CMS

Council for Medical Schemes

A REVIEW OF GOVERNMENT-FUNDED MEDICAL SCHEMES AND MEDICAL SCHEMES WITH LESS THAN 6000 MEMBERS

Policy Research and Monitoring

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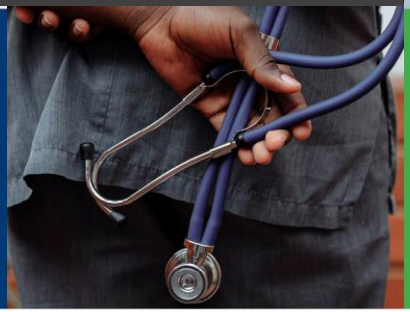

This report is published by the Policy Research and Monitoring Unit (PRMU) of the CMS. The unit serves beneficiaries of medical schemes and members of the public by conducting research, collecting, and analysing data to monitor, evaluate, and report on trends in medical schemes, measure risk in medical schemes, and develop recommendations to improve regulatory policy and practice. The unit contributes to the development of policy that enhances the protection of the interests of beneficiaries and members of the public. The research team comprises of multidisciplinary specialists in health economics, statistics, epidemiology, public health, and financial analysis.

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EXECUTIVE SUMMARY

In 2018, the Council for Medical Schemes (CMS) drafted a framework for medical scheme consolidation outlining the approach to reducing risk-pool fragmentation whilst strengthening financial protection in the current medical scheme environment.

This report reviews state employees' medical schemes, and schemes with fewer than 6000 principal members. According to CMS Industry Report data, the 11 state employees' medical schemes accounted for 1.1 million principal members and 2.9 million beneficiaries in 2021, which makes up about 33.1% of the medical scheme industry and 71% of restricted schemes in terms of beneficiaries. Among the 11 state employees' medical schemes, 5 had fewer than 6 000 members. The average age for state-funded medical schemes ranges from 29 to 57 years, while the dependant ratio ranges between 0.5 and 1.9. The state employees' medical scheme solvency ratio was above the minimum threshold of 25% as prescribed by the Medical Schemes Act (ten of the 11 schemes complied with Regulation 29) and year-end reserve of just over R34 billion as of December 2021.

This study found varying remuneration practices, with some schemes remunerating more than others. State-funded medical schemes had different demographic & risk profiles, varied in terms of scheme size, were generally in good financial position with good reserves, which must be managed with care for the benefit of beneficiaries.

ACRONYMS AND ABBREVIATION

BoT	Board of Trustees
CMS	Council for Medical Schemes
CDL	Chronic Disease List
GAE	Gross Administration Expenditure
GCI	Gross Contribution Income
GEMS	Government Employees Medical Scheme
MCO	Managed Care Organisations
MSA	Medical Schemes Act
NIA	National Intelligence Agency
PMB	Prescribed Minimum Benefits
PMSA	Personal Medical Savings Account
POLMED	South African Police Service Medical Scheme
SABC	South African Broadcasting Corporation
SAPS	South African Police Service
SANDF	South African National Defence Force
SASS	South African Secret Service

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1. INTRODUCTION

In order to reduce risk-pool fragmentation and increase financial protection in the current medical scheme's environment, the CMS developed a framework for medical scheme consolidation. The report reviews state-funded medical schemes, and schemes with fewer than 6000 principal members. As previously envisaged, consolidation had the following objectives:

- Reducing excessive fragmentation of risk pools,
- Mitigating against risk rating and
- Strengthening social solidarity (income and health status cross-subsidies).

2. PURPOSE

The report aims to review the performance of government-funded schemes and schemes with fewer than 6,000 principal members and assess how these compare to closed schemes and that of the industry.

3. METHODOLOGY

This was a retrospective cross-sectional analysis of government-funded schemes, and only those with fewer than 6,000 primary members were selected for the study. The data was sourced from the CMS industry reports and annexures, and the review period was 2021.

4. INCLUSION AND EXCLUSION CRITERIA

The inclusion criteria were state-funded medical schemes and schemes with less than 6000 members. Other medical schemes covering state employees, including open schemes such as Discovery Health Medical Scheme and Bonitas Medical Scheme were excluded, as were other optional medical schemes that cover government employees.

