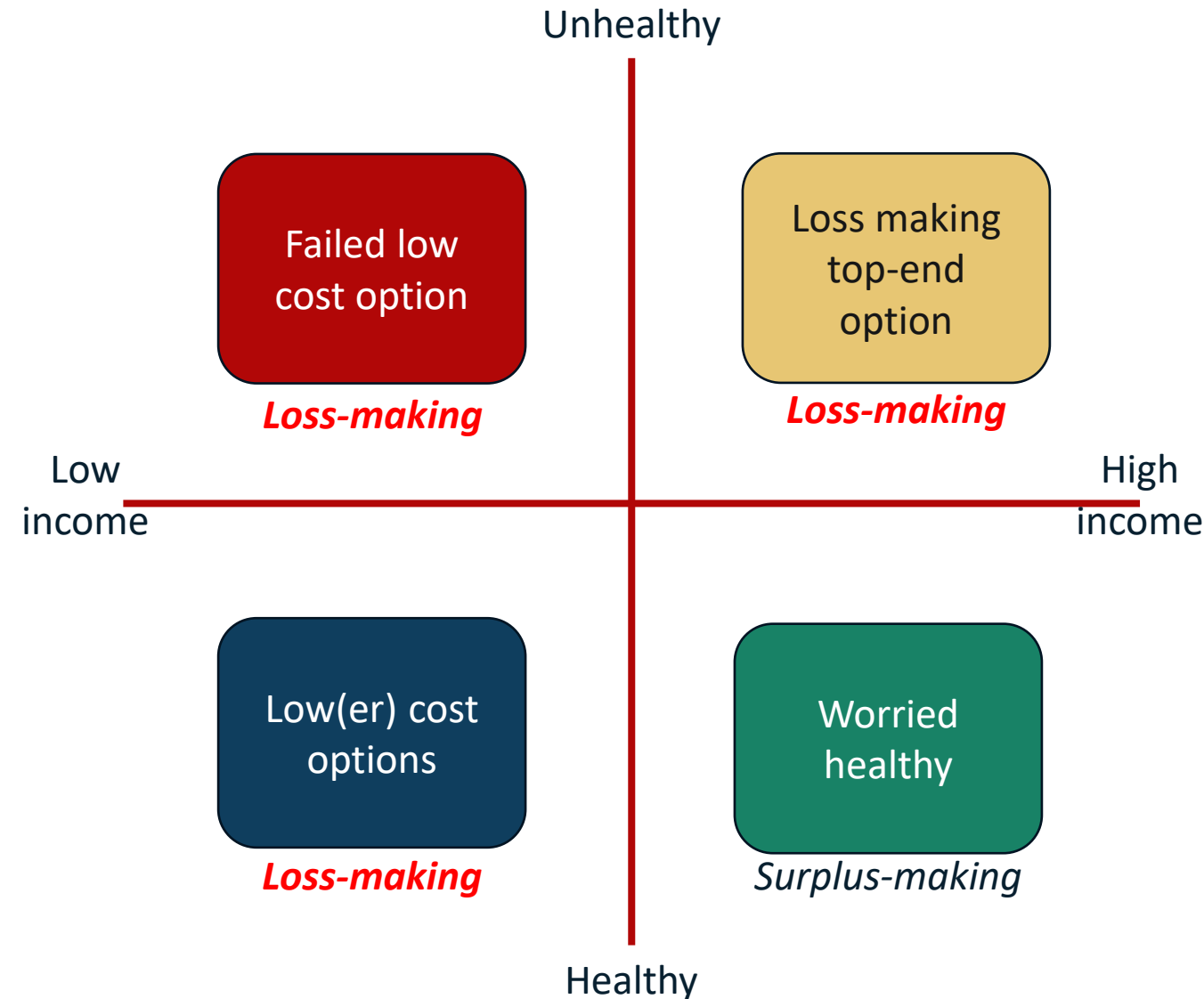
Unintended consequences of risk segregation



Alternatively, could option F reduce its benefits?

