Considerations for sustainable benefit design in the low-income market

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ABSTRACT

Options aimed at low-income members in medical schemes are subject to the same complications as other options in the medical schemes industry due to the lack of regulatory reform. The slow pace of regulatory reform means member protections such as prescribed minimum benefits (PMBs), community rating and open enrolment are in place, but scheme financial protections such as mandatory cover and a system of risk equalisation have not been implemented.

Since the implementation of the Medical Schemes Act (MSA), there have been various initiatives to try and solve for better affordability in the low-income medical scheme market. The Low Income Medical Scheme (LIMS) study results were published in 2006 and, under the Low-Cost Benefit Options (LCBOs) process that started in 2015, a lot of work has been done, but almost a decade later there is no clarity on when implementation will take place.

As the need for this type of healthcare cover remained and the lack of progress made since the original LIMS work, insurance companies used the gap in the market to launch primary healthcare insurance products under insurance licences. This regulatory gap was meant to be closed in 2017 when the Demarcation Regulations became effective, but with the LCBO process still ongoing, these products have received a number of extensions to their exemptions from the MSA.

The first aim of the paper is to provide an updated view of the main open market options aimed at low-income members and their performance based on net growth, demographic profile and

financial performance. This is to provide a snapshot of the health of the low-income medical scheme options in the current regime given the challenging economic environment and other challenges.

While the LCBO process is ongoing and can be influenced, the learnings from the analysis of current low-income options can be used to inform the LCBO design and framework and improve on some of the challenges highlighted. This includes the impact of PMBs, community rating and open enrolment, verification of income, type of business such as retail, types of groups such as compulsory and voluntary, and items of benefit design. The implication of the findings (see section 2) and the current external environment is unpacked to gauge the potential role primary healthcare insurance can play during the current regulatory uncertainty and in future.

The growth and financial experience of the primary healthcare insurance industry is unpacked to compare with the medical scheme environment and aims to provide insight into the healthcare insurance market's suitability to be an alternative low-cost healthcare solution.

Due to the rapid growth of the insurance-based options, primary healthcare insurance designers had to innovate in order to remain competitive, whilst managing the claims experience of a shifting demographic. One approach to mitigate high healthcare inflation, typically 1–3% above CPI, was the incorporation of telemedicine into product design. Telemedicine has the benefit of reaching more members at a lower cost but also allows for a more focused healthcare and network management approach. The result has been better health outcomes coupled with lower claims downstream, ensuring a more affordable price point. These learnings could assist current PMB medical scheme options or help to inform LCBO design and risk management.

KEYWORDS
Medical schemes, low-income, primary healthcare insurance, LCBO, benefit design, regulation, PMB, innovation

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1. INTRODUCTION

1.1 External environment influences on medical scheme options aimed at low-income members

Options aimed at low-income members in medical schemes are subject to the same complications as other options in the medical schemes industry due to the lack of regulatory reform. The slow pace of regulatory reform means member protections are in place, but scheme financial protections are not fully implemented. Member protections include:

— **Prescribed Minimum Benefits (PMBs)**
This provides a minimum level of cover all medical scheme options should provide. The intention is to protect members against erosion of benefits over time. The unintended consequence with a fairly comprehensive set of PMBs is that the minimum cost of a benefit option is fairly high.
— **Community rating**
This requires that all members on the same option, whether it is an Olympic medallist athlete of 18 or a pensioner of 80 with 10 chronic conditions, pay the same contribution on the same option. Contributions can only be varied by family size and income, and also through exemption from the Medical Schemes Act (MSA), provider choice, as in the case of Efficiency Discounted Options (EDOs).
— **Open enrolment**
Schemes must accept any potential members that want to join any option.

While these factors affect all options, the impact of PMBs on affordability and growth of low-income options is particularly severe. This is due to low-income members in schemes being very price sensitive. This group of members are also vulnerable to external economic shocks such as recently seen during the COVID-19 pandemic and the aftermath. A lack of growth during periods with challenging economic circumstances also makes it more difficult to manage the selection risks of open enrolment and community rating.

While schemes can apply limited underwriting and late joiner penalties, this is not sufficient on its own to manage selection risks. Planned regulatory scheme protections not implemented, amongst others, are:

— **Mandatory cover**
Previously social health insurance was the planned path to universal cover. This includes regulation for mandatory cover for persons with a certain level of income. Mandatory cover would avoid the selective opting out of medical scheme cover by the young and healthy and would improve both the size and demographic profiles of scheme risk pools
— **Risk equalisation fund (REF)**
Under the planned REF, based on PMB cost, schemes with high disease burdens would be a net receiver of payments from schemes with low disease burdens. This would encourage a focus on efficient provision of PMBs regardless of the disease burden of members, and help to manage selection risk.

Since the implementation of the MSA, there have been various initiatives to try and solve for better affordability in the low-income medical scheme market. Some of these initiatives were partly driven by the Council for Medical Schemes (CMS) with help from industry experts.

1.2 A short history of initiatives aimed at increasing private coverage for low-income populations

The Low Income Medical Scheme Study (LIMS)[1] was commissioned as early as 2005, only a few years after the implementation of the MSA and recommendations were published in 2006. This included a LIMS household survey which indicated respondents placing a higher value on out-of-hospital benefits. Some of the recommendations included that an upper income limit should be carefully chosen to avoid downgrades from current medical scheme members and a modified approach to PMBs for schemes aimed at low-income households due to affordability.

After that there seemed to be a lack of work on solutions based on the LIMS recommendations. The first significant movement was only in 2015 with the approval by the CMS of a framework and guidelines to apply for an exemption to the MSA to register what was referred to as Low Cost Benefit Options (LCBOs).[2] The Circular announcing this decision was however withdrawn shortly thereafter, citing a need for further analysis based on submissions received.[3]

The need for this type of healthcare cover remained and with the lack of progress made since the original LIMS study was published, insurance companies used the gap in the market to launch primary healthcare insurance products under insurance licences. This regulatory gap was meant to be closed in 2017 when the Demarcation Regulations became effective. The regulations stipulated which health insurance products are not deemed to be doing the business of a medical scheme according to the MSA definition;, those that are deemed to do the business of a medical scheme, but are exempted from the MSA; and those deemed to be doing the business of a medical scheme and not exempted from the MSA. Primary health insurance was the only health insurance product that was categorised under the latter definition. The Demarcation Regulations granted a two-year conditional exemption for primary healthcare policies at the time to allow for more work to be done on an LCBO guideline.

The exemption period was extended with a renewal framework in 2019 for another two years, and again for one year in 2021, with the reasons cited as an inability to engage stakeholders due to COVID-19. In 2022 there was an automatic extension for another two years while CMS Advisory Committees were formed with workstreams for LCBOs. An LCBO report was submitted to the Minister in 2023 and while this was being considered the exemption was allowed for another year from 1 April 2024 to 31 March 2025.[4]

While the 2006 LIMS study provided clear principles and lots of work has been done in workstreams, since this initiative has been renamed to LCBOs, the actual implementation

1 https://www.medicalschemes.co.za/wpfd_file/lims-final-report-draft-28-2-06/
2 https://www.medicalschemes.co.za/wpfd_file/circular54of2015/
3 https://www.medicalschemes.co.za/wpfd_file/circular62of2015/
4 https://www.medicalschemes.co.za/circular-16-of-2024-update-demarcation-exemption-renewal-framework/

timeframe is still uncertain and seems unlikely in the short term. As much as the medical schemes industry needs LCBOs to overcome the lack of regulatory reform of medical schemes as highlighted in section 1.1, it seems to be caught up in the slow pace of regulatory reform through the LCBO process.

Given the lack of progress on LCBOs and the various extensions, one would expect at least another extension of the demarcation exemptions for primary healthcare insurance products, which continue to grow in market share.

1.3 Aim of the paper in the context of the low-income medical scheme and insurance environment

The first aim of the paper is to provide an updated view of the main open market options aimed at low-income members and their performance based on net growth, demographic profile and financial performance. This is to provide a snapshot of the health of the low-income medical scheme options in the current regime given the challenging economic environment and other challenges highlighted in section 1.1. A summary of the medical scheme options included, followed by an analysis of each of the factors mentioned above, are covered in sections 2.1 to 2.4. Section 2.5 then summarises how the external environment might have played a part in the results.

Secondly, while the LCBO process in section 1.2 is still ongoing, it can be influenced by the findings in the earlier parts of section 2. These can inform how the LCBO design and framework could be improved to counter some of the challenges highlighted in section 1.1, which currently affect medical scheme options. This is unpacked based on various potential external environment factors in section 2.5 and summarised in section 2.6.

Similar to sections 2.5 and 2.6, the implication of the findings of the investigation and the current external environment is unpacked for primary healthcare insurance in section 2.7. It also summarises the potential role primary healthcare insurance can play during the current regulatory uncertainty.

Lastly, the growth and financial experience of the primary healthcare insurance industry is unpacked, similar to the medical scheme section in sections 2.2 to 2.4. This is provided in section 3. Section 4 highlights some of the innovations to manage the claims costs in the insurance industry, which could assist current PMB medical scheme options or again help to inform LCBO design and risk management.

Both sections aim to provide insight into the healthcare insurance market's suitability to be an alternative low-cost healthcare solution.

2. IMPACT OF THE EXTERNAL ENVIRONMENT ON LOW-INCOME OPEN SCHEME OPTIONS

An analysis was performed on eleven open medical scheme options aimed at members in the low-income market. These options were selected to ensure that it was representative of the open market options aimed at low-income members.

The first criteria was to ensure that the largest low-income options by membership size were included. Low-income options of as many of the top open schemes by total scheme membership size in 2022 regardless of the individual option size were included. In this way many different approaches of the main competitor schemes that might provide different learnings from the investigation are included.

Makoti Primary is also aimed at a low-income market and has a reasonable membership size, but was excluded due to the 2023 membership not being available at the time of writing; the scheme is not one of the largest competitors by overall membership. The option could therefore be excluded in line with the aims of the investigation highlighted above.

Throughout the Scheme section principal members will be referred to as members and membership numbers for aggregated numbers. References to beneficiaries include all dependants on the membership (e.g. other adult and child dependants).

The analysis in the following sections investigated both net growth between 2019 and 2023, and demographic profile and financial performance between 2019 and 2022. The analysis used CMS annual report annexures with information for benefit years 2019 and 2022, published in the following year. The integrated report or summary financials of the nine open schemes were used for 2023 membership numbers. The financial reporting for 2023 was excluded due to the change to International Financial Reporting Standard (IFRS) 17 to avoid potentially inconsistent results to previous years at an option level, compared to the standardised financial measures analysed in the CMS Annexures.

2.1 Summary of the open scheme options included in the analysis

Table 1 summarises the low-income open scheme options included in the analysis, shown in alphabetical order.