5. ANALYSIS, RESULTS AND DISCUSSIONS

5.1 State employees' risk pools

The state employees' medical schemes are constituted by employees of the South African Police Service (SAPS), employees of local government and associated agencies, employees of state-owned enterprises, national and provincial departments, entities listed in Schedule 3 of the State Act (excluding SANDF, NIA, SASS, and SAPS), employees of Rhodes University, and members of the South African Parliament. These medical schemes cover serving former employees and their dependents. The average age of state employees' medical schemes ranges from 29 to 57 years (see figure 1), while the dependant ratio ranges between 0.5 and 1.9. State employees' medical schemes accounted for 1.1 million principal members and 2.9 million beneficiaries in 2021, which makes up about 33.1% of the medical scheme industry.

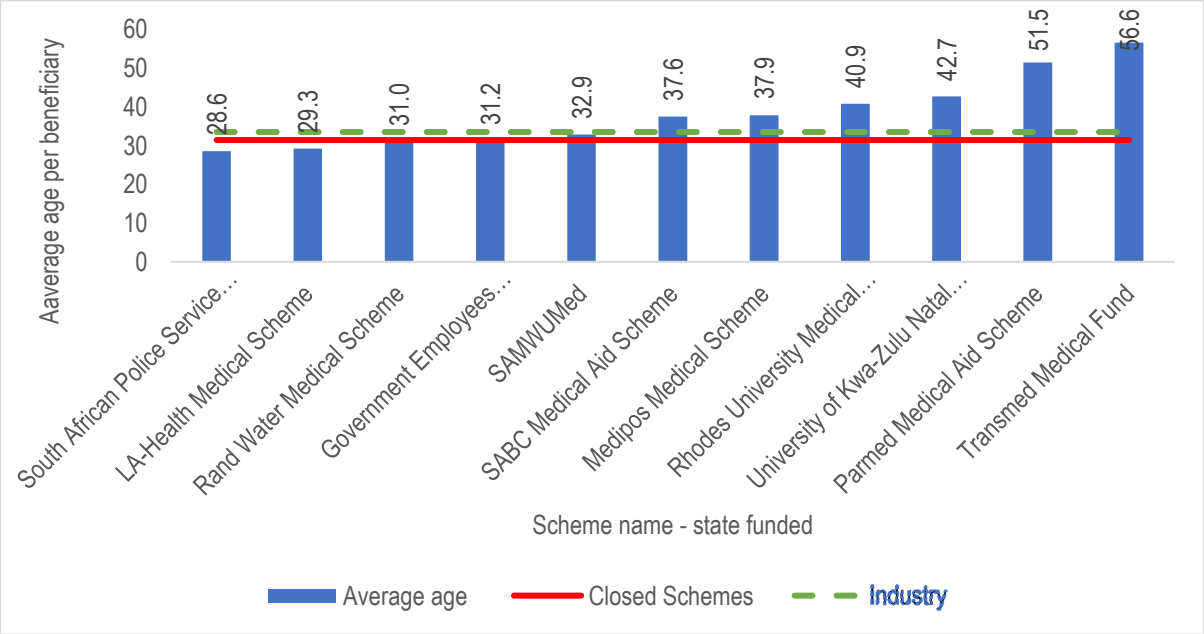

Figure 1: Average age of state employees' medical schemes

5.2 Benefit paid

A large proportion of healthcare expenditure for government-funded schemes was paid towards hospital services ranging from 24.85% to 40.88%. Medipos Medical scheme had a significantly higher proportion of hospital expenditure relative to the industry average of 35.72%. Parmed Medical Aid Scheme had a larger proportion of spending paid towards specialists' services than other government-funded schemes. **Table 1** below illustrates the percentage of total benefits paid by the scheme on selected discipline.

