



QUANTIFYING RISK, ENABLING OPPORTUNITY

Exploring the impact of option consolidation

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Agenda

- **Current landscape**
- **Scope of consolidation**
- **Why the consolidation drive?**
- **Consolidation past, present, future?**
- **Impact scenarios**
- **Proposed approach**

Industry narrative

NHI White Paper

“...consolidated from the current 323 benefit options in 83 schemes to one option per scheme”

Registrar & CMS

BHF 2017: Dissolve 29 schemes in Jan 2018 that do not meet membership criteria as per MSA

“Consolidation is part of the fundamental restructuring of the sector in preparation for the NHI”

“Schemes covering state employees will be consolidated into one scheme”

2018 option underwriting deficit: inconsistent with Section 33(2)(c) & (d) of MSA

Media

“Medical scheme body presses on with consolidation draft plan”

Draft consultative framework on consolidation expected June 2018

Medical scheme consolidation



Scope of medical scheme consolidation

Small schemes/options < 6000 members

– Regulation 2(3)



“Loss-making” options

– Section 33(2)(c) & (d)

Civil servants risk pool

– GEMS, Polmed, Parmed, SAMWUMed, & Transmed

Other options & schemes

- 1 option per scheme
- 2 or 3 private supplementary schemes ?

Making sense of the consolidation drive

Regulatory view

Reduce fragmentation

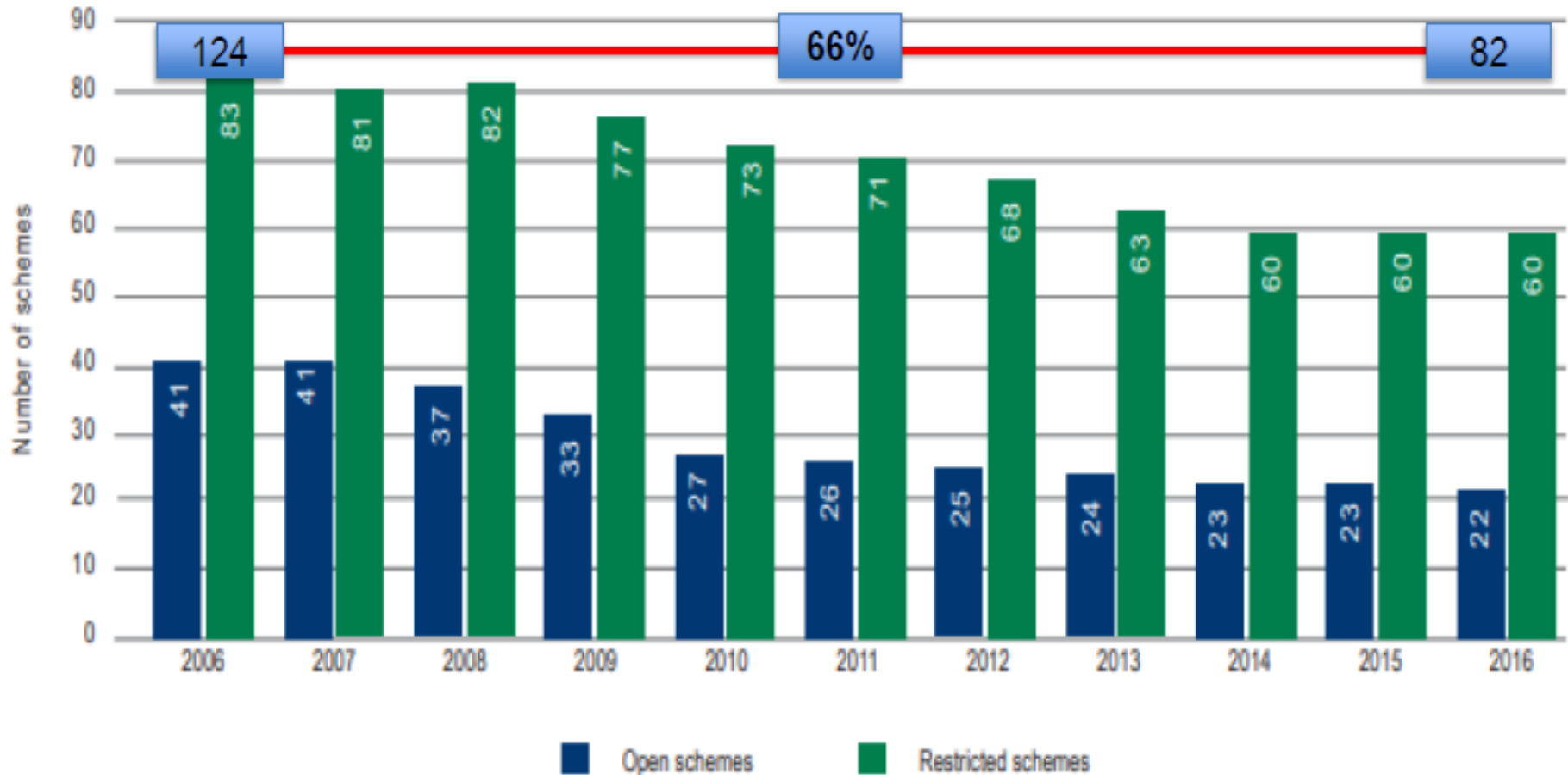
Maximise income and risk cross-subsidisation

Lower costs

Enhanced implementation of social solidarity principles?