Table 1. Low-income open scheme options included

Medical scheme (after amalgamation)	Benefit option name (latest)
Bonitas Medical Fund	BonCap
Bestmed	Rhythm1
CompCare Wellness Medical Scheme	Umbono (Networx)
Discovery Health Medical Scheme	KeyCare Core
Discovery Health Medical Scheme	KeyCare Plus
Discovery Health Medical Scheme	KeyCare Start
FedHealth Medical Scheme	My Fed
Medihelp	Medelect
Medshield Medical Scheme	MediPhila
Momentum Medical Scheme	Ingwe
Sizwe Hosmed Medical Fund	Copper Essential

Nine of the top ten open schemes are represented in the analysis; only KeyHealth that does not have a similar option, is excluded. All three KeyCare options aimed at low-income members are included due to a range of different benefit designs: a traditional low income, partly capitated design with day-to-day benefits; a design with limited day-to-day benefits; and EDO design with more restricted in-hospital and out-of-hospital benefits. Bestmed Rhythm 1 was created out of a restructure of a higher benefit option only in 2022 and the membership is still fairly small.

For simplicity the net growth analysis accredits the growth in the entire period to the latest scheme and option name, provided that the benefit design was broadly similar over the investigation period, while some options were renamed or affected by scheme amalgamations. For completeness, some of the changes to note are:

— CompCare Networx had a name change after the investigation period to Umbono.
— Medihelp Medelect had a name change during the investigation period (previously Necesse)
— Sizwe Hosmed Copper Essential were created as part of the amalgamation between Sizwe Medical Fund and Hosmed Medical Aid Scheme with a merge of the Sizwe Copper Core Plan and the Hosmed Access plan.
— FedHealth My Fed had a name change at the start of the investigation period.
— KeyCare Start was created out of a restructure of the KeyCare Access plan at the start of the investigation period.

This group of eleven options is all aimed at low-income members, but with very different approaches in benefit design, funding of benefits and contribution structures.

Typical design features of medical scheme options aimed at low-income members are:

— income-banded contributions for affordability.
— limited provider networks as a means to lower cost.
— basic day-to-day limits with low limits, restricted medicine formularies and only specific basic pathology and radiology covered,
— capitated reimbursement structures for day-to-day benefits to manage utilisation risk, and
— chronic cover provided is as per the Chronic Disease List (CDL) PMBs.

Table 2 compares the eleven options based on some typical design features of options aimed at low-income members.

Eight of these options use capitated reimbursement structures to varying degrees, as can be deduced from the details of risk transfer arrangement in the CMS annexures. KeyCare Core does not provide significant out-of-hospital benefits to warrant capitation and Sizwe Hosmed Copper Essential does not use any capitation agreements. Only BonCap has cover beyond CDLs, adding additional cover for depression and CompCare Umbono covers 32 conditions in total.

Table 2. Common benefit design feature comparison of investigated options

Medical scheme (after amalgamation)	Benefit option name(latest)	Income banded contributions	Limited networks	Basic day-to-day benefits	Capitated reimbursement structure	CDL conditions only	EDO design	State DSPs for high-cost benefits	Overall limit
Bonitas Medical Fund	BonCap	√	√	√	√	X	X	X	X
Bestmed	Rhythm1	√	√	√	√	√	X	X	X
CompCare Wellness Medical Scheme	Umbono (Networx)	√	√	√	√	X	X	X	X
Discovery Health Medical Scheme	KeyCare Core	√	√	X	N/A	√	X	√	X
Discovery Health Medical Scheme	KeyCare Plus	√	√	√	√	√	X	√	X
Discovery Health Medical Scheme	KeyCare Start	√	√	√	√	√	√	√	X
FedHealth Medical Scheme	My Fed	√	√	√	√	√	X	X	X
Medihelp	Medelect	√	√	√	√	√	X	X	X
Medshield Medical Scheme	MediPhila	X	√	√	√	√	X	X	√
Momentum Medical Scheme	Ingwe	√	√	√	√	√	√	√	X
Sizwe Hosmed Medical Fund	Copper Essential	√	√	√	X	√	X	X	X

Less common design features include EDO design, which is only used by Momentum Ingwe, Discovery KeyCare Start and CompCare Umbono. Also, only the three KeyCare options and Momentum Ingwe use State facilities as designated service providers (DSP) for certain high cost benefits. MediPhila has an overall limit for non-PMB admissions of R1 million.

The following sections investigate the experience of the eleven options investigated by net membership growth, demographic profile and the financial experience.

2.2 Net growth

This section summarises the net growth between 2019 and 2023 for the eleven selected options. Net growth drivers are varied and difficult to disentangle. Some of the factors include the brand of the medical scheme, the sales channels employed, economic environment, the individual design and contributions of each option, potential downgrades from higher cost options and movements between schemes, amongst others. Part of the aim is to measure the overall coverage provided by these options over time. Medical scheme options aimed at low-income members are the most affordable options in the industry and therefore the most likely to meet the needs of the employed, but uncovered population. By implication, these options are key to the growth of the medical schemes industry.

Table 3 summarises the total membership included in the analysis.

Table 3. Low-income open scheme membership coverage 2019–2023

Measure	2019	2020	2021	2022	2023
Options included in low-income analysis – membership	372 234	353 084	369 102	369 944	360 774
Total open scheme membership	2 377 444	2 329 424	2 351 958	2 381 337	2 375 240
Low-income member options as percentage of total (coverage)	15.7%	15.2%	15.7%	15.5%	15.2%

No membership data was available for the Cape Medical Plan in 2023. It was assumed that their membership remained constant in 2023 so as not to skew the numbers.

The membership of the eleven options decreased by 3.2% from over 372 000 to around 361 000. The total open scheme membership only reduced slightly by 0.1%.

Low-income coverage was fairly volatile, but decreased from 15.7% of total open scheme membership to 15.2% in 2023, as measured by this representative group of options.

One of the main influences in the period investigated is the COVID pandemic. Lower skilled and low-income workers are more likely to be laid off during challenging economic times. Low-income coverage was the lowest at 15.2% in 2020. This was as the initial response to the pandemic was in the form of lockdowns. While temporarily recovering to pre-pandemic levels in 2021, the consequent economic impacts have reduced the coverage back to the levels in the pandemic of 15.2%.

These options aimed at low-income membership are the most affordable medical scheme options available, with contributions cross-subsidised by higher options. However, the minimum cost that PMBs impose on these options means that they are still a significant expense for low-income members, who are sensitive to external economic shocks. The cost of these medical schemes options therefore contributes to this sensitivity.

The next section summarises the per option experience underlying the overall experience summarised above.

Six of the eleven options had positive net growth in the period investigated. Figure 1A shows the build-up of the total net growth between 2019 and 2023. The options are shown from the option with the highest net growth increase to the option with the highest net loss in membership. A year with positive net growth is shown as a green bar and a year with a net membership loss is seen as a red bar. The first graph shows all eleven options for context of the relative size. Figure 1B is shown excluding KeyCare Plus, that is a significantly larger option by membership. This is to ensure smaller changes can be more easily interrogated.

Two of the options also feature in the top 15 options with the highest net growth across all option types in the industry in the same period, namely Bonitas BonCap and Medshield MediPhila.

While Bonitas BonCap, Discovery KeyCare Start and Momentum Ingwe experienced overall net growth in this period, the growth was fairly erratic. Medshield MediPhila's had net growth in all of the years investigated, but the net growth per year has reduced over time,

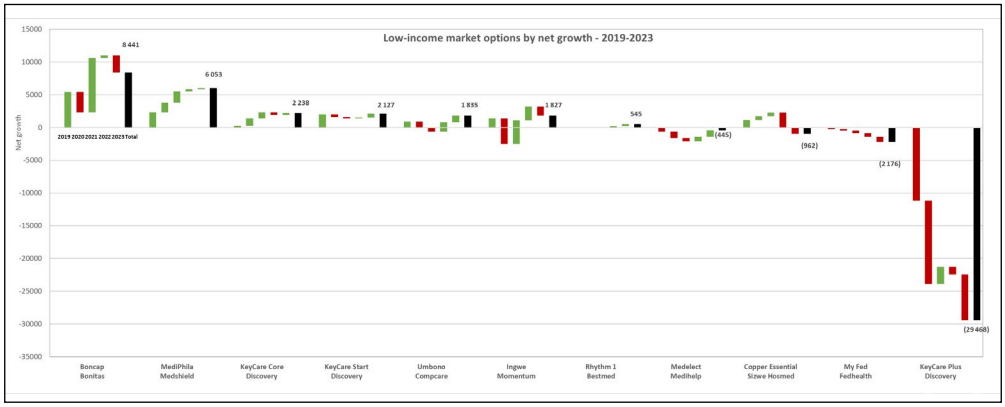

Figure 1a. Low-income open scheme options by net growth 2019–2023

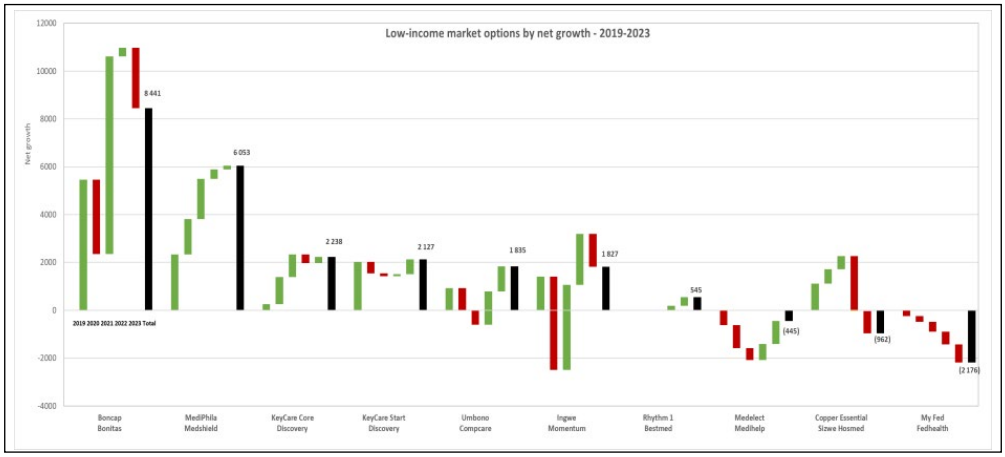

Figure 1b. Low-income open scheme options by net growth 2019–2023 (excl. KeyCare Plus)

Discovery KeyCare Core grew in all but one year in the period investigated. CompCare Umbono seems to have returned to net growth per year, after some membership losses earlier in the investigation period

Medihelp Medelect have recovered somewhat after net membership losses earlier in the investigated period. FedHealth My Fed has experienced membership losses in all years, with the losses per year increasing over time. Sizwe Hosmed Copper Essential had significant membership losses after the amalgamation compared to net growth in the respective options that were merged to form the new option in the amalgamated scheme.

Discovery KeyCare Plus experienced fairly large net losses for most of the investigated period. This option constitutes 58% of the membership of the options in the period investigated and is therefore the main driver of the lower coverage of this group of options over time.

Figure 2 shows the percentage growth per year for the investigated options to get a view of the net growth in Figures 1A and B relative to the size of the option. Bestmed Rhythm 1 was excluded due to very small membership numbers.