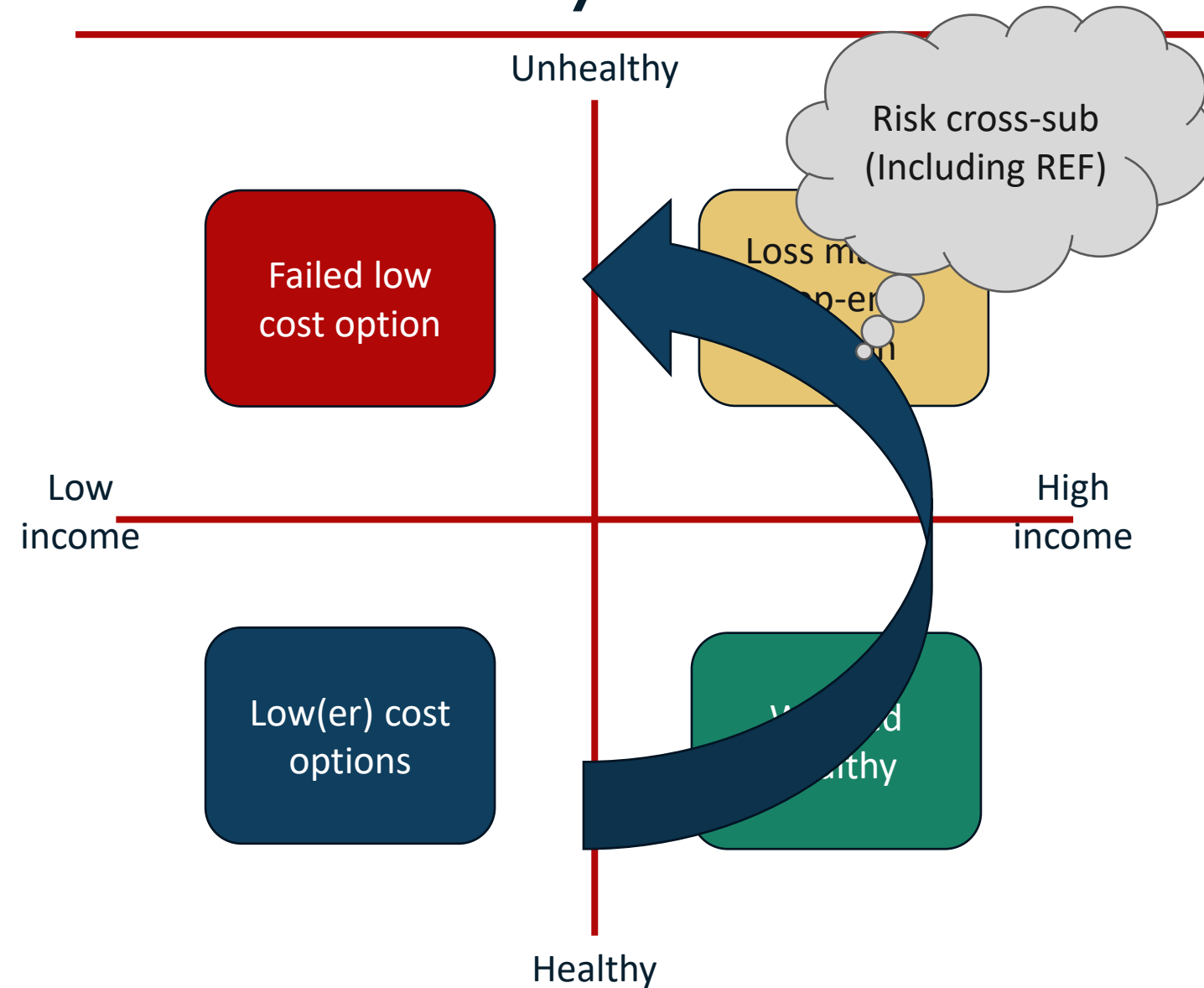
Even if benefits are cut all the way to PMB-only level, it would remain more expensive than A,B,C despite the fact that those offer non-PMB benefits as well.