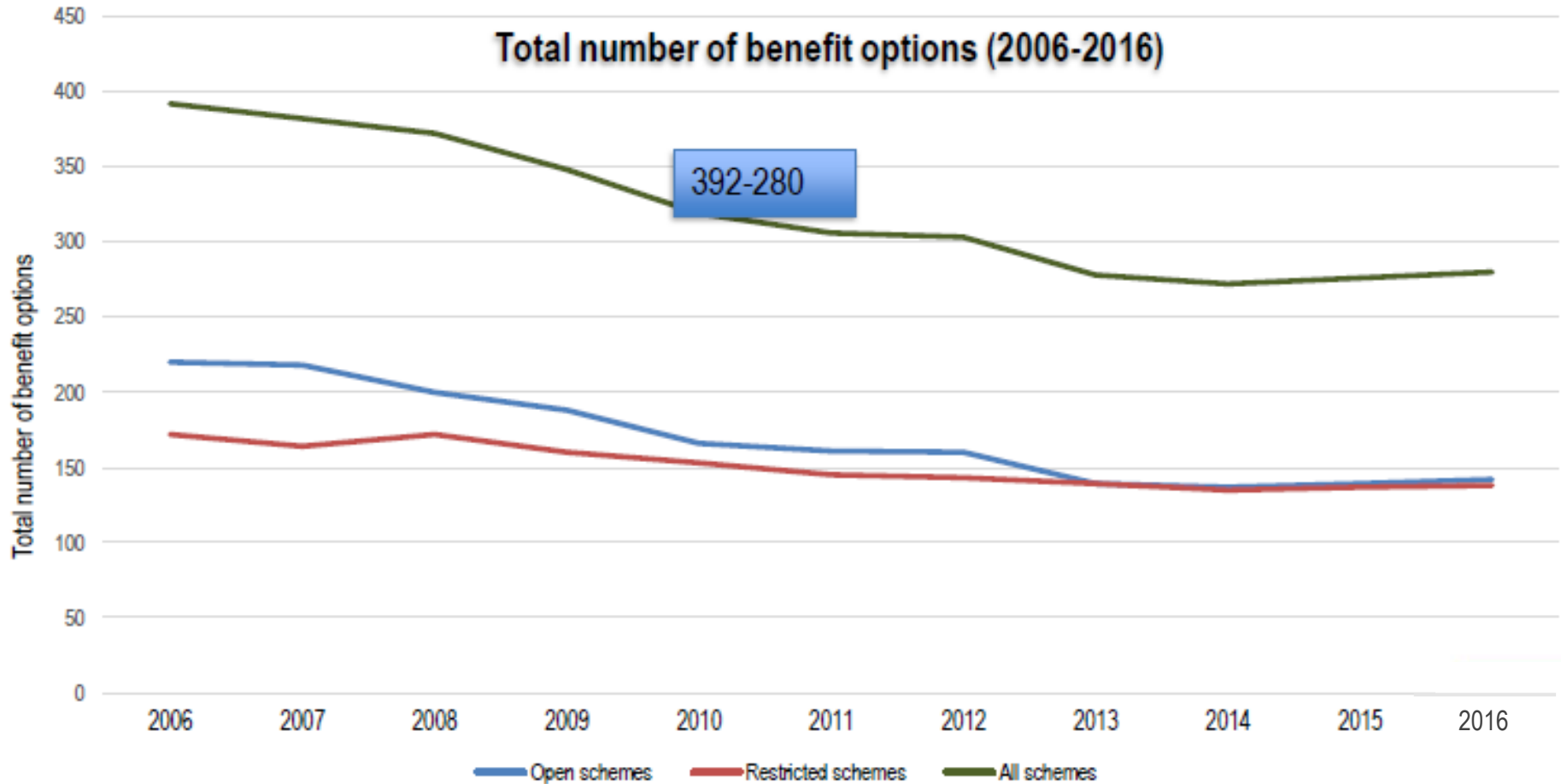
Ease of transition to NHI?