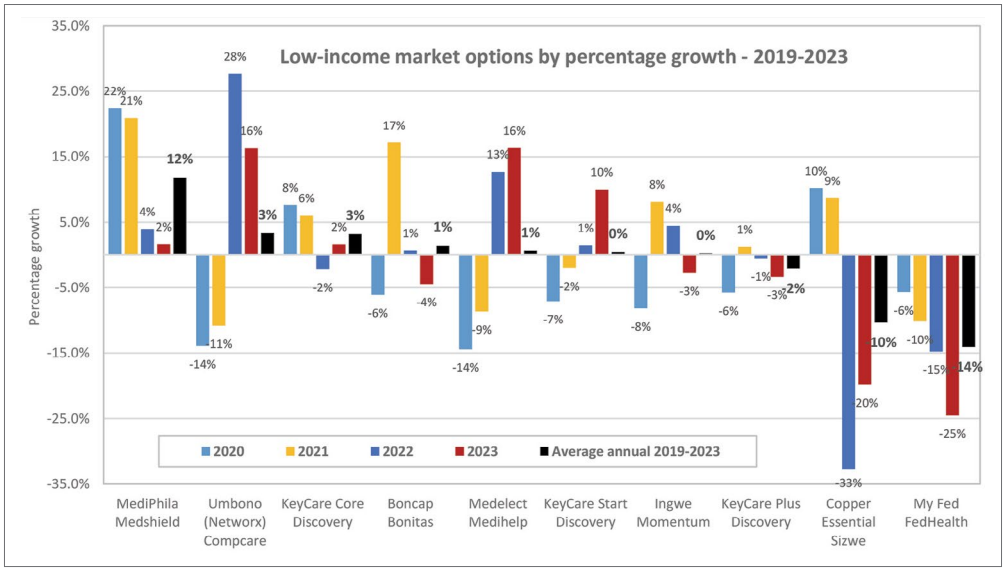

Figure 2. Low-income open scheme options by percentage growth 2019–2023

As expected, the smaller options have larger and more volatile growth experience. Medshield MediPhila had large membership growth at the start of the period off a fairly low base, with 12% average growth per annum. After large initial membership losses, CompCare Networx had some significant growth in 2022 and 2023 and an average of 3% growth per year over the period.

Of the larger options, KeyCare Core and BonCap had 3% and 1% growth per annum respectively in the period. Momentum's Ingwe and Medihelp Medelect membership remained fairly flat, despite fairly large membership losses and gains in between. Discovery KeyCare Plus had significant member losses during 2020 and 2023 and a 2% membership loss per annum over the period.

The next section looks at the demographic profile of the included options.

2.3 Demographic profile

The demographic profile of a medical scheme option is a significant factor, particularly in the open scheme market, given open enrolment, community rating, limited underwriting and the lack of mandate cover or REF summarised in section 1.1. The underlying demographic profile of a medical scheme option drives the claims experience of the option.

There is also a direct link between the net growth summarised in section 2.2 and the demographic profile. The average age of an option with no new members or membership

losses will increase by one year. New members are often younger than the option average age, especially in low-income options suited to those in employment for the first time. Net growth therefore dilutes the ageing effect, lowering the average age of the option and the medical scheme, all else being equal. Members leaving an option are usually also younger, as these members are more likely to change employment or be able to move schemes without underwriting. A loss of members is therefore also usually selective, in other words, the demographic profile of the option worsens as the average age of the option increases due to the loss of younger members.

It is also possible that the average age could be increased with growth of a large number of members older than the average, which could be a concern if it increases above competitor options. Alternatively the average age could improve with a loss of older members.

Figure 3 shows the build-up of the change in average age of the investigated options between 2019 and 2022. The options are shown from the option with the lowest total increase in average age over the period to the option with the highest increase in average age. A decrease in average age in a year is shown as a green bar, with an increase in average age shown as a red bar. Bestmed Rhythm 1 is excluded due to only having data available for 2022.

Medihelp MedElect is the only option that has a lower average age at the end of the period, due to significant growth in 2022. Discovery KeyCare Core and Momentum Ingwe

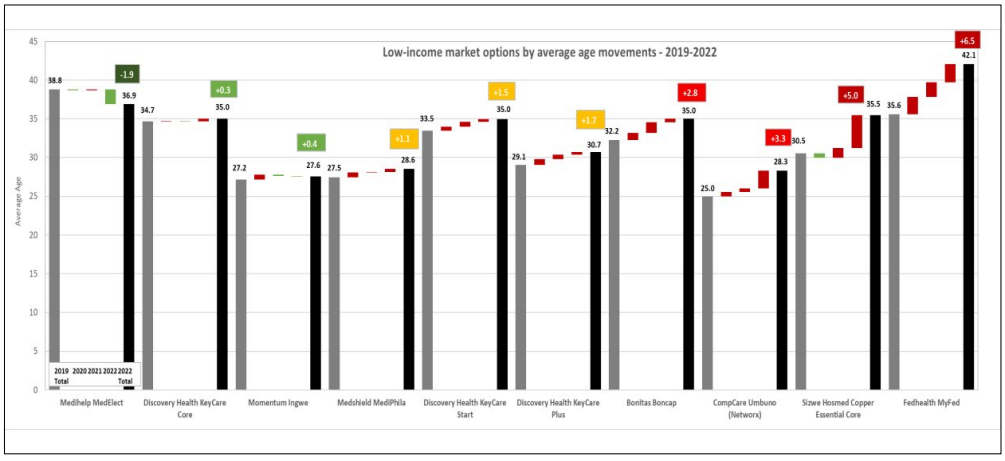

Figure 3. Low-income open scheme options by average age movements 2019–2022

aged by less than 0.5 years in the three years investigated. Medshield MediPhila aged by only 1.1 years, due to net growth in the corresponding period. Discovery KeyCare Start aged by 1.5 years. Discovery KeyCare Plus only aged by 1.7 years, despite net membership losses, with a decreasing rate of ageing over time.

Bonitas BonCap and CompCare Umbono both aged by around the three years of the time period investigated, while both options had net growth in the investigated period.

Sizwe Hosmed Copper Essential and FedHealth MyFed aged significantly by 5.0 and 6.5 years in the three years investigated, due to net membership losses.

The change in pensioner ratio further gives insight into the distribution of member age. It is possible that the average age of the option could potentially hide an increase in the proportion of members with higher ages. Table 4 shows the change between 2019 and 2022. It is sorted by the options with the lowest to the highest pensioner ratio in 2022.

Table 4. Low-income open scheme membership pensioner ratio

Option	Pensioner ratio		% Change
	2019	2022	
Umbono (Networx)	0.32	0.38	18.8%
MediPhila	2.53	3.58	41.5%
Ingwe	3.74	3.73	–0.3%
KeyCare Plus	6.54	8.02	22.6%
BonCap	7.26	8.10	11.6%
KeyCare Start	7.59	8.65	14.0%
Copper Essential	5.73	11.85	106.8%
KeyCare Core	12.03	13.08	8.7%
Medelect	17.53	15.70	–10.4%
My Fed	12.84	22.18	72.7%

CompCare Umbono, Medshield MediPhila and Momentum Ingwe all have pensioner ratios below 5%. Both Umbono and MediPhila had large increases from a low base, while Ingwe was reasonably flat.

Discovery KeyCare Plus, Bonitas BonCap and KeyCare Start have pensioner ratios below 10%. All of these options had an increase in pensioner ratio of between 11.6% and 22.6%.

Sizwe Hosmed Copper Essential, KeyCare Core, and Medihelp Medelect have pensioner ratios in excess of 10%, with FedHealth MyFed in excess of 20%. MedElect's pensioner ratio reduced in the investigated period, while KeyCare Core increased by 8.7%. Both Copper Essential and My Fed had significant increases in the period investigated.

The next section summarises the financial experience of these options between 2019 and 2022, which should be seen in the context of the demographic profile changes in this section and the net growth experience in section 2.2.

2.4 Open scheme financial experience

This section aims to measure the financial experience of the investigated options aimed at the low-income market over time, as well as the potential impact of the individual result on the entire scheme.

It is expected that low-income medical scheme options are partly cross subsidised by higher benefit options in an environment with community rating where contributions

can only differ by family size and income. It is difficult to disentangle the effects of income cross-subsidies and risk cross-subsidies. A presentation at the ASSA Healthcare Committee Seminar on 22 May 2024 presented by Christoff Raath titled 'Loss-making / self-supporting options and section 33(2)(b) of the Act', suggested a potential methodology to use community-rated PMB costs across options applied to an individual option, to calculate whether an option's cross-subsidy is at an appropriate and expected level. This could be considered as a future extension to the work of this paper to further try and unpack income and risk cross-subsidies in options aimed at low-income members.

A worsening in the demographic profile highlighted in section 2.3, together with a worsening in the financial performance in this section could be an indication of increased risk cross-subsidies needed beyond the implied income cross-subsidies.

The investigated period does include the COVID-19 pandemic. In 2020 and to a lesser extent in 2021, the claims experience for many schemes and individual options in the industry was generally very low, counterintuitively due to the COVID-19 pandemic. During this time there was generally lower healthcare utilisation of non-COVID-19 healthcare services due to the lockdowns instituted in response to the pandemic or members avoiding seeking healthcare services in fear of contracting COVID-19 in healthcare facilities. This offset the high claims for severe COVID-19 cases. Options and schemes with older and/or high disease burden members were the exceptions as more members experienced the high per person cost of severe COVID-19 cases.

The analysis includes smaller options which would be expected to have more volatile financial results.

Figures 4A and B show the net underwriting result as a percentage of risk contribution income over the investigated period. It is sorted by the highest average net underwriting result as a percentage of risk contribution to the lowest. A positive net underwriting result in a year (a surplus after claims and expenses) is shown in green and a negative net underwriting result in a year (a deficit after claims and expenses) is shown in red. The first graph (Figure 4A) is shown for context with all options included, in the second graph options (Figure 4B) with an average deficit in excess of 15% is excluded. This is to ensure smaller changes can be more easily interrogated.

Sizwe Hosmed Copper Essential's experience is shown separately in the two schemes before the amalgamation and then the combined view of the merged option after amalgamation.

The lower claims seen in the industry in 2020 are also apparent in the results of the investigated options as a temporary improvement in the surplus or deficit trend otherwise seen. In commenting on trends below, 2020 is not included as it is a temporary outlier.

Six of the eleven options experienced a surplus or a deficit of less than 10% of risk contributions on average during the investigation period.

Both KeyCare Start and Core had surpluses in all of the years included in the investigation. KeyCare Core's surplus margin has reduced significantly in recent years.

