ANNEXURE 2

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Attention: Patrick Matshidze
By e-mail

Dear Patrick

Comments on Circular 8

Thank you for the opportunity to submit comments on Circular 8. In this response we present the opinion of actuaries who are members of the Health Care Committee of the Actuarial Society of South Africa.

We include requests for clarification of statements within the Circular throughout this document, and we have highlighted such requests for ease of reference.

Overall, we support the need for removal of s33(2) of the Act by allowing cross-subsidisation in pricing across the risk pool. The current requirement of the Act that each option should be self-sustaining leads to option downgrading, which inevitably results in a fragmented risk pool by option. The Actuarial Society has long advocated the need for removing the s33 requirement. Further, we support the introduction of measures that effectively provide more bargaining power to schemes when negotiating with service providers, and the introduction of underwriting for movements between medical scheme options.

We commence this letter by stating the implications of Circular 8 for medical schemes, members, service providers and administrators, as we understand it:

1. Community rating in respect of common benefits, which includes the risk-equalised cost of PMBs, implies that option downgrading would not affect a scheme adversely, at least in respect of the cost of common benefits. This is a significant advantage. However, at the same time, the currently fragmented risk pool, where members of "low cost" options tend to be healthier, and where schemes are forced by s33(2) of the Act to price for lower risks in such options, leads to a situation where such members would have to experience a significant contribution increase upon introduction of the principles of Circular 8. Many of these members are also low income members, and such

high increases might lead to selective withdrawals amongst lower income individuals. We quantify this in more detail below.

2. This effect is exacerbated by the introduction of the REF. Since the REF imposes the cost of the community rate on every individual beneficiary of a scheme, this means that the cost of equalisation for PMBs would also have to be taken into account for current low cost options. To the extent that the cost of PMBs was lower in the past for members of such an option, and was priced as such due to the provisions of the Act, such members will experience a further contribution increase due to the introduction of the REF.

3. The impact of the above two implications would be different for every single scheme. For some high cost options, the lower cost of equalised common benefits and the introduction of the REF might lead to contribution decreases, thereby increasing affordability for members who used to belong to high cost options.

4. A further impact arises with the provisions 32 to 36 of the Circular that relate to contribution determination. The limitation of community rated contributions to three family members, and the provision that such contributions have to be equal, effectively implies that small families would subsidise the cost of contributions for large families, and for single members, as well as families consisting of two beneficiaries. This has a number of implications, which include:

    a. Higher contributions for small families in low cost options, particularly for those with one or two or even three children, in schemes where current child rates are considerably lower than one third of adult rates (which would be the case in most schemes).
    b. But this is offset by "family size subsidies" for singles, couples (to an extent) and large families, typically with more than 4 children.
    c. The scheme would now be exposed to family size changes in terms of:
        i. Changes in average family sizes as members register dependents to benefit from these provisions
        ii. Changes in average family sizes in the common benefit risk pool, vs. the different supplementary benefit risk pools
        iii. Changes in average family sizes arising out of membership movements between different schemes
    d. With the significant changes to benefit structures introduced by Circular 8, it would be very difficult to predict which families will select which benefit options, how the family size might change, how families might join or leave the scheme, and what their underlying health status would be. This means that pricing would have to build in significant risk margins to account for this.

5. It appears that a key concern underlying this proposal is that pensioner members are predominantly single members and are adversely affected by the current adult/child rate differentials. This concern needs to be countered by the concerns that larger families are not registering all their dependants for benefits and that the existing subsidy from smaller to larger families could be affected. For example, on a current scheme the relativities of contributions to a single rate of R100 are R75 for an adult dependant and R35 per child

(maximum of 3 children are charged for). Using the actual family size distribution we have calculated the impact of the proposed amendment on the different families (ignoring adult dependants). This calculation has been done by setting a uniform rate per beneficiary to a maximum of 3 and calculating the single rate that gives the same overall average contribution per family. The impact in this case is that the small families (member + adult + one child) face an increase to support a reduction at all other levels.

Family size	Count of families	Current Contributions	New Contributions	Change
1	2263	100	81.64	-18%
2	4401	175	163.28	-7%
3	5847	210	244.92	17%
4	4385	245	244.92	0%
5	2076	280	244.92	-13%
6	733	280	244.92	-13%
7	241	280	244.92	-13%
8	75	280	244.92	-13%
9	23	280	244.92	-13%
10	5	280	244.92	-13%
11	1	280	244.92	-13%
12	1	280	244.92	-13%

6. The need for risk margins in pricing is increased due to the provisions of paragraphs 29 to 31 of Circular 8. One of the fundamental problems is still that schemes have no source of capital other than contribution increases. Since a scheme would now not be allowed to use benefit reserves for non-health costs, every scheme would effectively be required to hold non-health reserves, to provide for unforeseen costs, such as, for instance, legal fees. Members would have to pay for this.