Consolidation to date



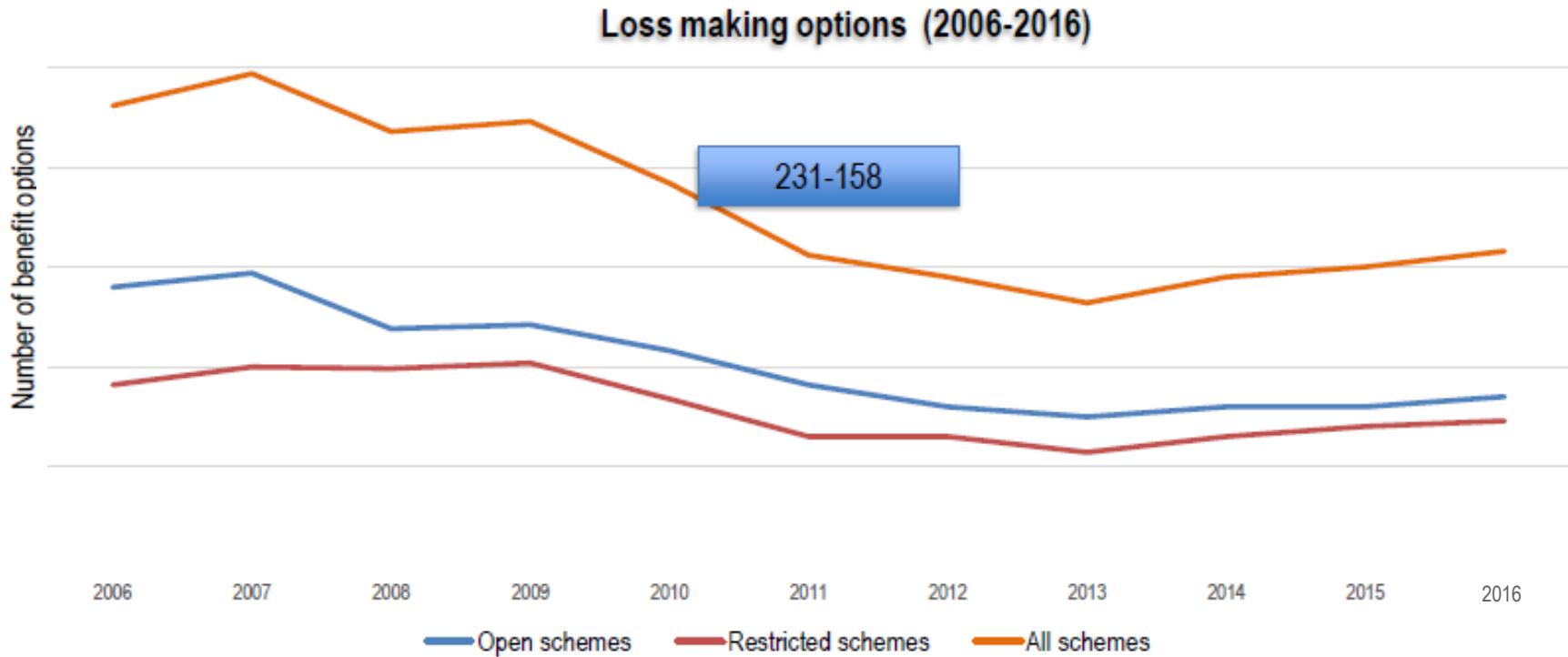
Source: CMS

Consolidation to date



Source: CMS

Consolidation to date



Source: CMS

Schemes with membership < 6000

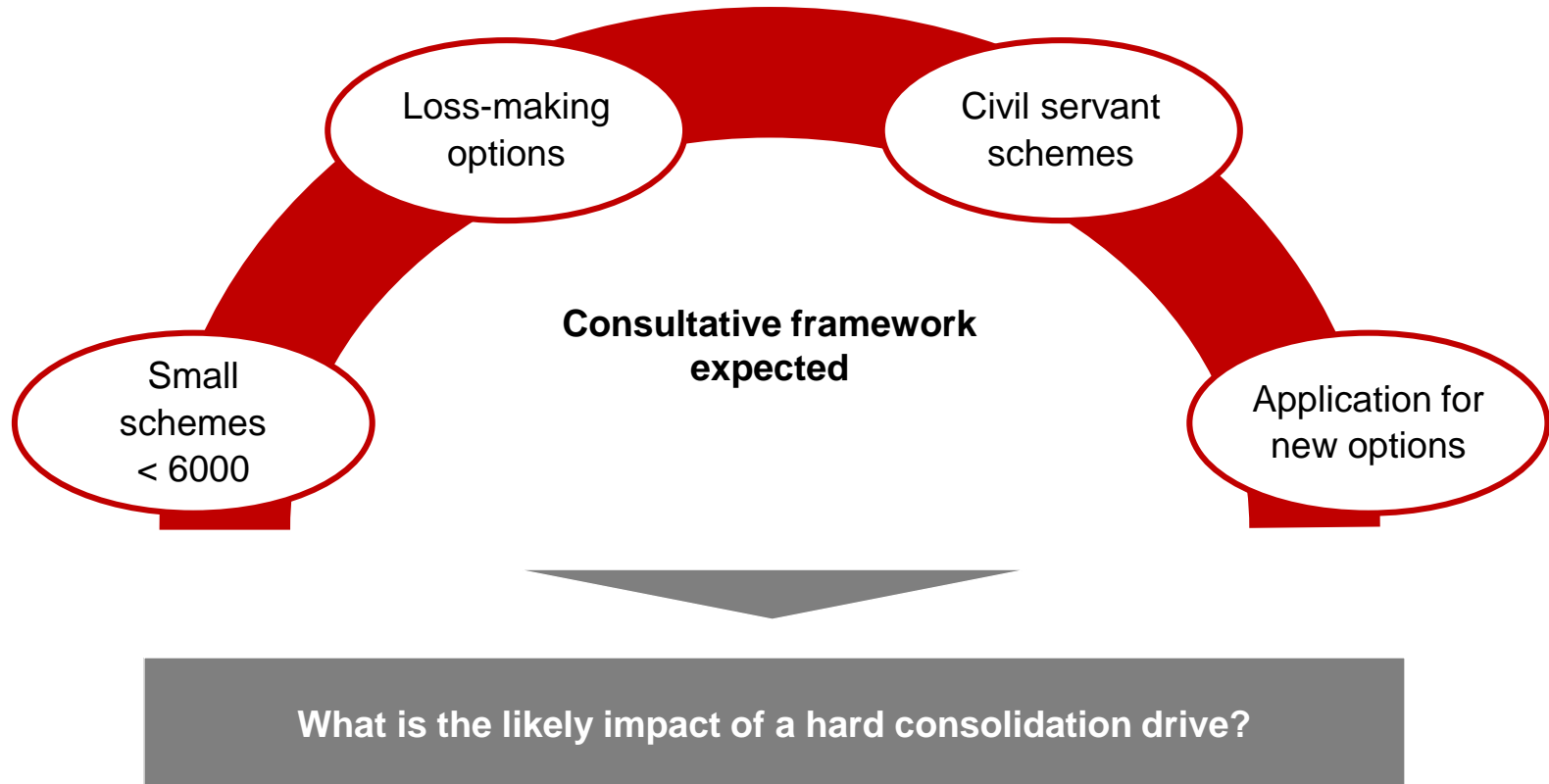
	Schemes < 6000	All schemes
Schemes	31	82
Options	53	280
Members	104 385	3.99m
Beneficiaries	228 435	8.88m
Average beneficiary age	34.5	32.5
Pensioner ratio	10.5%	7.9%
Expenses pbpm	R109	R133
Solvency	84.9%	31.6%