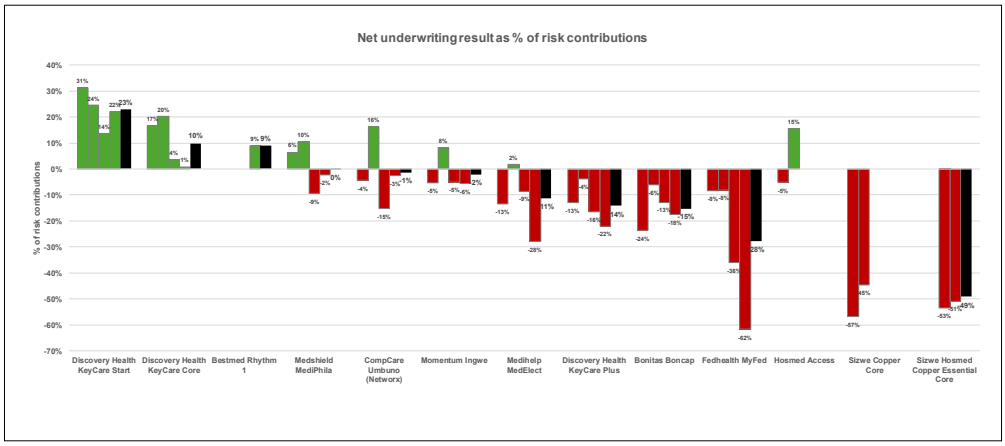

FIGURE 4A. Low-income open scheme all options – net underwriting result as % of risk contribution 2019–2022

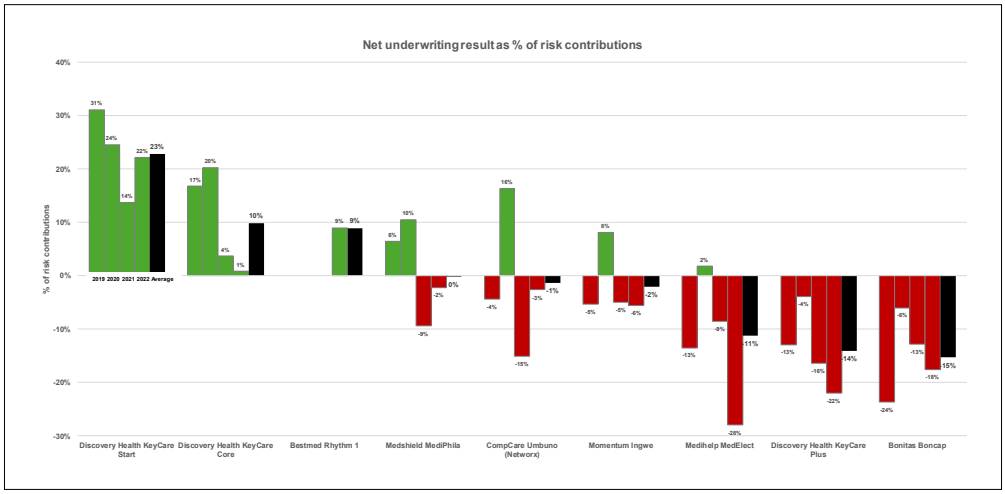

FIGURE 4B. Low-income open scheme options – average deficit excluded, 2019–2022

Medshield MediPhila broke even on average, but had surpluses in the first two years and deficits in the last two years, with the highest deficit being 9%.

CompCare Umbuno experienced a deficit of less than 10% in most years in the investigation period, except for 15% in 2021. Momentum Ingwe had a fairly consistent deficit of between 5% and 6% over time.

Five of the eleven options had deficits in excess of 10% of risk contributions on average between 2019 and 2022.

Medihelp MedElect, Discovery KeyCare Plus and Bonitas BonCap on average had deficits of between 10% and 15% of risk contributions. For MedElect and KeyCare Plus the deficit was in excess of 20% in 2022. KeyCare Plus's deficits seems to be on an upward

trend. BonCap had a deficit in excess of 20% in 2019 and while it has been below that level since, it seems to be also experiencing an increasing trend since 2021.

Hosmed Access had a small deficit in 2021, but Sizwe Copper Core experienced significant deficits in excess of 40% and as high as 57% before the amalgamation. This continued in the amalgamated scheme such that during the period investigated the option had close to a 50% deficit on average. FedHealth MyFed had a similar large increase to above a 60% deficit in 2022 and close to 30% on average during the period investigated.

To put the option-level financial results into context, for the included options the net underwriting results of the scheme in its entirety is investigated, with the open scheme average shown for comparison. Figure 5 shows the net underwriting result of the entire scheme as a percentage of risk contribution income over the investigated period. A positive net underwriting result in a year (a surplus after claims and expenses and before investment returns) is shown in green and a negative net underwriting result in a year (a deficit after claims and expenses and before investment returns) is shown in red. It is sorted from the scheme with the highest average surplus percentage to the scheme with the highest average deficit percentage over the investigated period.

All of the nine schemes included in the analysis, as well as the open scheme industry on average experienced significant surpluses in 2020. During 2021 and 2022 various contribution increase strategies were employed to use some of the reserves built up in 2020 to assist members with lower increases. Six of the nine schemes still had cumulative surpluses or were breaking even at the end of the investigated period. FedHealth, Sizwe Hosmed and CompCare had significant deficits after 2020 and cumulative average deficits in excess of 5%.

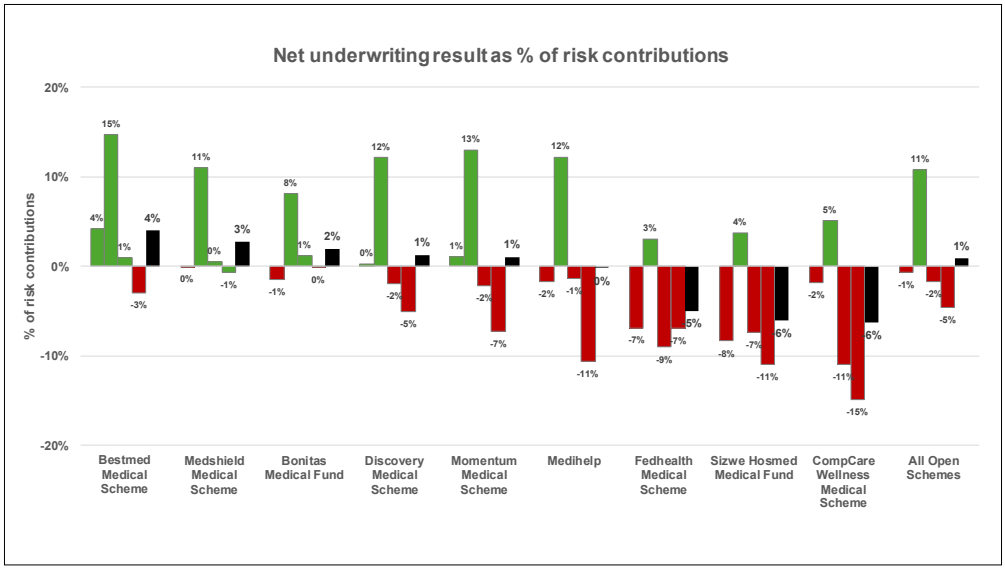

Figure 5. Schemes with options included – net underwriting result as % of risk contribution 2019–2022

Looking at Figures 4A/B and 5, one can better understand what the impact of the option financial result was on the scheme. For instance, one can deduce that the 4% deficit on Discovery KeyCare Plus and the 6% deficit on Bonitas BonCap in 2020 was cross-subsidised from other surplus-making options since the scheme as a whole had a surplus in 2020.

The next section shows the net healthcare result of each option as the rand value of the surplus or deficit. For the eleven options investigated between 2019 and 2022 this amounted to R4.06 billion in deficits that either needed to be funded through cross-subsidies if the scheme was surplus-making before investment returns or the use of investment income and/or reserves if the scheme experienced a deficit before investment returns.

Figures 6A and B show the net underwriting result as a rand amount in millions over the investigated period. It is sorted from the highest total surplus to the highest total deficit. A surplus in a year is shown as a green bar and a deficit is shown as a red bar. The first graph (Figure 6A) is shown for context with all options included and in the second graph (Figure 6B) options with a total deficit in excess of R100 million is excluded. This is to ensure that smaller changes can be more easily interrogated.

Seven of the ten options made a surplus in total or deficits of less than a R100 million during the four-year period.

Both KeyCare Start and Core made a total surplus over the investigated period, with a cumulative surplus value of around R217 million.

Medshield MediPhila made surpluses at the start of the period, but needed cross-subsidies of around R28 million in the last couple of years. CompCare Umbuno had a cumulative deficit of around R2 million only. Momentum Ingwe had a fairly consistent deficit of between R20 million and R30 million. Both MedElect and MyFed had an

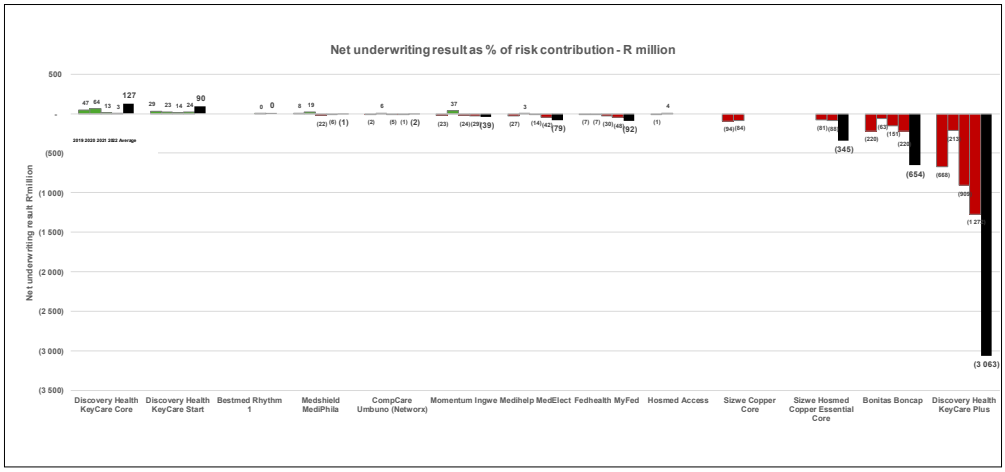

Figure 6A. Low-income open scheme all options – net underwriting result in R million 2019–2022

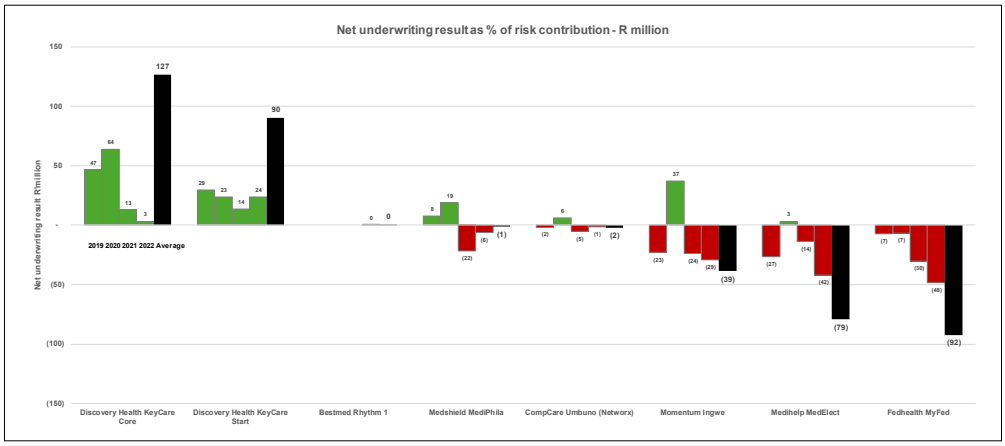

Figure 6B. Low-income open scheme options – total deficit >R100 million excluded , 2019–2022

increasing trend in deficits with cumulatively R79 million and R92 million respectively.