Risk segregation as a means to offer diverse pricing



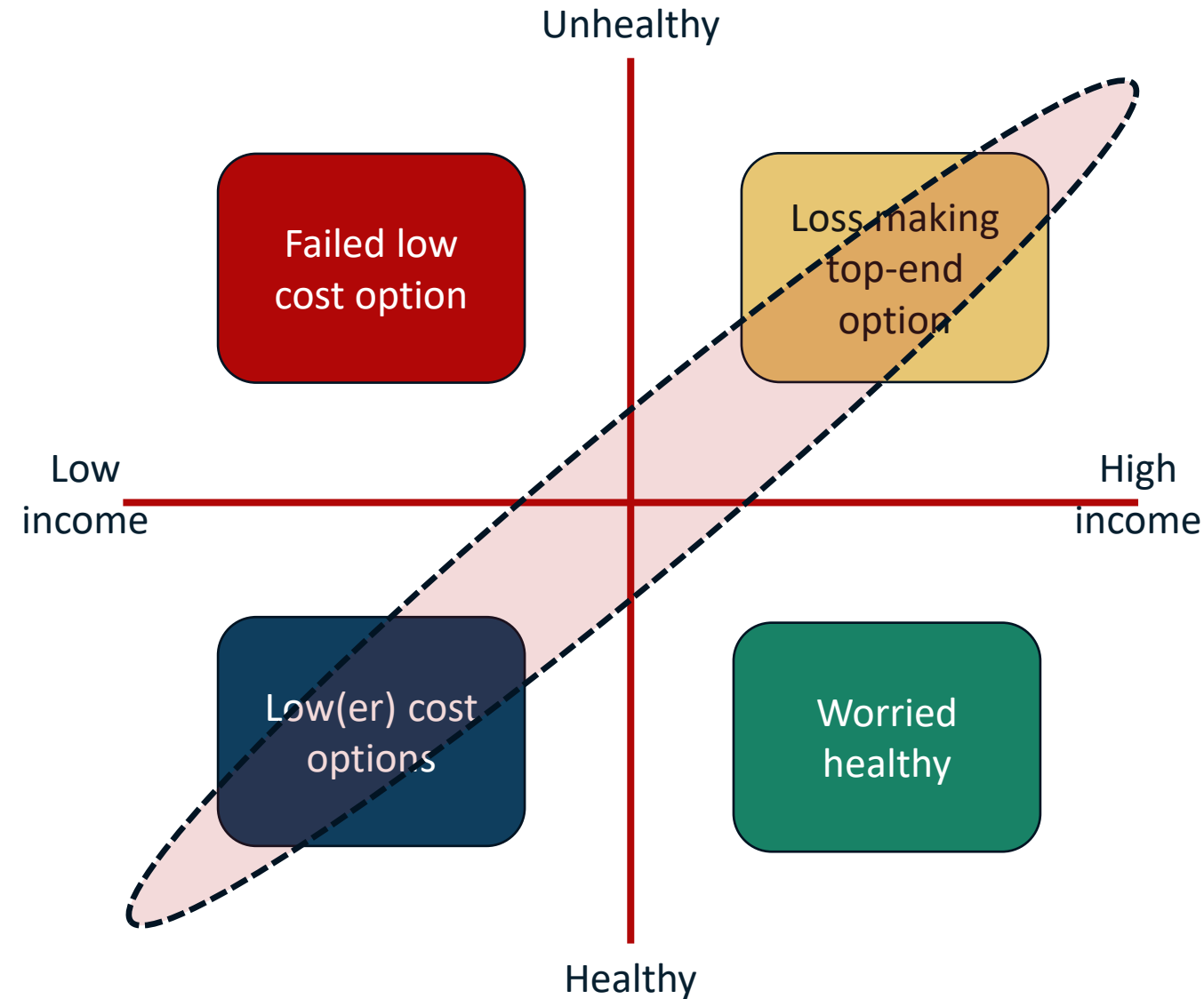
1. Schemes can attract young and healthy lives by designing options targeted at lower income, healthier lives. Risk-segregation required, which is difficult to achieve.
2. Quite often, these options fail when the “wrong risk” selects them
3. Surpluses in medical schemes arise when members select more comprehensive options than required – “worried healthy”. This requires fearful or uninformed consumers
4. As members select against more comprehensive options, these become less attractive to healthy leaving a loss-making comprehensive option

Income elasticity of demand?