Source: CMS

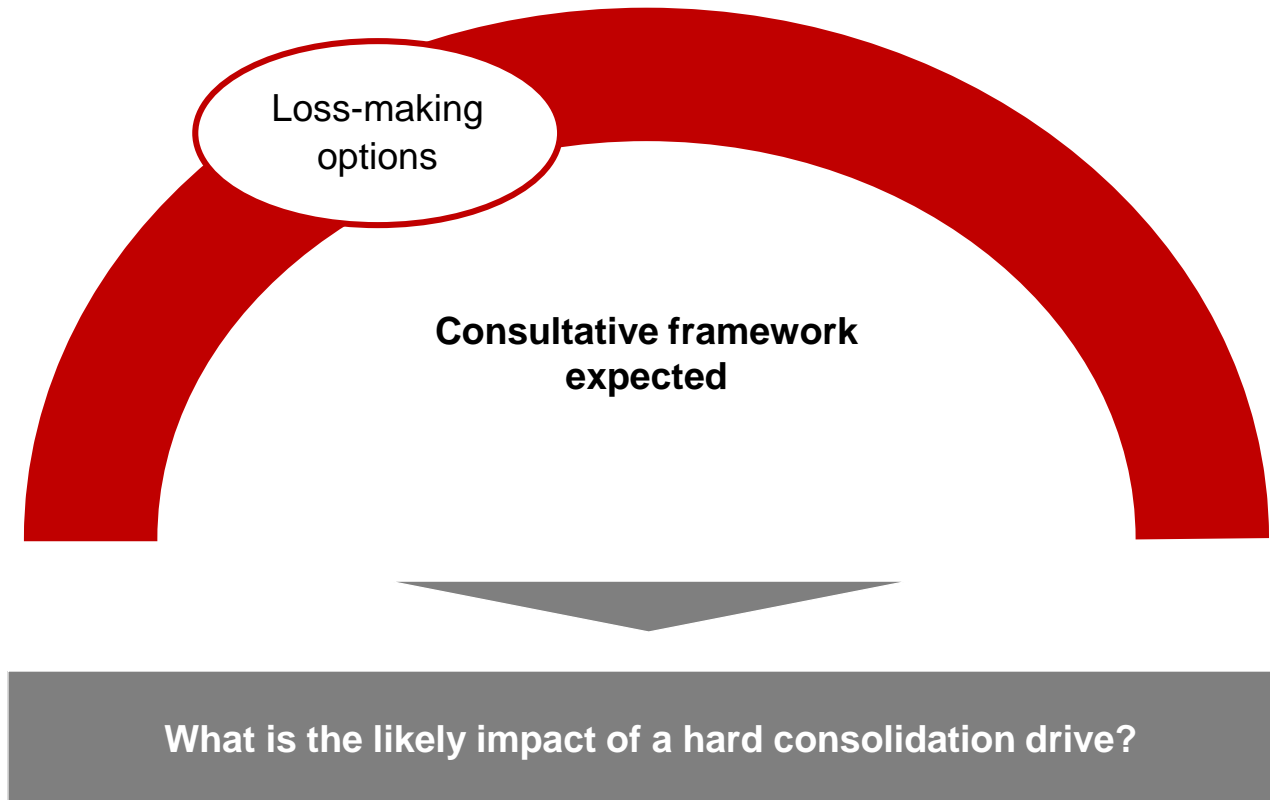
Extent of Jan 2018 consolidation

	New options	Discontinued options	Amalgamated options	(Rejected options)	Net change
Open schemes	2	1	4	6	-3
Closed schemes	3	4	4	0	-5

Consolidation from here?