Four of the eleven options had cumulative deficits in excess of a R100 million during the period.

While Hosmed Access was close to break even, Sizwe Copper Core was running at deficits of between R80 million and R90 million per year before the amalgamation. This trend continued after amalgamation in the new option; the cumulative deficit reached a significant R345 million, even considering the size of the amalgamated scheme.

BonCap made deficits of between R150 million and R220 million per year and a cumulative deficit of R654 million between 2019 and 2022. KeyCare Plus had deficits of between R660 million and R1.3 billion per year during the period, and R3.1 billion cumulatively. These schemes are fairly large, but the increasing trend of the cross-subsidies might still be of concern.

To get a sense of the potential financial strain of the low-income option on the entire scheme's financial result in a particular year, the net underwriting result is shown as a proportion of the gross contributions of the entire scheme.

A deficit could be funded through cross-subsidy from a surplus in the scheme as a whole or through investment returns or the use of reserves. This way of measurement does not consider the use of investment returns or the total member reserves, but it is intended to give an idea of the potential financial strain on a scheme during a certain year and cumulatively over the period. To put into context the cumulative R4.06 billion of deficits mentioned earlier, was 0.9% of total gross contributions of the nine schemes included between 2019 and 2022. It is therefore not a negligible financial strain for these schemes, which includes most of the largest schemes.

Figures 7A and B show the net underwriting result of each investigated option as a percentage of the gross contribution income of the entire scheme. It is sorted from the highest percentage surplus to the highest percentage deficit. A surplus percentage in a

year is shown as a green bar and a deficit is shown as a red bar. Figure 7A is shown for context with all options included; in Figure 7B options with a total deficit in excess of 1% of scheme gross contributions are excluded to ensure smaller changes can be more easily interrogated.

Seven of the eleven options either improved the scheme's financial results with a surplus or only had a cumulative deficit of less than 0.5% of scheme gross contributions.

KeyCare Core and Start are fairly small in the context of the Discovery Health Medical Scheme and therefore do not significantly improve the financial result of the scheme. MediPhila and Umbuno have not had deficits above 0.5% of the scheme's gross contributions, apart from 2021 when both had a deficit of 0.6% of scheme gross

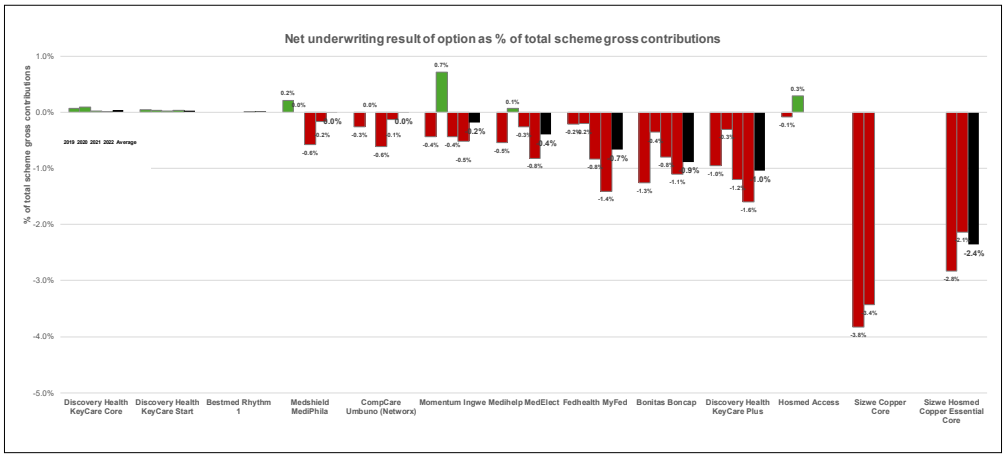

Figure 7A. Net underwriting result of all options shown as % of gross contributions of scheme 2019–2022

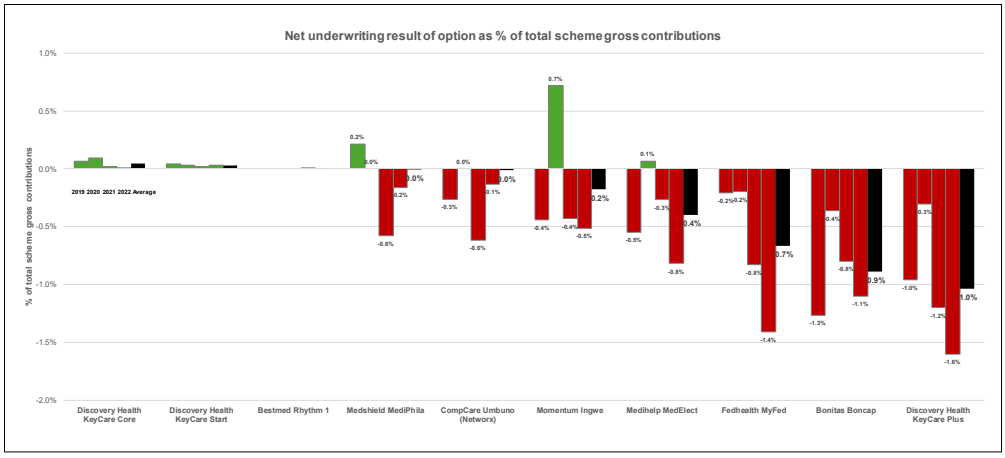

Figure 7B. Net underwriting result of options with total deficit >1% gross contributions excluded, 2019–2022

contributions. Momentum Ingwe's deficits is a consistent percentage of between 0.4% and 0.5% of the scheme's gross contributions. MedElect had deficits of 0.5% and 0.8% of gross contributions in 2019 and 2022, but an average of below 0.5% over the period.

Four of the eleven options ran at deficits of more than 0.5% of the scheme gross contributions on average between 2019 and 2022. MyFed had an increasing trend of deficits to 0.8% of gross contributions in 2021 and to 1.4% in 2022.

BonCap had deficits of between 0.8% and 1.3% of gross contributions of the scheme, with an average of 0.9%. KeyCare Plus has seen an increasing trend of deficits relative to gross contribution income of the scheme with 1.2% in 2021 and 1.6% in 2023. Both these schemes seem to have managed this level of strain, while keeping their cumulative financial results before investment returns during the period to a surplus, with a bit of help from the windfall of lower general claims levels during the COVID-19 pandemic as shown in Figure 5. Schemes included in the analysis – Net underwriting result as % of risk contribution 2019–2022. The trend of increasing deficits would be of concern, especially if there is a further increase from these levels.

Before the amalgamation, Sizwe Copper Core's deficits of between 3% and 4% of gross contributions were already a financial strain on the smaller Sizwe Medical Plan. Although the combined option is a smaller portion of the amalgamated scheme there have been significant deficits of just over 2% and close to 3% of scheme gross contributions in the two years since the amalgamation. This highlights part of the reason for the strain on the scheme's financial situation, leading to the CMS recently intervening and placing the scheme under statutory management.

2.5 Summary of the external environment impact on low-income scheme options and potential learnings for LCBO design

Table 3 in Section 2.2 shows that the coverage of low-income options, measured as the membership on these options as a proportion of total open scheme membership, has decreased over the investigated period. This period included the direct impact of lockdowns in response to the COVID-19 pandemic and the economic impact in the aftermath. It highlights that, while these are the most affordable options in the industry, with income cross-subsidies from other options, the minimum contributions are at such a level that members are fairly price sensitive in the face of external economic shocks.

Section 2.3 highlights the importance of carefully managing the demographic profile of low-income options in the open scheme market. It shows schemes that could improve their demographic profile through growth and others that grew without seeing an improvement in profile. Some schemes with membership losses could minimise the selective demographic impact and others experienced a worsening demographic profile in the face of large membership losses.

Section 2.4 shows the culmination of the impacts of both the net growth and demographic profile changes on the financial experience of the low-income option and

the relevant schemes. Some low-income options are surplus-making or making fairly low consistent deficits, which makes financial management and setting contribution increases simpler. Some of the deficits on low-income options are at a significant level relative to the size of the scheme. In the face of significant deficits on low-income options, some schemes seem to have managed the specific losses such that they did not affect the overall scheme's financial position significantly. Other options seems to be in the throes of a perfect storm of membership losses, significant worsening in demographic profile and increasing deficits that put severe strain on the scheme's sustainability.

This snapshot of the recent trends of low-income medical scheme options is not dissimilar to the medical scheme market as a whole. This is the outcome of the lack of regulatory reform in the medical scheme market. However, the impact of this lack of regulatory reform on the low-income market means that the group of options that is best placed to ensure growth for the medical scheme industry and increase the private cover of previously uncovered lives, now has lower coverage. The barrier to entry through the high legislated cost of cover may be exacerbated by further rounds of increased financial pressure on schemes from low-income options as indicated by recent trends. This could signify a spiral of a lack of growth, worsening demographic profiles, increase financial strains on schemes to a point where higher contribution increases are needed, with further selective withdrawals from these options.

The preceding analysis of recent trends could assist with urging regulators to make the needed reform in the current regulatory framework, but also provides some considerations for the LCBO process and design. Ideally, features of the current environment that are not assisting to ensure sustainability should not be replicated. There is an opportunity to build in missing features that would assist with a sustainable system. This is even more important given that the regulatory reform has been at a fairly slow pace, and there might not be an opportunity to redesign for any unintended consequences in design timeously.

While it is difficult to attribute the relative impact of a specific factor on the industry trends, some possible factors and their potential impact on the low-income medical scheme market are summarised below. This is an attempt to summarise possible considerations for both reform of the current regime and the LCBO process. Section 2.6 summarises the potential impacts the current primary healthcare insurance sector can have while the medical scheme regulatory reform path is still being plotted out.

2.5.1 PMBs

PMBs legislate a minimum cost for all options, which affects the affordability of all options, but especially those aimed at low-income members, even if the option provides close to the minimum levels. As shown in section 2, affordability challenges means that the potential growth of these options is limited and without the addition of younger members over time the demographic profile of the options worsens, with a knock-on effect on the option's financial experience. Beyond a certain level this puts pressure on scheme financials that

in turn puts pressure on the affordability of cross-subsidies. Therefore the contribution increases needed on these options might eventually need to be increased, leading to a vicious cycle of higher increases and selective lapses.