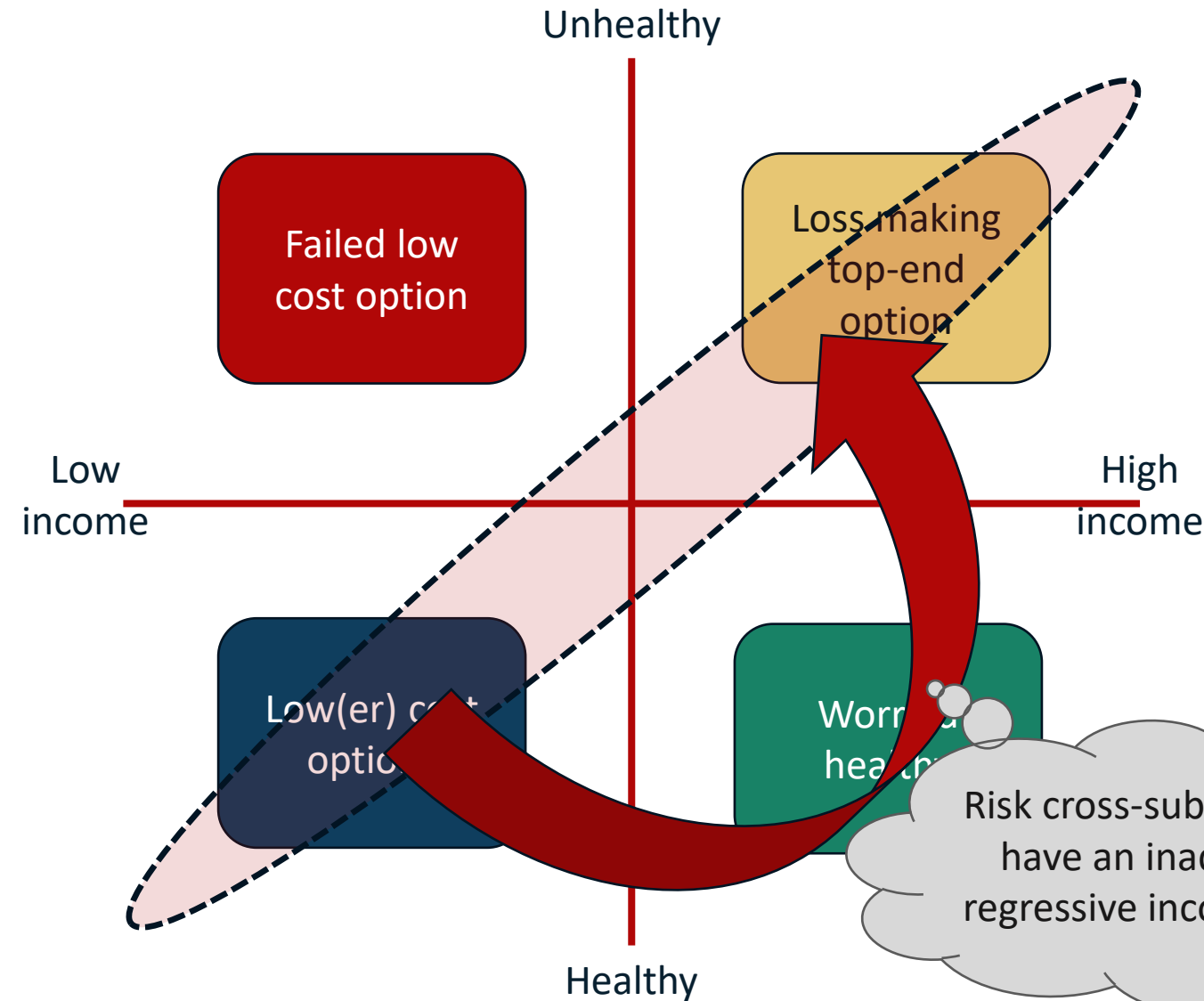
1. Risk cross-subsidies should cross-subsidise from the bottom to the top quadrants

Income elasticity of demand?