Table 1: Percentage of Benefits paid in 2021 per scheme

	% Of total benefits paid in 2021					
Scheme Name	**Hospitals**	**Specialists**	**Medicines**	**GPs**	**Dentists**	**Supplementary and Allied Health Professionals**
Rhodes University Medical Scheme	24.85%	23.38%	23.58%	7.06%	4.79%	11.26%
SAMWUMed	37.60%	24.12%	12.37%	7.97%	2.88%	10.69%
LA-Health Medical Scheme	35.31%	23.94%	16.82%	6.85%	2.63%	8.77%
Rand Water Medical Scheme	36.98%	24.14%	18.14%	6.81%	2.06%	8.29%
SABC Medical Aid Scheme	33.26%	24.61%	17.87%	3.96%	3.14%	10.37%
Parmed Medical Aid Scheme	31.56%	27.94%	22.11%	2.81%	2.57%	9.31%
University of Kwa-Zulu Natal Medical Scheme	31.17%	25.71%	19.57%	4.20%	2.98%	10.50%
Medipos Medical Scheme	40.88%	22.07%	16.68%	5.32%	2.76%	7.96%
South African Police Service Medical Scheme (POLMED)	34.58%	23.84%	15.97%	7.63%	2.45%	7.56%
Transmed Medical Fund	31.00%	24.99%	27.36%	4.92%	0.15%	4.72%
Government Employees Medical Scheme (GEMS)	36.71%	24.70%	15.91%	6.75%	2.15%	8.22%
Restricted Schemes	**35.73%**	**24.77%**	**16.09%**	**6.29%**	**2.35%**	**8.22%**
Consolidated (Open & Restricted Schemes)	**36.19%**	**26.40%**	**15.63%**	**5.08%**	**2.02%**	**7.90%**

5.3 Governing structure

According to Section 57 of the Medical Schemes Act, closed schemes' board structures consist of nominated and elected trustees depending on the sector, which is a key factor in the composition of the board. The board composition of state employees' medical schemes ranges between 7 and 25 trustees. The remuneration philosophy of trustees in the schemes varies significantly, with some schemes offering higher remuneration packages than others. In 2021, GEMS and POLMED paid substantially more per trustee than the industry and restricted schemes, at R744 and R426 000 respectively, while the industry and restricted schemes paid R178 000 and R109 000 respectively. The 11 state-owned entities' remuneration packages ranged between R73 000 and R744 000 per trustee (except for Rand Water Medical Scheme, SABC Medical Aid Scheme, Rhodes University Medical Scheme, University of KwaZulu Natal Medical Scheme, and Parmed Medical Aid Scheme, which did not incur any remuneration expenditure).