Consolidation from here?



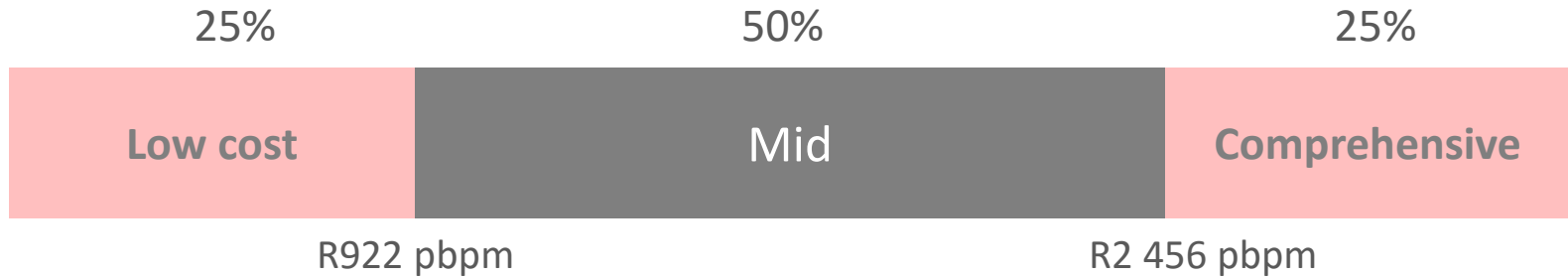
How many options are loss-making?

	2015			2016		
	Deficit	Surplus	Total	Deficit	Surplus	Total
Open	78	60	138	84	54	138
Closed	70	67	137	73	65	138
TOTAL	148	127	275	157	119	276