1. Risk cross-subsidies should cross-subsidise from the bottom to the top quadrants
2. Income-elasticity of demand suggests that higher income lives may claim more, and thus potentially appear less healthy, creating a relationship between income and risk

Income elasticity of demand?



1. Risk cross-subsidies should cross-subsidise from the bottom to the top quadrants
2. Income-elasticity of demand suggests that higher income lives may claim more, and thus potentially appear less healthy, creating a relationship between income and risk
3. **Attempts to cross-subsidise risk could therefore inadvertently also result in cross-subsidisation from low income to high income**



Does the Act allow for “appropriate” cross-subsidies?

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- (a) includes the prescribed benefits;
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- (c) is financially sound; and
- (d) will not jeopardise the financial soundness of any existing benefit option within the medical scheme.

“Self-supporting” vs “surplus making”

Risk of jeopardising the financial soundness of any existing benefit option if “surplus-making” is enforced

Income-cross subsidies are allowed for within an option, but should also be allowed for across options – clear intention of spirit of the Act.

Members belong to a scheme, not an option. Regulation 4(2)



Appropriate cross-subsidies – illustrative 2-option scheme

	Option A	Option B
Contributions	3831	1602
Claims	3916	894
Result	-85	708

Deficit (even on a gross level)

PMBs	Option A	Option B	Total
Contributions	1349		
Claims	1813	628	1349
Result	-464	721	

Deficit of up to R464 PLPM may be “appropriate” based on profile / common benefits

Non-PMBs	Option A	Option B
Contributions	2482	253
Claims	2103	173
Result	379	80

Non-PMB benefits are in fact “self-supporting”



Appropriate cross-subsidies – illustrative 10-option scheme

	Option A	Option B	Option C	Option D	Option E	Option F	Option G	Option H	Option I	Option J	
Contributions	2 119	6 427	1 257	1 486	2 340	3 833	2 682	5 080	5 399	8 143	
Claims	2 417	5 748	1 100	1 352	2 131	3 546	2 313	4 991	5 079	8 430	
NHE	238	291	168	175	188	176	163	228	221	264	
Result	-537	388	-11	-40	20	111	206	-138	99	-550	
PMBs	Option A	Option B	Option C	Option D	Option E	Option F	Option G	Option H	Option I	Option J	Total
Contributions	1 108										
Claims	1 701	3 497	1 003	788	1 124	1 484	988	2 112	2 092	2 695	1 108
Result	-593	-2 389	105	320	-15	-376	120	-1 004	-984	-1 586	
Non-PMBs	Option A	Option B	Option C	Option D	Option E	Option F	Option G	Option H	Option I	Option J	
Contributions	1 011	5 319	149	378	1 232	2 725	1 574	3 972	4 291	7 035	
Claims	716	2 251	97	564	1 008	2 062	1 325	2 879	2 987	5 736	
Gross Result	295	3 068	52	-186	224	663	249	1 093	1 304	1 300	
NHE	238	291	168	175	188	176	163	228	221	264	
Net Result	56	2 777	-116	-361	36	487	86	865	1 083	1 036	

Potential income cross-subsidy justification?