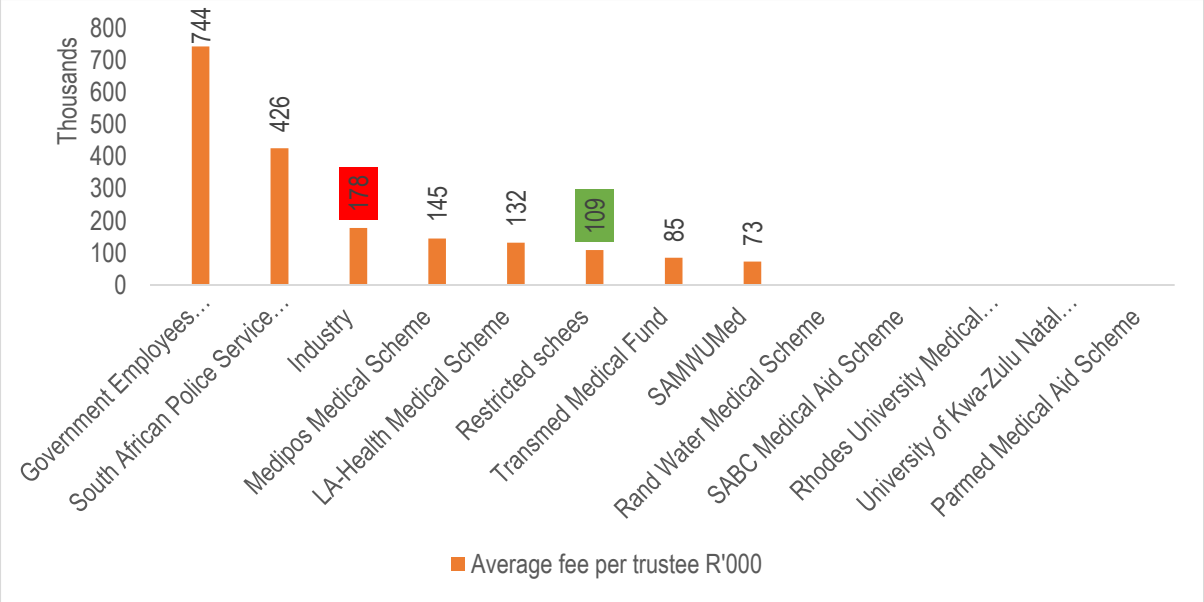

Figure 2: Average fee per trustee R'000- State-funded medical schemes

5.4 Contributions and Risk claims -2021

In 2021, the state employees' medical schemes accounted for R69 billion in gross contribution income, accounting for 30% of the industry's contribution income. For the year 2021, the gross contribution income per average beneficiary ranged between R976 and R5 554 per month. Figure 3 below shows that Parmed Medical Aid Scheme members contributed significantly more than R5 000. All state employees' medical schemes recorded a year-end risk claim ratio greater than 90%, except LA-Health Medical Scheme, Rhodes University Medical Scheme, and the University of KwaZulu Natal Medical Scheme, which all had lower risk claims than 90%. Medipos had a claims ratio of over 190%, a function of challenges concerning contributions that were not paid to the scheme by the employer.

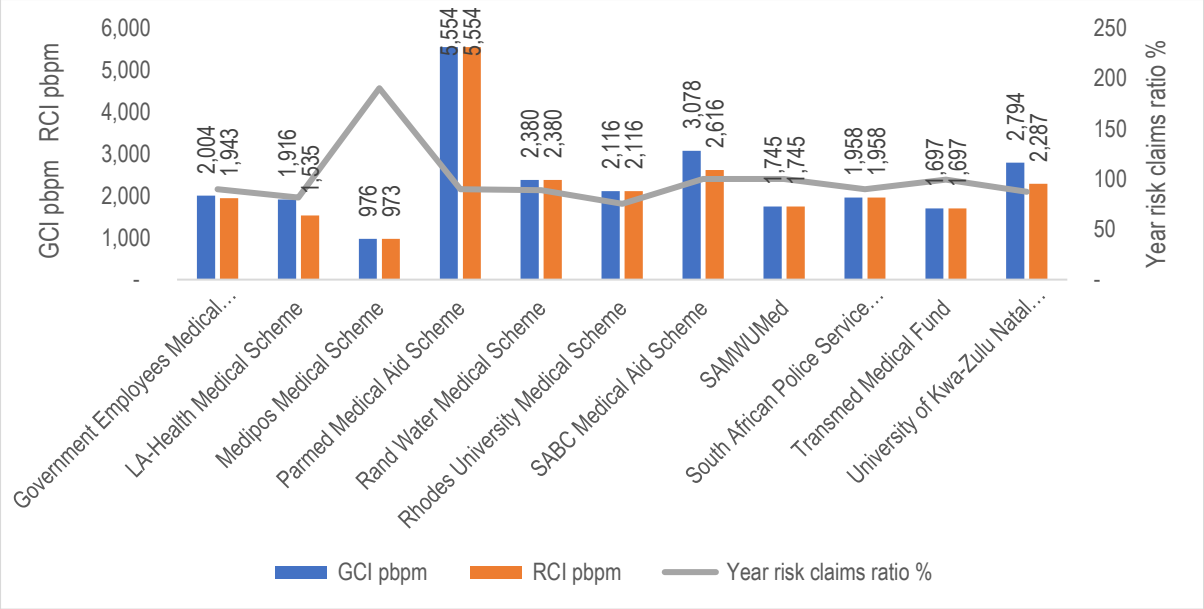

Figure 3: Gross and Risk Contribution Income and Risk Claims ratios (%) - 2021

5.5 Administration expenditure

The business model of the medical scheme entails outsourcing administration functions to for-profit entities such as administrators while others conduct these functions in-house. Administration functions for medical schemes are typically outsourced to third-party administrators, managed care organisations (MCOs), and brokerage firms (32). The three administrators, Discovery Health (Pty) Ltd (19 schemes), Medscheme Holdings (Pty) Ltd (14 schemes), and Metropolitan Health Corporate (Pty) Ltd (1 scheme), account for 80% of the market share in terms of average beneficiaries. The table below depicts accredited administration service fees paid to the administrator in cases where customer service is a significant component of the administration function.