A key design element to inform the success of LCBOs is therefore the expected cost of the lower level of PMBs suggested. If the level is not low enough, it could have a significant effect on the affordability of these types of options and the potential growth for the industry. The primary healthcare insurance industry could provide some insight on the sensitivity to external economic shocks at a lower pricing point compared to the experience seen for low-income options at the current PMB level during the pandemic and in the aftermath.

2.5.2 Community rating and open enrolment

These requirements admirably aim for access and fairness through solidarity principles. Open enrolment means schemes cannot exclude any potential members from joining any option and by implication a low-income option cannot be ring-fenced for low income members other than through income bands.

For low-income options in the open market it means that demographic profiles need to be carefully managed through overall pricing strategies and risk management of these options. Growth with the right profile of members greatly assists with this endeavour. Where a low-cost option has growth challenges, schemes need to particularly ensure that both income and risk cross-subsidies are at levels that are sustainable for the scheme. More complex managed care and other interventions increase the administration and other healthcare costs of the option and need to be cost-effective, considering the direct claims impact.

To assist with sustainability of LCBOs and to simplify the risk management, consideration should be given to allowing all schemes, including open schemes, to choose to only provide LCBOs for employer groups of a certain minimum size. This could be for a limited time to ensure that stable risk pools are first built up. Being able to differentiate the contributions between compulsory (in other words the entire employer group goes onto cover) and voluntary groups (subject to a minimum number joining, individual employees have the option of choosing to be on cover or not going onto cover, increasing selection effects) would also assist to manage risks through pricing.

Recently there have been renewed discussions on following the social health insurance path to universal cover. This includes mandatory cover for employed persons and/or persons with a certain level of income. This would have an immediate positive impact on risk profiles of the medical scheme industry in its current form, which can then be rolled out to LCBOs. This would be another way of increasing access by ensuring stable risk pools at various levels, which could be used as a base to increase cover over time.

2.5.3 Income-banded contributions

Income banded contributions are meant to ensure income cross-subsidies in a scheme.

It can however be difficult and costly to verify income, particularly for retail business. Income as a measure of affordability does have some drawbacks e.g. pensioner members with low incomes and high asset values. Pensioners generally have lower incomes and higher healthcare needs. It also adds a potential level of selection against the scheme.

To illustrate the difficulty of verifying retail income, compared to receiving payroll income from an employer group, Table 5 summarises the income band distribution of retail members and members on small groups compared to those on groups of ten and more members for a specific option in the Momentum Health Solutions (MHS) universe for a particular month in 2023.

Table 5. Income band distribution between retail and small groups compared to larger groups

Income bands	Retail and small groups	Groups 10+
Lowest income bands	80.1%	49.6%
Other income bands	19.9%	50.4%

Retail and small groups have a much higher proportion of members on the lowest income bands. This could be both due to understating of income and members with low verified incomes, but high asset values.

While income verification could be difficult and costly the return on investment of applying checks could be well worth the spend, based on the number of retail members on the option. A regulator or industry body initiative to make this more cost effective could also be considered, perhaps with the help of the South African Revenue Service (SARS).

For LCBOs this would also present a case for allowing cover to be limited to only employer groups of a certain size to avoid the complexity of retail member income verification, as employer group payroll can be used.

Consideration should also be given to whether the complication of income banded contributions would be worth the increased take-up of making LCBOs more affordable to the lowest income members. A broad maximum income for those that can join LCBOs without income banded contributions could be a simple structure to avoid downgrades and ring-fence this solution to low-income members and possibly avoid some risk cross-subsidies of higher income members who are likely older. This approach would have the same difficulties in verifying income, but could possibly simplify the need to have an accurate assessment to manage contribution income with the correct income per income band.

2.5.4 Type of business

Another indicator of potential claims experience of an option is the type of business between an individual membership (retail) or part of a small group, compared to those in

larger groups. In the MHS universe, group members have claims ratios that are around a 30% lower than retail business. In the low-income market this increases to around 50%. This is partly due to the better demographic profile of employer groups, but there is also a selection effect after standardising for demographic profile. In a compulsory employer group the scheme receives both the low and high disease burden members, which improves the ability to pool risks. Therefore, attracting a high proportion of retail business is also expected to add a strain on the cross-subsidies needed for all options, but particularly for low-income options.

This again provides a case for allowing only group members in the initial period if LCBOs become available.

2.5.5 Inclusion and type of non-PMB day-to-day cover offered

Some of the options highlighted in section 2.4 with surpluses or relative low deficits either have fairly low non-PMB day-to-day cover or relatively lower day-to-day cover compared to competitors in potentially anti-selective areas such as specialist benefits. Some options also do not offer face-to-face care with GPs, but either virtual consults or face-to-face visits with nurses at the first instance.

There are some learnings for the LCBO benefit design. While these benefits are highly valued and generally proposed as the types of benefits preferred by low-income members, they need careful design to avoid anti-selection in the open scheme market and to carefully manage waste and abuse.

2.5.6 Conclusion of LCBO considerations

The analysis above shows that there is a strong case for a more affordable type of medical cover to increase coverage of low-income persons in the private sector. It has also shown the consequences of a well-intentioned, but partially implemented regulatory environment with high levels of member protection, but very little risk and financial protection for schemes. It also provides a potential checklist of considerations to ensure the sustainability of an LCBO regime.

2.6 Implications for the role of primary healthcare insurance in the low-income health market

The primary healthcare insurance market came into being due to the market need for more affordable healthcare cover at lower benefit levels. As part of insurance regulations through exemptions to the MSA it provides more flexibility in design and ability to manage risks to ensure better product sustainability. At first glance this seems to come at a cost of member protections, in the absence of PMBs, community rating and open enrolment.

While there are no PMBs required in the insurance market, products are nonetheless fairly homogeneous due to competitive pressure to be in-line with the benefits of competitor options. There is more flexibility to set benefits around target price points.

In the absence of open enrolment, some products choose to focus on the group market. Without community rating different contributions for compulsory and voluntary groups or retail business can be charged. The resulting premium rates are therefore better matched to the risk, more equitable on this basis and negate the need for late joiner penalties.

Despite any type of community rating allowed, due to competitive pressure and the need for simplified products in this market most contributions are fairly standard, while discounts for good profile could be given on fairly simple rating factors.

While the primary healthcare market has some undisputed drawbacks from a member protection perspective, it provides many of the needed building blocks needed to almost immediately start adding to current membership levels to attain sustainable risk pools in the absence of a finalised LCBO regime. In addition the anticipated fairly long process to fully roll out the National Health Insurance (NHI), provides another means of immediately increasing private cover and take pressure off public resources.

Consideration should be given to how the current base of primary healthcare insurance cover could be used for a more legitimised and fair primary healthcare insurance regime. Some of the considerations should be to allow new insurers or product entrants and the regulation of potential market failures such as member protection.

3. EXTERNAL ENVIRONMENT IMPACT ON HEALTH INSURANCE

Health insurance products are currently exempted from parts of the MSA. These products are therefore not under the same scrutiny from CMS and are not expected to follow the same rules and guidelines as medical schemes. There are also very limited reporting requirements and no standardised annual reports available as is the case for medical schemes. Therefore, it is challenging to compare the growth and financials of the various providers. However, some information does become available anecdotally and we have collated what was available since 2022 in the analysis.

In the interest of fairness, we have kept the providers anonymous, save for Health4Me where we have a direct view of the product movements.

3.1 Providers considered in the growth analysis

The market has been closed to new insurer entrants since 2017, when the demarcation legislation became effective. However, there are many white labelled solutions and licence acquisitions that have taken place since the initial exemption window closed. In addition to the open market solutions available there are also bargaining council products that focus on the security and transport sector. These are restricted solutions and have been excluded from the analysis to give a view of the open market as it pertains to group and retail business.

The main competitors in the health insurance market are:

Table 6. Main health insurance competitors

Administrator	Product	Underwriter
Momentum	Health4Me	Momentum Life
Kaelo	Kaelo Health	Centriq
Discovery	Flexicare	Auto & General
Affinity	Affinity Health	Affinity Life
Unity	Unity Health	Bryte
National Healthcare	Various	African Unity Life

Products are usually priced based on member profile in employer groups and as a single rate for retail business. The market is highly contested and, as a result, benefits are very similar and cannot be easily cut due to member expectations, even though there are no prescribed minimum benefits. Benefits covered include but are not limited to:

— GP visits – both virtual and face-to-face,
— specialist visits,
— pathology and radiology,
— dentistry,
— optometry,
— health screenings and vaccinations, and
— chronic and acute medication

Primary healthcare is the entry point into the healthcare system and whilst it cannot address all health needs, many patients are sufficiently treated as part of this without the need for secondary or tertiary care. As a result, there is an implicit package of benefits and services required to serve these needs. The above benefits coupled with limited trauma/hospitalisation benefits seem to be delivering on this promise. Importantly, the bulk of members in low-cost insurance products were previously uncovered and now have access to private healthcare for the first time, so apart from offering appropriate benefits there is also the responsibility of member education that lies with the insurer.

Given the need for some access outside of primary healthcare, providers often sell major medical buy-up options such accidental risk cover and hospital cash-back options.

Benefits and premiums are typically reviewed annually, and premium increases are driven by a combination of utilisation and provider tariff increases but these increases are carefully balanced with the competitive pressures in the market.

3.2 Growth in the insurance market

Even though the CMS has not issued new exemptions since 2017, the health insurance market saw positive growth through partnerships and white labelling of exempted

products. Momentum Health4Me offers a white labelled retail product outsourced via a binder agreement and marketed under mybloom. There are a number of similar retail options in the market.

Figure 8 shows the beneficiaries under administration for 12 health insurance providers – these are all competitors and not just the main ones in Table 3. It is clear there is persistent and predictable growth across the top five competitors with somewhat muted and volatile growth in the rest of the market. The membership values have been collated using press releases, adviser presentations and aggregated data sources.

Zooming in on the Health4Me product, it is evident that there is demand for such products well in excess of what is suggested by GDP growth.