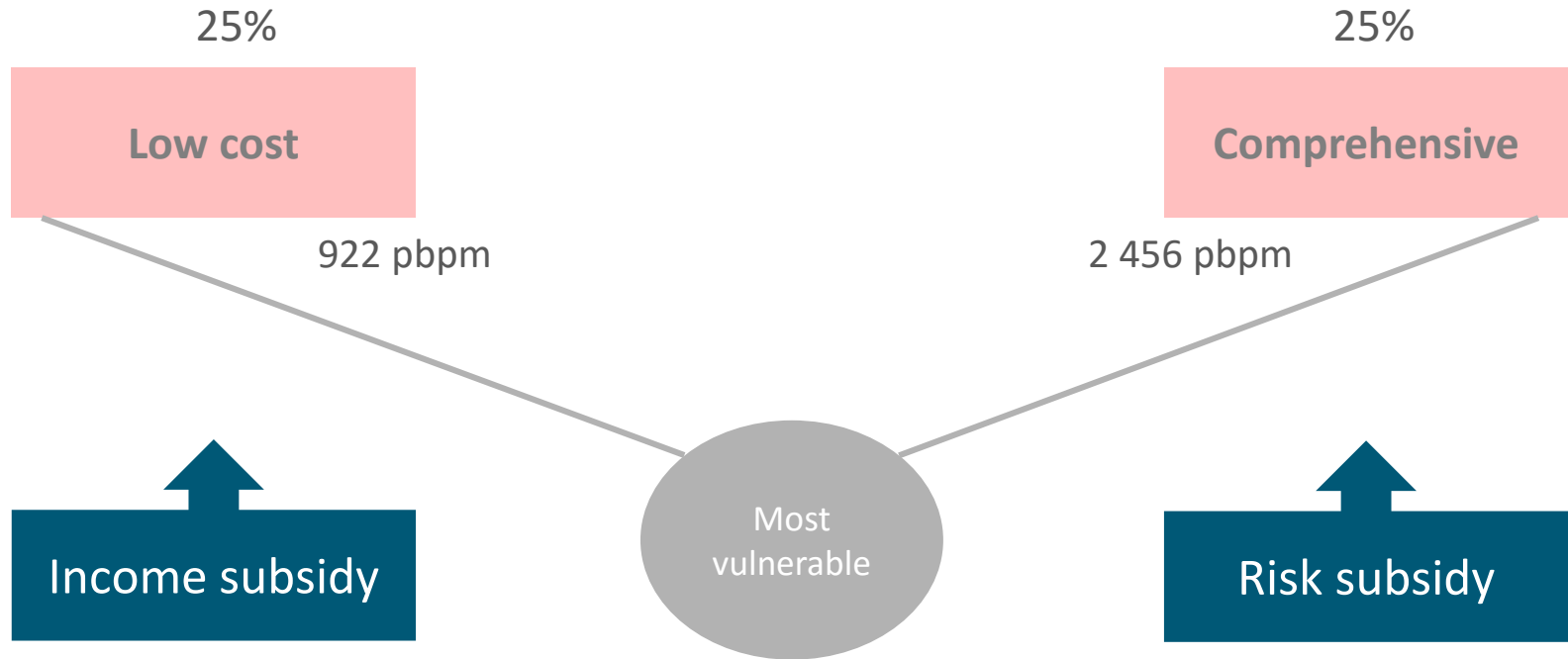
54%

57%

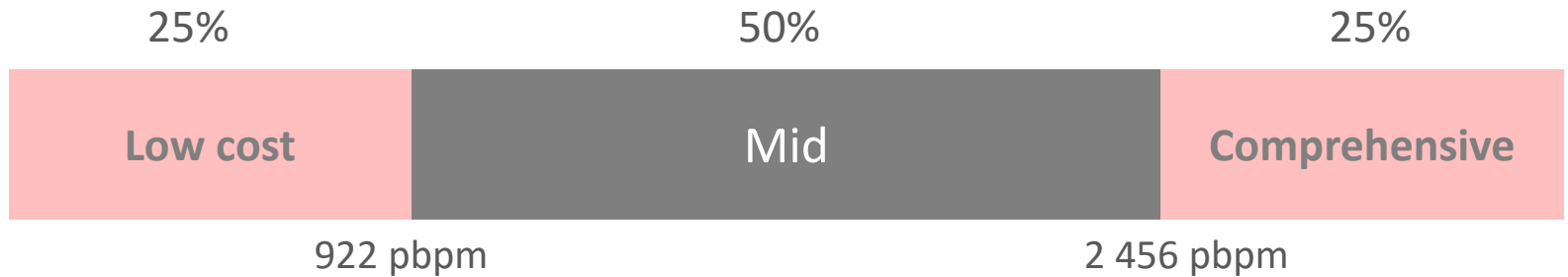
Which options are loss-making and why?



Which options are loss-making and why?

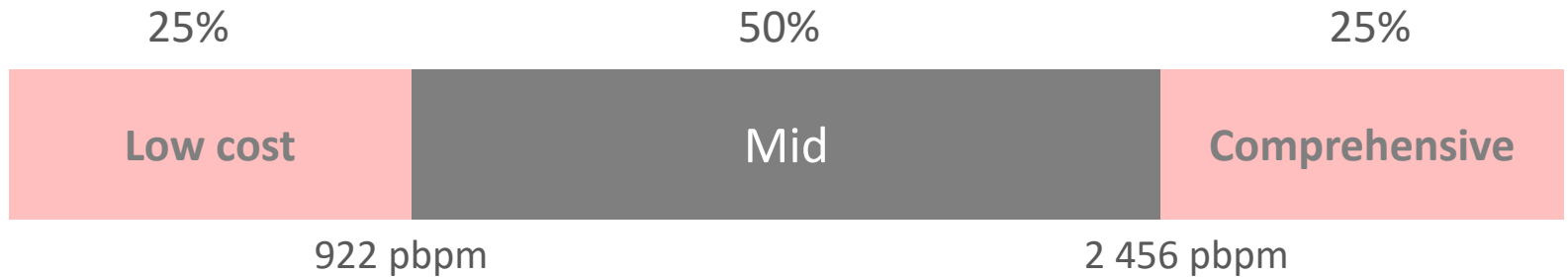


Cross-subsidy between options



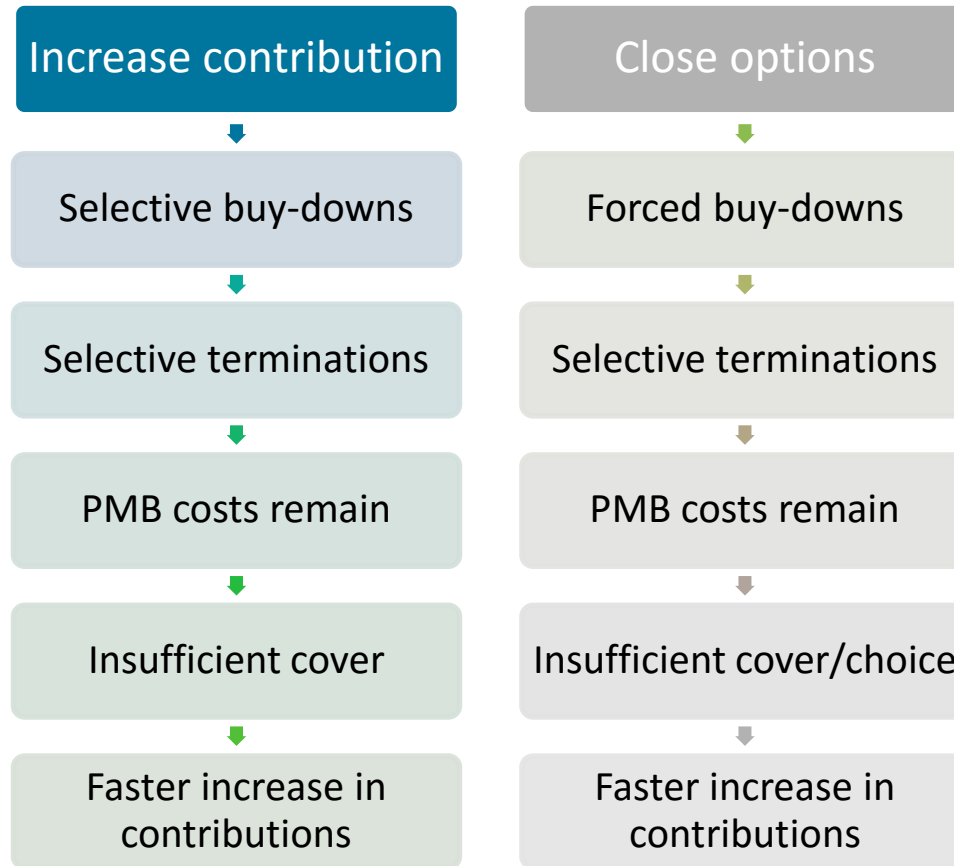
2015 Result (pbpm)	-60	38	-165
2016 Result (pbpm)	-64	34	-207
Average	-62	36	-186