Table 2: Accredited administration service fees paid to administrator – 70,9% of Gross Administration Expenditure (GAE)

Component of accredited administration service	Open schemes % of total fee	Restricted schemes % of total fee
Member record management	10.63	8.01
Contribution management	8.73	8.17
Claims management	14.44	22.08
Financial management	1.63	3.49
Information management and data contro	16.68	15.62
Broker remuneration management	2.67	0.24
Customer services	45.22	42.39

Source: CMS (2022)

Figure 4 shows how government-funded, restricted schemes and the industry compare in terms of gross administration costs as a percentage of gross contribution income. Medipos Medical Scheme and Transmed Medical Fund incurred significantly higher gross administration expenditures, at 12.32% and 9.78% than the restricted and industry, at 5.11% and 6.54% respectively. The South African Police Service Medical Scheme and the Parmed Medical Aid Scheme had less than 4% gross administration expenses, as depicted in the figure below.

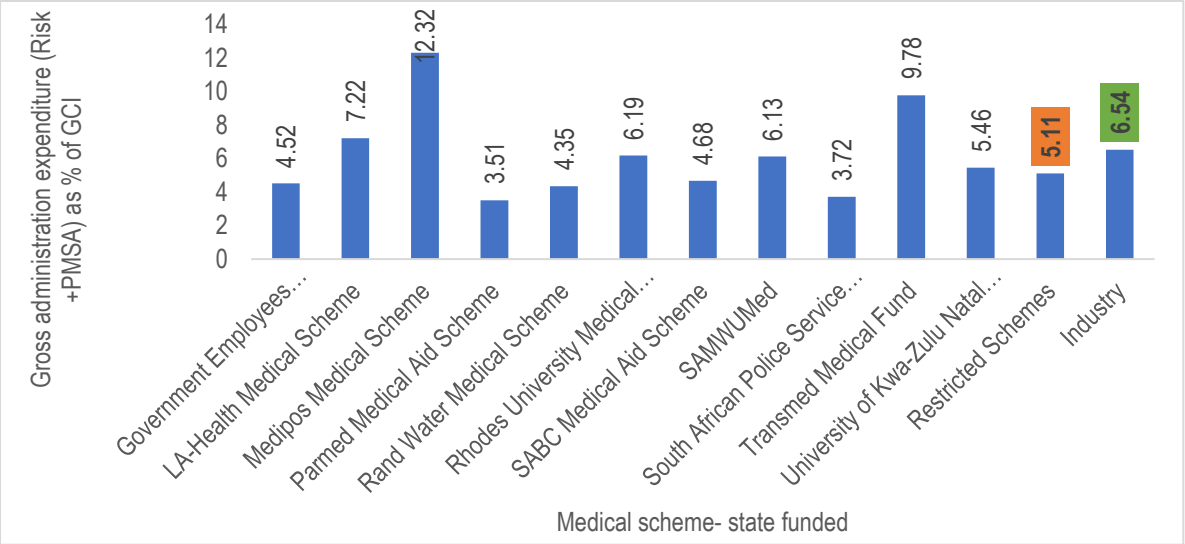

Figure 4: Gross administration expenditure (Risk +PMSA) as % of GCI- state-funded schemes

5.6 Liquidity and solvency requirements

Regulation 29 of the Medical Schemes Act prescribes the minimum accumulated funds to be maintained by medical schemes. The accumulated funds must always be maintained at a minimum of 25.00% of the gross contribution. The solvency ratios of the 11 state employees' medical schemes ranges from 19.72% to 157.53%. Ten of the 11 medical schemes complied with Regulation 29 and had solvency levels greater than the prescribed 25%, as illustrated in Figure 5, except for Transmed Medical Fund. The GEMS and POLMED solvency ratios were 46.44% and 54.61%, respectively.