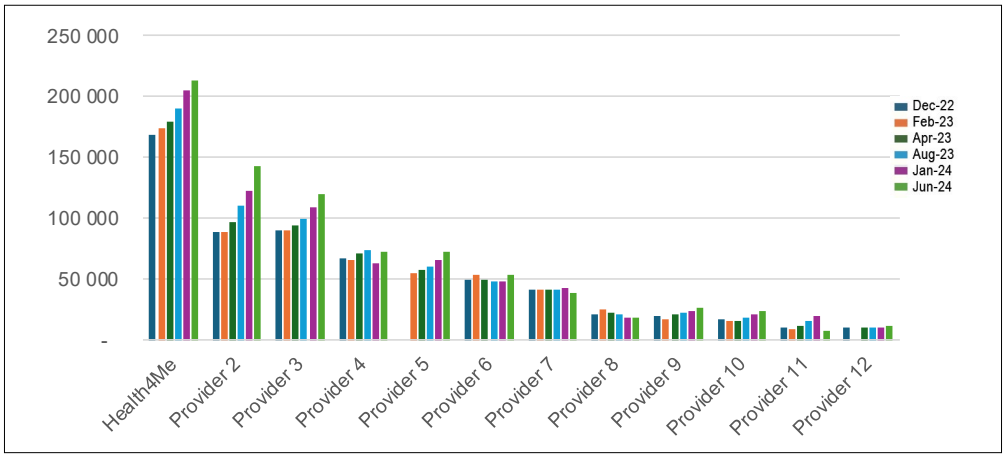

Figure 8. Health insurance product growth

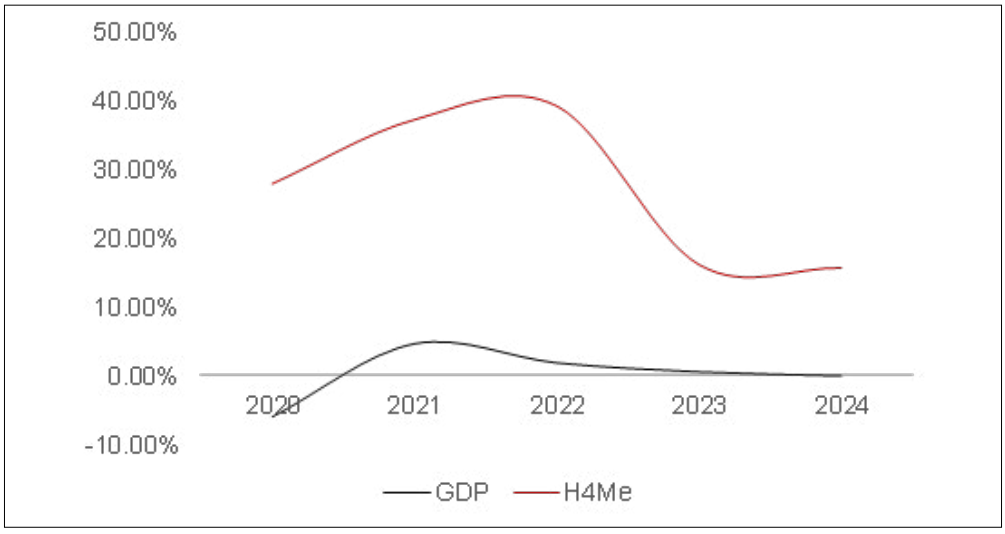

Figure 9. Health4Me growth relative to GDP

The members that typically buy health insurance products are usually previously uncovered members, i.e. the membership growth is mostly not buy-downs from a medical scheme option into insurance-based products. On the Health4Me product less than 0.5% of members are from scheme options and therefore it demonstrates limited buy-down. This is key to the sustainability of medical scheme options. Medical scheme membership has been steady for the last decade, and this hasn't changed as a result of insurance products surfacing in the market. Even though the number of schemes reduced, the beneficiary growth remained between 0.5 and 1% p.a. which is in line with GDP growth.

At the time of writing, the CMS annexures for 2023 were not available and therefore the analysis is cut off at 2022.

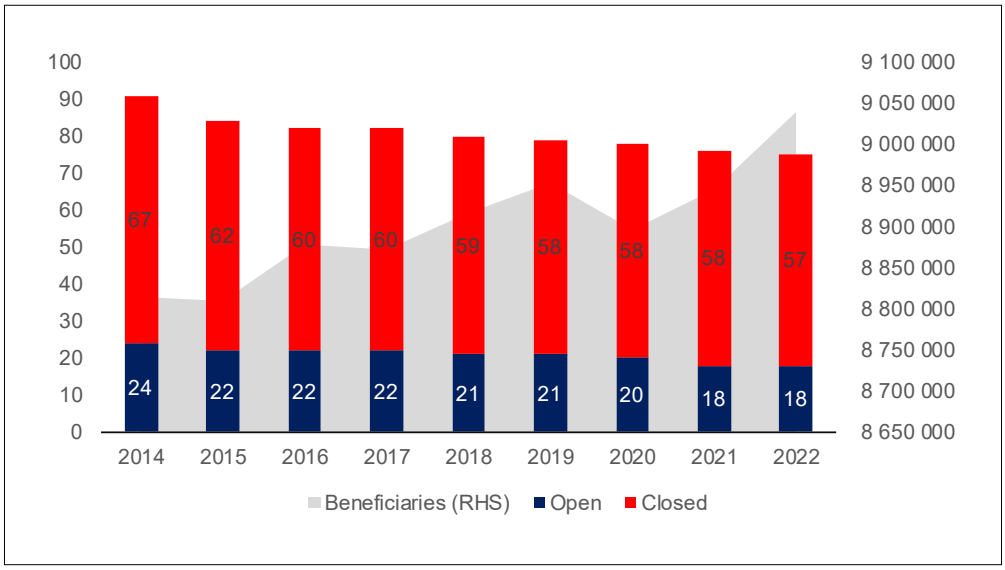

FIGURE 10. Number of medical schemes and scheme beneficiaries

3.3 Financial experience

In the absence of published financials for health insurance products we will focus on the experience of the Health4Me product which can then be compared to that of the Ingwe option in the medical scheme section above. These products share an administrator, aspects of benefit design and provider networks and can therefore be compared directly.
We will consider the impact of claims and lapses across various member groupings from retail through to large employer groups. These groups exhibit homogeneous lapse and claims behaviour. One of the key differentiators between medical scheme options and health insurance is the ability of the insurer to underwrite and price for the member groupings. which greatly adds to the sustainability of the products.

For the purposes of this paper small employer groups are groups with fewer than 10 employees and large groups have 10 or more employees. Compulsory business refers to

business that is either fully subsidised by the employer or where membership is a condition of employment, similar to other employee benefits arrangements:

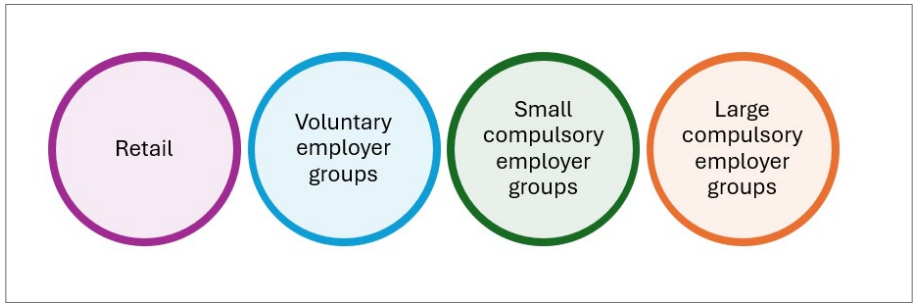

FIGURE 11. Types of business considered

TABLE 7. Types of business descriptions

Type of business	Description
Retail	Sold to individual retail members where premiums are paid by the member via debit order.
Small groups	Group business with fewer than 10 members.
Large groups	Group business with 10 or more members.
Voluntary	Group business where individual employees can choose to take insurance cover.
Compulsory	Group business where cover is a condition of employment or a non-flexible staff benefit.

3.3.1 Lapse experience

Lapses are calculated as the members lost in the first year of policy inception and excludes business that was not taken up, i.e. where the first premium was not collected. Group lapses include both staff turnover and entire groups leaving cover (see Figure 12).

First year retail lapse rates put immense pressure on the pricing, especially from an expense recovery point of view. There is a steep drop in lapses as the business becomes less anti-selective. Retail lapses improve in year two onwards, but given the large loss in year one it is impossible to recover from those member losses.

Looking at a cohort of retail members over a five-year period we can see that less than 10% of members are still in-force and paying premiums after five years. Depending on the cost of distribution this could still be an attractive opportunity for growth given the vast number of uncovered lives in the country.

Insurance products can anticipate these extreme lapses and allow for that in expense loadings when pricing. Similar options in the scheme environment have to have community rate and are therefore exposed to this retail anti-selection. Pricing for that will affect competitiveness negatively in the scheme and since the CMS requires options to be self-sustainable it won't be legally (at least in the letter of the law) possible to run

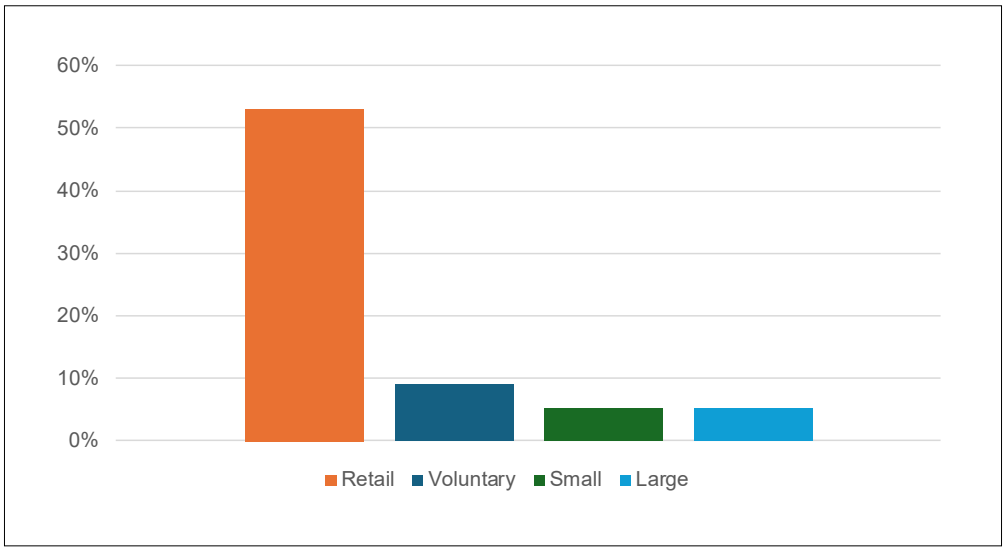

FIGURE 12. Lapse rates by business type on the insurance licence

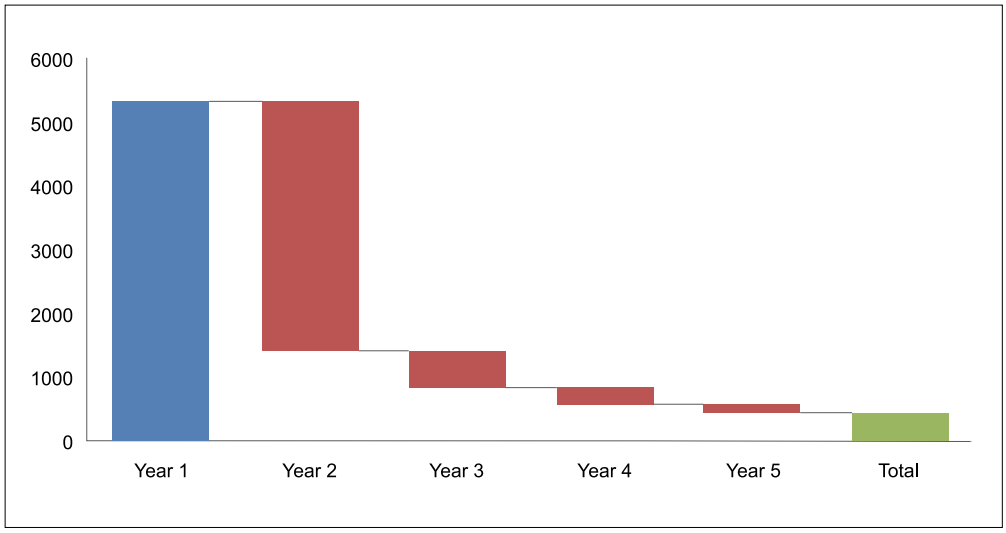

FIGURE 13. Retail business rundown

these options sustainably at scale – we have seen this in section 2 above. Even though the medical scheme does not carry the administration loss of these lapses (cost of onboarding, membership cards, upfront expenses, etc.), the exposure to members utilising benefits and then lapsing only to re-enter at a later stage is similar to that in the insurance context, but without any means to mitigate it by refusing cover or differential pricing, unless it can be proven that the claims were due to non-disclosure of a condition.