7. In addition, since paragraph 29 requires schemes not to cross-subsidise the costs of common benefits and supplementary benefits, our reading of the circular implies that schemes would have to hold separate reserves for common benefits and supplementary benefits. Such reserves would have to be sufficient to account for all family size changes within supplementary vs common benefits, changes in underlying member risk profiles resulting from large changes in contributions due to the implications of the REF and Circular 8, as well as changes in NHRPL for different service provider groups, and changes in service provider behaviour as a result of changes in the NHRPL. Again, there would have to be substantial risk margins priced into contributions for supplementary benefit options to make sure that supplementary benefit reserves would be sufficient. Since schemes have no source of capital other than member contributions, any requirements for additional reserves would have to be met from member contributions.

8. Given that it is proposed that the entire reserving policy of schemes change under Circular 8, we believe that it now becomes necessary to urgently review the reserving requirement itself. In other words, **we are not sure whether each one of these separate reserves would have to amount to 25% of the**

element of gross contributions allocated to the component covered by the reserve, or whether some other reserving requirement would be set, and how any new reserving requirement would relate to the current 25% of gross contributions. It would be useful to obtain clarification on this aspect. Further, we would like to suggest that the discussion on risk-based capital be continued, as it becomes a great priority to introduce risk-based capital at the same time as any provisions relating to the separation of reserves for different components of costs.

9. In terms of provider contracts, we believe that the introduction of contribution discounts for member selection of particular provider groups might well allow schemes considerably more bargaining power with service provider groups. However, this would only be the case where there is an over-supply or adequate supply of particular service providers. Unfortunately, this is not the case, as members are typically spread over a wide geographical area, and the supply of specialise services in particular is limited. Further, whilst a particular hospital group may appear cheaper than another, this may be due to case mix of that group. Where a large group of members select a new restricted network, they may find that the particular procedure that they need, or specialist services that they require, might not be available in the network that they chose initially. Members may not, of course, know what procedures they would have to undergo in future when they select their service provider group now, or how many other members might have to undergo similar procedures in the same restricted network. In the workshop that we had in Centurion, it was indicated that schemes would be in a position to impose penalties for out-of-network use of services. **However, it is not clear whether such penalties would apply in the following situations:**

   a. **Where the procedure is in respect of PMBs;**
   b. **Where the particular procedure or service was not available in the chosen network**
   c. **In emergencies**
   d. **When members travel to areas where there might not be network facilities available, and if so, how far away from network facilities they would have to be before penalties might not apply.**
   e. **Please provide clarification on the above areas of uncertainty.**

10. One of the implications of equal income-rated contributions for different components of cost is that schemes would not be in a position to have income-rated contributions, where lower income members have lower contributions. This in itself might lead to unaffordable increases for low income members of schemes.

11. Whilst schemes would be able to offer lower cost, restricted treatment protocols to members who choose particular service provider networks, they would not be in a position to do so where the restricted protocol is not linked to a particular network. In other words, schemes would not be allowed to offer discounts relating to members choosing to always make use of generic medication, or the like.

12. The application of discounts to restricted networks would in our opinion still lead to fragmented risk pools between those healthier members choosing a restricted network and those who need freedom of choice and hence are willing to pay more for it. At least schemes would now be free to cross-subsidise costs between those who choose restrictions vs those members who have freedom of choice, but in practice, the problem of downgrading between network choices (similar to option downgrading) would most likely not disappear.

13. In terms of the waiting period rules described in paragraph 28 of the circular, we strongly support the need for schemes to protect themselves against anti-selection between common and supplementary benefits, and between restricted vs open network choices. However, we submit that the waiting period provisions are too complex to administer as they currently stand, and that most schemes would in practice find it impractical to impose waiting periods. This is particularly true if the exceptions mentioned in par. 9 above also apply to waiting periods. Further, schemes are vulnerable to the fact that members who do not want to have waiting periods imposed on them might simply move between schemes to avoid such waiting periods and hence anti-selection would occur at industry level. Due to open enrolment, the receiving scheme would not be protected against such anti-selection. There are no easy solutions to this problem, other than to allow waiting periods to be transferable between schemes, although this again increases administrative complexity. A potential solution to the problem of anti-selection without the introduction of extremely complex waiting period administration would be to allow schemes to deny membership or membership movements where they are being selected against, or to allow contribution loadings where schemes are selected against, or to allow risk rating for supplementary benefits. Such provisions might well be necessary given the significant potential for anti-selection. Due to the scenarios described above, numerous bodies have highlighted the need to allow for risk rating of benefits that are not risk equalised (albeit to a limited degree) in an open enrolment environment. The Report of the International Risk Panel to the Risk Equalisation Task Group has recommended that "the same supplementary package can be sold to different risk groups at different prices" and "insurers should be free to use any risk factors they want, but must accept any applicant (open enrolment) at a price within the approved contribution rate band". Thus, it is recommended that benefits that are not risk equalised be exempt from community rating and be allowed to charge contributions that reflect the expected risk profile of the individual (at least to a limited degree). In this way, the gaming effect under open enrolment is eliminated, or at least reduced.