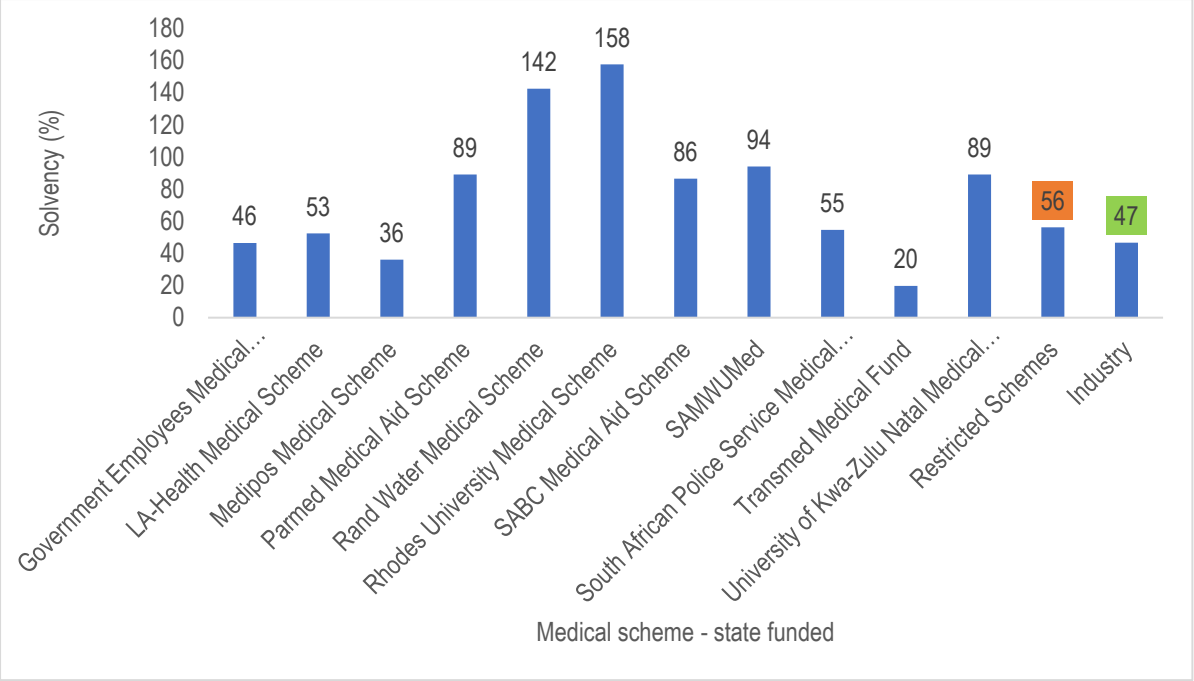

Figure 5: State employees' medical schemes Solvency ratio - 2021

5.7 Medical Scheme Reserves

This section outlines and unpacks the purpose of medical scheme reserves, what they are funded for, and CMS' role in their governance. Furthermore, it highlights some of the associated risks. The Medical Schemes Act (131 of 1998) (MSA) prescribes that those reserves must always be maintained at a minimum of 25% of annualised gross contributions, except for new medical schemes where case phase-in solvency ratios apply. Medical scheme reserves are derived from various sources, which are outlined as follows:

- Retained surplus between contributions and claims,
- Investment Income,
- Over-payment recoveries and
- Other sources.

Total reserves per Regulation 29 for all medical schemes amounted to R105 billion on December 31, 2021, while those for restricted and state-funded schemes were R55 billion and R34 billion, respectively. The figures depicted are based on the impact of state-funded schemes, which account for nearly a third of the savings.

Table 3: Year-end reserve position (per Regulation 29) state-funded schemes

Government Funded Schemes	**R34,500,415,000**
Restricted Schemes	**R54,649,414,000**
Industry	**R105,660,333,000**

Table 4 below illustrates the estimated Prescribed Minimum Benefits (PMB) cost based on the treated prevalence of CDLs called community rate. The community rate is used to measure the risk profile of medical schemes. The benefit options for state employees' medical schemes presented a community rate that ranged from R487.01 to R4,802.27. Out of the 27 benefit options, 11 had a community rate lower than the industry average PMB cost of R1,012.00 pabpm. Prime plan and Guardian belonging to Transmed Medical Fund had a cost four times the industry average PMB cost. The high cost for these two options may be attributed to older age profiles.