Investment income, reserve use

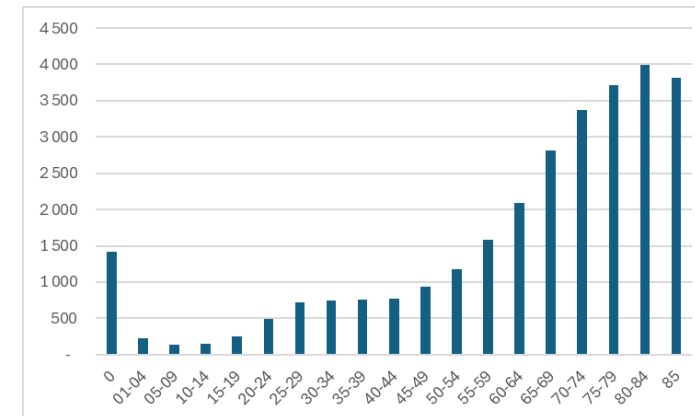
- High investment income sufficient cause for losses
- “Reserve shedding” could also be considered
- Added a model to consider
 1. Annual “reserve strain” if current reserves were to be maintained
 2. Annual “reserve strain” if 25% should be targeted
- “Reserve strain” = aggregate contribution increase minus other sources of income, multiplied by targeted solvency

Income cross-subsidy

- May require separate socio-economic justification

PMB identification

- Administrator coding often problematic
- SRMS cost curve as a potential proxy



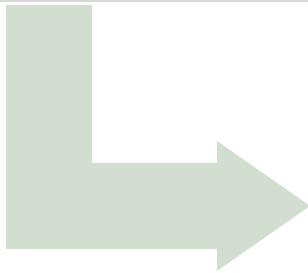
Latest statutory returns PMB cost curve

Is the option
surplus-making?



If not, is the cross-
subsidy less than an
“appropriate” PMB
cross-subsidy?

- Consider how PMBs are identified
- Use community-rated PMBs across options



Take account
investment income
and reserve strain

- Reserve strain calculated to *maintain* reserves at current levels



If not, at reserve
strain required to
maintain 25%?

- Reserve strain required to aim for 25% reserves
- Could enhance this to aim for RBC level

Four layers of testing “self-
supporting” requirement

...And, finally, to
what degree is this
justified as an
income-based
cross-subsidy?

Reserve strain =
(Aggregate contribution increase (R'amt)
minus other sources of income)
x (targeted solvency %)

Health Squared medical scheme



		Literal surplus	Profile adjustment	Profile + current reserve strain	Profile + 25% reserve strain
Health Squared Medical Scheme	Prosper				
Health Squared Medical Scheme	Optimum				
Health Squared Medical Scheme	Rise				
Health Squared Medical Scheme	Cobalt				
Health Squared Medical Scheme	Foundation				
Health Squared Medical Scheme	Aspire				
Health Squared Medical Scheme	Flex				
Health Squared Medical Scheme	Ultimate				
Health Squared Medical Scheme	Millennium				

Using this approach, none of the HSMS options in 2022 show up as making appropriate or justifiable losses



Caveats

1. PMB identification remains tricky.
 2. Common benefits may exceed PMBs.
 3. Some risk cross-subsidy for non-common benefits may be justifiable.
 4. Not all PMBs are equal. Allowing for networks or EDOs is possible, but complex.
 5. Income cross-subsidies must be separately justified based on external socio-economic data.
 6. Need to aim for something that is pragmatic, implementable, enforceable.
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Conclusion

1. Conflict between the spirit and letter of the Act
 2. Literal enforcement of s33(2) results in discrimination based on state of health
 3. Literal interpretation of “self-supporting” as “surplus-making” is contrary to the spirit of the Act and the community rating principle. Also impedes cross-subsidies from higher income options to lower income options.
 4. The relationship between risk cross-subsidies and income cross-subsidies is complex, partly due to income elasticity of demand (higher income -> higher claims, not necessarily indicative of state of health)
 5. It is possible to equip the regulator with a framework that can reasonably adjudicate appropriate risk cross subsidies by separating PMBs from non-PMBs
 6. Income cross-subsidies must be super imposed over these, and may require justification from external socio-economic data
 7. Perfect is the enemy of good
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