3.3.2 Claims experience

While it would not be appropriate to show Momentum's Health4Me product loss ratio directly, we can analyse the relative claims experience of each of the above groups, indexing the overall claims per life per month (plpm) to 100%.

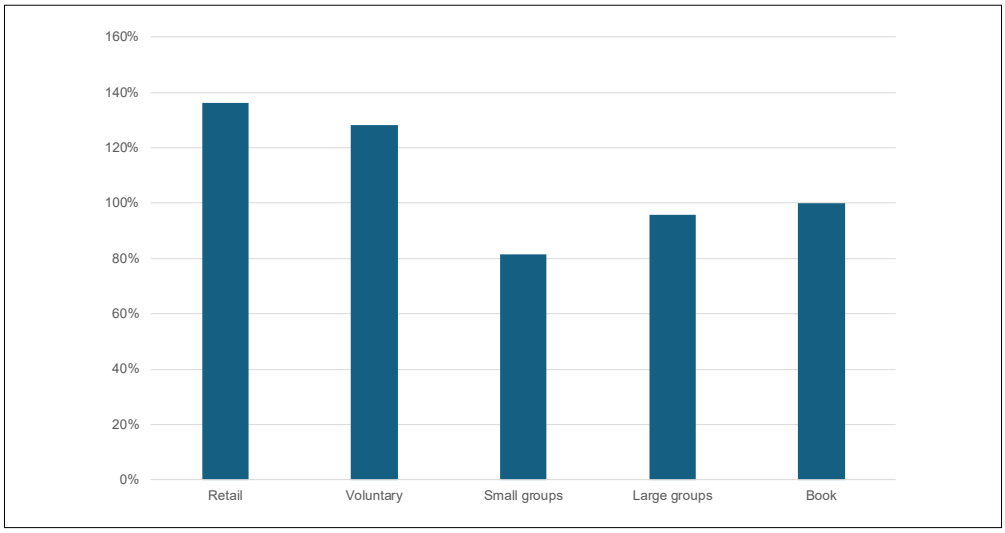

FIGURE 14. Claims experience by business type

Again, the variance is around 40% between retail and voluntary and group business, making it critical to be able to price for the risk.

4. INNOVATION IN THE LOW-INCOME MARKET TO ADDRESS SUSTAINABILITY

Due to the rapid growth of the insurance-based options, product designers have had to innovate to remain competitive, whilst managing the claims experience of growing and ageing books, off a fairly low base. To mitigate high healthcare inflation, which is typically 1–3% above CPI, telemedicine has been widely adopted and built into product design. Telemedicine has the benefit of being able to provide access to care for more members at a lower cost and also allows for a more focused healthcare and network management approach. Members are typically guided by the telehealth doctor to use the appropriate network for additional screening such as radiology and pathology. Furthermore, the doctor only deals with formulary and processes within a single product and therefore they are best equipped to prescribe medication within the set formulary and dispensed at an appropriate network pharmacy. This adds, not only, to cost management but also an improved member experience with no unexpected co-payments. The result has been better health outcomes coupled with lower claims downstream, (such as lower specialist and hospital cost by avoiding a worsening of a condition through earlier treatment by a

GP) ensuring a significantly more affordable price point. For example, identifying and managing a member's chronic illness in the early stages comes at a much reduced expense that is mostly limited to medication to control the illness (often in the formulary) compared to complications when untreated.

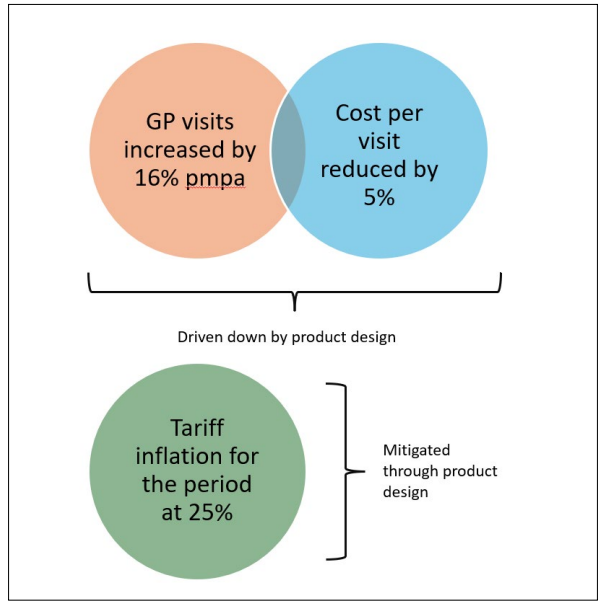

FIGURE 15. GP claims experience since 2020

In the GP environment the Health4Me product utilised telemedicine successfully to provide members with more access to healthcare whilst reducing the effective cost of care in an environment where provider tariffs escalated. Adding technology-driven benefits like these is possible in the medical scheme environment, but because it cannot be priced for separately the impact of the change will be less pronounced.

5. CONCLUSION

While low-income options are the most affordable in the industry, and much of the hope of growth in the current medical scheme environment rests on them, the coverage, measured by membership of these options as a proportion of total open scheme membership, has decreased over the last five years. The minimum contributions are at such a level that members are fairly price sensitive in the face of external economic shocks, such as the COVID-19 pandemic. It is important to carefully manage the demographic profile of low-income options in the open scheme market. With open enrolment and community rating, in the absence of mandatory cover and REF, the only levers available to schemes are to grow sustainably with members of a good demographic profile and to try and minimise the impact of selective lapses.

The culmination of the impacts of both the net growth and demographic profile changes is the financial experience of the low-income option and the relevant schemes. Low-income options that are surplus-making or making fairly low consistent deficits makes financial management and setting contribution increases simpler. Large medical schemes, with a larger base of membership to assist with cross-subsidies, have kept deficits on low-income options at a manageable level relative to the size of the scheme, although there has been a significant increase in the levels of deficits. For smaller schemes with low-income options under financial pressure, it is more difficult to manage as the cross-subsidy is a larger strain relative to the scheme. If the option needs significant repricing of the low-income and perhaps other options, it may lead to further selective membership losses, triggering a cycle of further repricing which puts severe strain on a small scheme's sustainability.

While the impact of the regulatory environment is not new, there is a significant worsening of the main measures of health in the low-income medical scheme market. This is similar to other options in the industry, but the impact is on the options that are best placed to deliver growth. The impact on low-cost options is the consequences of a well-intentioned, but partially implemented regulatory environment with only high levels of member protection, but very little risk and financial protection for schemes. These recent trends provide evidence that important regulatory reform is more urgent than ever.

The analysis of low-income medical schemes shows that there is a strong case for a more affordable type of medical cover to increase coverage of low-income persons in the private sector. Less price sensitivity would mean more resilience to external shocks such as COVID-19, and the economic impacts thereafter, to provide a more stable level of coverage.

There are also some considerations for the LCBO process and design arising from what has been learned from the recent trends in the current environment. Ideally, features of the current environment that do not help ensure sustainability should not be replicated or considered carefully. It is also an opportunity to build in missing features that would assist with a sustainable system. Some important considerations are summarised below.

— The expected cost of the lower level of suggested PMBs for LCBOs is an important consideration. If the level of benefits is too high, it could have a significant effect on the affordability of these types of options and the potential growth for the industry.
— Strong consideration should be given to allowing all schemes, including open schemes, to choose to only provide LCBOs for employer groups of a certain minimum size, to assist with sustainability and to simplify the risk management. This could be for a limited time to ensure that stable risk pools are first built up.
— The ability to differentiate the contributions between compulsory and voluntary groups would also assist to manage risks through pricing.
— If renewed discussions on mandatory cover does result in it being implemented, LCBOs can be mandated in the next stage of reforms. This would be another way of increasing access by ensuring stable risk pools.

— Consideration should also be given to the trade-off of better affordability and increased take-up with income banded contributions compared to the complexity to verify and apply a more complex contributions structure. A broad maximum income for those that can join LCBOs without income banded contributions would be a simpler structure to avoid downgrades and ring-fence this solution to low-income members, by somewhat simplifying the income verification needed.

The primary healthcare insurance market came into being due to the market need for more affordable healthcare cover at lower benefit levels. As part of insurance regulations through exemptions to the MSA it provides more flexibility in design and ability to manage risks to ensure better product sustainability.

It does already allow the ability to implement some of the above suggested considerations for LCBO due to the flexibility of the insurance regime, which allows it to greatly improve the expected sustainability. While the primary healthcare market has some undisputed drawbacks from a member protection perspective, in the absence of PMBs, community rating and open enrolment, it provides many of the needed building blocks to almost immediately start adding to current membership levels to attain sustainable risk pools in the absence of a finalised LCBO regime.

While there are no PMBs required in the insurance market, insurance products offer similar and competitive benefits based on the needs of members.

Products can already focus on the group or retail market, based on risk appetite. Compulsory and voluntary groups or retail business can be charged commensurate with the anti-selection risk. The resulting premium rates are therefore better matched to the risk, more equitable on this basis and negate the need for late joiner penalties.

Despite any type of community rating allowed, due to competitive pressure and the need for simplified products in this market most contributions are fairly standard, with simple rating factors. Even moderate risk rating, i.e. in groups of members, sufficiently mitigates this anti-selection. Therefore, equity can still be achieved without making the product unaffordable to certain members.

Consideration should be given to how the current base of primary healthcare insurance cover could be used for a more legitimised and fair primary healthcare insurance regime, given that this could provide a solution that is simpler to design (e.g. without the complexity of specifying a level of PMBs) and could be implemented faster as a result. As part of this process care should be taken not to overregulate the insurance products so as to unnecessarily constrain a fairly efficient market and to only intervene where there are significant concerns or market failures. There are improvements in possible sustainable access to much needed primary healthcare benefits with more flexibility and fewer constraints and the freedom to introduce and test innovative ways of managing costs. A new regime would also need to consider how to allow for new insurers or product entrants, and regulation of potential market failures such as member protection.