Table 4:The estimated Prescribed Minimum Benefits (PMB) cost in 2021

Scheme Name	Benefit Option	Community Rate(R)
Rhodes University Medical Scheme	RUMED	1,457.14
Samwumed	Option A	1,327.14
	Option B	1,495.39
Rand Water Medical Scheme	Option A	779.97
	Option B Plus	487.01
SABC Medical Aid Scheme	SABC Plan 009	1,296.86
Parmed Medical Aid Scheme	Plan - 007	1,981.88
Medipos Medical Scheme	Option A	2,212.82
	Option B	663.50
	Option C	509.62
South African Police Service Medical Scheme	Marine	1,164.27
	Aquarium	576.90
Transmed Medical Fund	Link Plan	1,823.39
	Select Plan	2,106.54
	Guardian	4,126.03
	Prime Plan	4,802.27
Government Employees Medical Scheme	Tanzanite One	615.11
	Beryl	821.79
	Ruby	850.40
	Emerald	1,242.26
	Onyx	3,285.87
	Emerald Value	1,078.99
La-Health Medical Scheme	LA Core	3,182.22
	LA Comprehensive	3,477.59
	LA Active	802.19
	LA Focus	667.93
	LA Keyplus	652.84

6. MEDICAL SCHEMES WITH LESS THAN 6 000 MEMBERS: RHODES UNIVERSITY MEDICAL SCHEME

The minimum membership requirement for a medical plan at registration is outlined in Section 2 (3) of the Medical Schemes as follows:

"The minimum number of members required for the registration of a medical scheme established after these regulations have come into operation is 6 000, and this number must be admitted within a period of three months of registration of the medical scheme."

The minimum number of members required after registration, which may change depending on factors including market conditions and sustainability threats owing to a potential reduction in membership, is not specified in the referred section. Among the 11 state employees' medical schemes, 5 had fewer than 6 000 members, namely the Rhodes University Medical Scheme, Parmed Medical Aid Scheme, University of Kwa-Zulu Natal Medical Scheme, Rand Water Medical Scheme, and SABC Medical Aid Scheme. Table 5 depicts characteristics of schemes with fewer than 6 000 members, represented by 29 medical schemes (3 restricted schemes and 26 closed schemes). The three open schemes accounted for 0.5% of open schemes, while the 26 closed schemes represented 5% of the closed scheme market. Membership in these schemes ranged from 1 038 to 5 883 principal members; these schemes are financially sound, with more than a 25% solvency ratio as of December 2021. The solvency levels ranged between 45.87% and 354.38%.

Table 5: Medical schemes with less than 6 000 members:2021

Scheme type	Classification	N	Members	Beneficiaries	Pensioner ratio (%)	Dependency ratio (%)
Restricted Schemes	All	56	1,707,639	4,109,404	10	1.10
	< 6000 members	26	82,016	178,742	13	1.14
	6000+ members	30	1,625,623	3,930,662	8	1.07
Open Schemes	All	17	2,351,958	4,835,649	13	1.00
	< 6000 members	3	10,855	24,241	14	1.12
	6000+ members	14	2,341,103	4,811,408	13	0.98
All	Consolidated	73	4,059,597	8,945,053	11	1.08

Table 6 below further shows some smaller scheme risk pools merged with either medium or larger schemes between 2018 and 2020. One scheme with a similar operating model to government-funded smaller risk pools is the University of the Witwatersrand, which merged with Discovery Health Medical

Scheme in 2018. The scheme had 4 919 members at the time of the merger. This scheme has a very similar operating model to the University of KwaZulu-Natal Medical Scheme and Rhodes University Medical Scheme, thus proving key learning for possible future mergers.

Table 6:Previous mergers of small risk pools

Scheme	Date Merged	Merged To
Grintek Electronics Medical Aid Scheme	7/1/2020	Bestmed Medical Scheme
Selfmed Medical Scheme	9/1/2019	Compcare Wellness Medical Scheme
Topmed Medical Scheme	8/1/2019	Fedhealth Medical Scheme
Resolution Health Medical Scheme	12/31/2018	Health Squared Medical Scheme
University Of the Witwatersrand	1/1/2018	Discovery Health Medical Scheme

7. GOVERNMENT EXPENDITURE ON MEDICAL SUBSIDIES FOR STATE EMPLOYEES

The table below summarises government expenditure on medical subsidies for state employees. The total government medical scheme subsidy for 2020/21 was R23.7 billion.