14. The provisions of paragraph 19 read together with paragraph 31 seems to imply that companies offering capitation fee arrangements would not be in a position to offer risk sharing arrangements to schemes, or alternatively that third party capitation providers would not be allowed to make any profits, and only capitation arrangements offered by service providers themselves would be allowed to make profit (since they can build their profit margins into the cost of health services). **Please clarify whether this is the intention**.

15. We are concerned about the fact that supplementary benefit options would only be allowed to offer out-of-hospital cover. This is likely to increase the incidence of unnecessary hospital procedures, as service providers may well have an incentive to hospitalise patients in order to obtain cover from common benefits. We recommend that some in-hospital cover be allowed within supplementary benefits.

16. The definition of "family" in paragraph 33.3 also needs to be clarified. **Would "single adults" mentioned in this paragraph also include the aged parent of an adult couple?** If this is the case, a married couple might be in a position to obtain membership for an aged parent (defining the parent as a "single adult"), plus all their children and any children dependent on the parent, and only have to pay a contribution for 3 beneficiaries. Please clarify whether this is the intention.

17. We submit that the discount allowed under par. 28.3 for chronic members is problematic. Since this discount would only be available to members who suffer from chronic conditions, members would be in a position to obtain a discount depending on their state of health, which we believe is in contravention of s29 of the Act. **Please clarify this paragraph**. Further, a system whereby discounts are only available to chronic members is unlikely to be successful as a result of resistance to such cross subsidisation and the incentive it creates for members to register for unnecessary chronic medication. An alternative suggestion is to only allow for one preferred provider network per scheme so that the benefit can be differentiated as "open access" or "preferred provider". We suggest that the proposals under 28.3 are given significant more work to reduce the risk of unintended consequences.

18. It is not clear from paragraph 25 of the Circular whether a fixed number of supplementary benefit options also imply that the contents of such benefit options would be fixed. **Please clarify whether this is the intention**.

We have noted reports in the media indicating that Circular 8 might be implemented in a phased manner. We believe that the implementation of Circular 8 together with the Risk Equalisation Fund in 2007, might imply such significant contribution increases to members of low cost options that it would be impractical to impose this on the industry within a short time frame. Further, the very substantial administration system changes would dramatically affect the ability of schemes to offer benefit structures on this new basis to members in 2007.

Members of the Health Care Committee have performed calculations on behalf of clients to indicate the very significant impact of Circular 8 on the contributions of members of low cost options. These will be provided to Council in the submissions of the individual schemes involved.

Further, the content of par. 15 of Circular 9, read together with Circular 8, is of great concern to members of the Health Care Committee. Circular 9 seems to imply that Trustees would have to use benefit design and cost management to make sure that increases in NHRPL do not lead to high contribution increases. The question now arises whether high contributions as a result of the re-design necessitated by Circular

8 and the implications of the REF would be allowed. Further, the ability of Trustees to use benefit design and cost management is severely constrained by the fact that fixed benefit structures are prescribed by Circular 8, and that the cost of PMBs is set at industry level under the REF, rather than at individual scheme level.

We therefore suggest that the industry might find it easier to implement changes involving only the following:

1. The removal of s33(2) of the Act, allowing schemes to decide on the level of cross-subsidisation between different benefit options, given their membership structures, the risks of anti-selective behaviour, and the extent to which their risk pools had been fragmented already due to the provisions of s33(2) of the Act.
2. Differentiated contributions for adults and children, with the ability to levy contributions for as many children within a family as the scheme chooses.
3. The ability to offer discounts within options to members who choose particular restricted networks or restricted treatment protocols.
4. The ability to use reserves for all costs of a scheme, rather than implementing a policy of fragmented reserves.

We hope that you find these comments helpful – please contact me on any of the numbers indicated below if you have questions.

Yours sincerely

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