Cross-subsidy between options



2015 Result	-R644m	R1 509m	-R1 380m
2016 Result	-R726m	R1 351m	-R1 589m
Average	-R685m	R1 430m	-R1 484m

Likely implications of rejecting loss making options



Scenario Model A

Increase contributions of loss-making options

- Loss making options identified as options with healthcare deficits in both 2015 and 2016 (65)
- Contributions adjusted to ensure a R0 healthcare result in 2016
- Buy down / exit impact assumed –
 - Contr increase 0%-5% 5% of bens
 - Contr increase 5%-7.5%: 10% of bens
 - Contr increase 7.5%-10%: 20% of bens
 - Contr increase > 10%: 30% of bens
- Members leaving option claim 10% less
- Claims adjustment: Medscheme Benefit Richness Model

Scenario Model A

Increase contributions of loss-making options

	Before	After	Change
Number of loss-making options	84	89	+5
Lives covered	4.94m	4.78m	-158 000
Industry result	(R927m)	R1 244m	+R2.2bn
Total contr	R83.2bn	R83.8bn	+R551m
Risk contr pbpm	R1 404	R1 460	+4.0%
Claims pbpm	R1 253	R1 270	+1.4%
Result as % of total risk cont	-1.1%	1.5%	+2.6%

8% for bens
in loss-
making
options

-3.2%

Scenario Model B

Close loss-making options

- Loss making options identified as options with healthcare deficits in both 2015 and 2016 (65)
- All members assumed to move to next lower non loss-making option on same scheme (if possible)
- Low cost options closed: 30% of beneficiaries exit cover
- Members leaving low cost options claim 10% less
- Claims adjustment: Medscheme Benefit Richness Model

Scenario Model B

Close loss-making options

65 loss-making in
2015 & 2016,
minus 11 that cannot
be closed

	2016 Before	Options Closed	2016 After
Loss making options	84	54	42
Other options	54		42
Total	138	54	84

50%

Scenario Model B

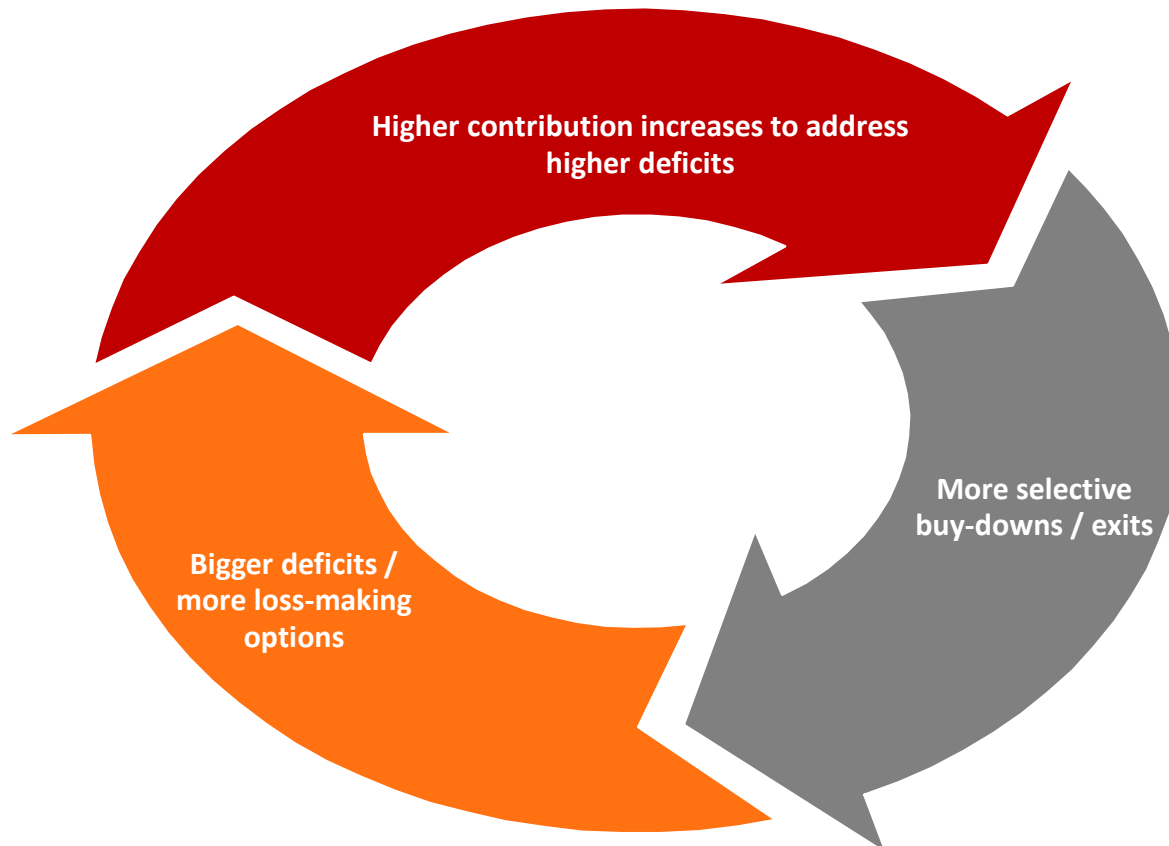
Close loss-making options

	Before	After	Change
Lives covered	4.94m	4.77m	-170 000
Industry result	(R0.9bn)	(R6.5bn)	(R5.6bn)
Total contributions	R83.2bn	R75.3bn	(R7.9bn)

Result as % of total risk cont	-1.1%	-8.6%	-7.5%
Risk contr pbpm	R1 404	R1 316	-6.3%
Claims pbpm	R1 253	R1 262	+0.7%
Result pbpm	(R16)	(R114)	727%

Loss ratio	89.2%	95.9%
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Extreme scenarios, extreme results



The way forward?

The MSA, “Financial soundness”

“33. Approval and withdrawal of benefit options

(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*
- (d) Will not jeopardise the *financial soundness* of any existing benefit option within the medical scheme”

The MSA, “Financial soundness”

“33. Approval and withdrawal of benefit options

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

35. Financial soundness (scheme) –

- (a) *Having sufficient assets*
- (b) *Providing for its liabilities*
- (c) *Conducting its business so as to be in a position to meet its liabilities at all times*

(c) Is *financially sound*

(d) Will not jeopardise the *financial soundness* of any existing benefit option within the medical scheme”

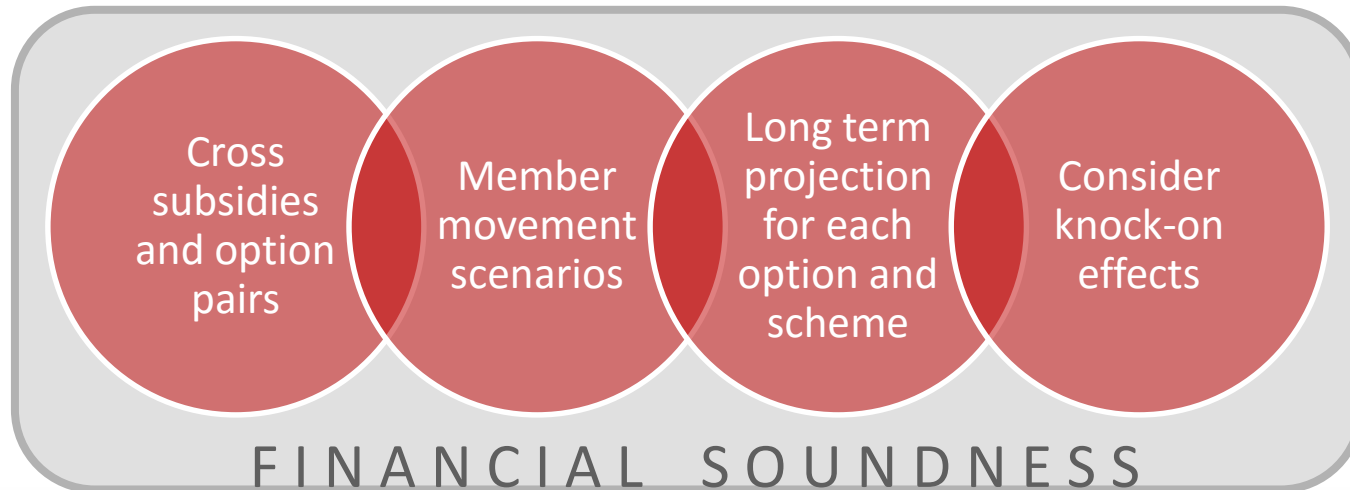
Financial guarantees

Advice on implications of option closure (Healthcare Committee)

33. Approval and withdrawal of benefit options

- (3) The Registrar may demand from the principal officer such **financial guarantees** as will in the opinion of the Council ensure the financial soundness of benefit options

Can the closest equivalent option provide such guarantee?



Where are we heading?

Now and then: different frameworks



Separate risk pools, no risk equalisation

Voluntary participation

Limited underwriting, open enrolment

Product based cross subsidy

Hospicentric minimum benefit package

Anti-selection

One major risk pool

Mandatory participation

No underwriting

Income and risk based cross subsidy

Primary care focused benefit package

No anti-selection

How do we get there?

Align principles rather than looks?



Risk equalisation mechanism, Risk based solvency

Steps toward mandatory membership

Increase scope for underwriting

Keep consumer choice, extend cover (LCBO?)

Primary care focused minimum package

Reduce anti-selection

One major risk pool

Mandatory participation

No underwriting

Income and risk based cross subsidy

Primary care focused benefit package

No anti-selection

Shared vision

**Universal, quality, affordable health
cover for all South Africans**

**Hard consolidation likely to undermine social solidarity
and create additional cost during transition phase**

Consultative approach critical,
informed by in-depth research and impact analysis

Thank you