Table 7:Government subsidy

	2020/21			2021/22 (Estimate)		
Sphere	Expenditure R'000	FTE	Unit Cost	Expenditure R'000	FTE	Unit Cost
Eastern Cape	R 2,629,061	76,305	R 34,455	R 2,787,029	74,762	R 37,279
Free State	R 1,347,098	37,174	R 36,238	R 1,483,150	37,891	R 39,143
Gauteng	R 3,630,957	102,911	R 35,283	R 4,228,406	111,618	R 37,883
KwaZulu Natal	R 4,124,593	115,895	R 35,589	R 4,397,849	114,595	R 38,377
Limpopo Province	R 2,258,450	62,282	R 36,261	R 2,388,070	61,015	R 39,139
Mpumalanga	R 1,620,886	44,242	R 36,637	R 1,771,777	44,735	R 39,606
National Departments	R 4,676,149	268,359	R 17,425	R 5,013,729	265,172	R 18,907
North West	R 1,351,632	37,413	R 36,127	R 1,483,333	38,179	R 38,853
Northern Cape	R 487,351	13,553	R 35,959	R 523,176	13,421	R 38,981
Western Cape	R 1,634,130	48,356	R 33,794	R 1,793,386	49,142	R 36,494
Total	**R 23,760,307**	**806,491**	**R 337,766**	**R 25,869,904**	**810,530**	**R 364,662**

Figure 6 below illustrates medical tax expenditure estimates from 2017 to 2021. Government expenditure on medical tax credits increased from R27 billion in 2020/21 to R29 billion in the 2020/22 financial year.

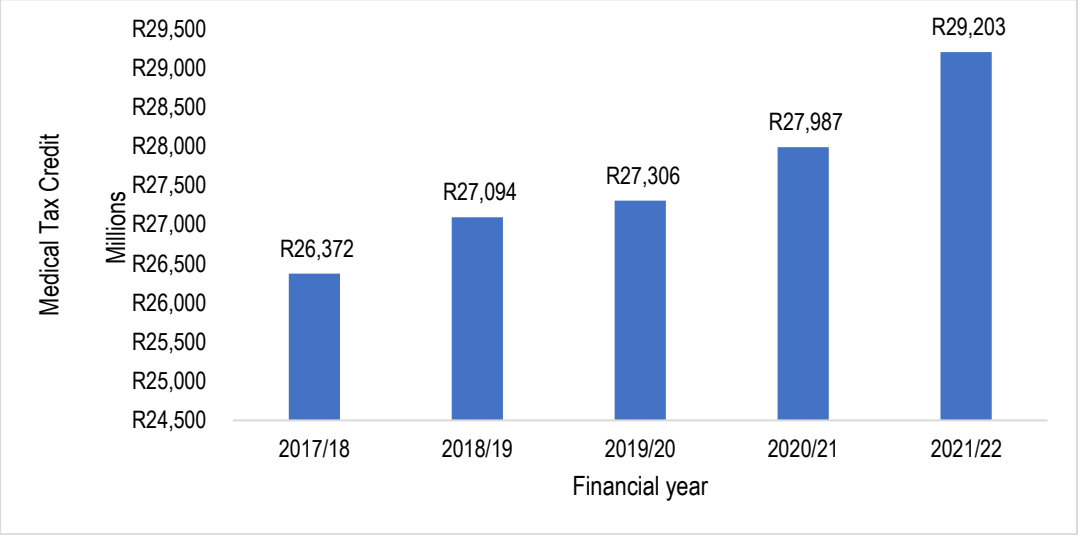

Figure 6: Estimated medical tax credits on contributions

8. UMBRELLA FUNDS

According to the MSA's outlined definitions, medical schemes are categorised into open and restricted schemes. Further classification is also made in terms of size, and schemes could further be classified as large medium (> 30 000 beneficiaries), medium schemes (> 6000 members but <= 30 000 beneficiaries and small schemes (< 6 000 members). The size effect impacts how medical schemes negotiate tariffs with the providers. Small and medium schemes are price takers for these negotiations, while large schemes with resources and larger economies of scale can negotiate better rates with the providers. Consequently, members of small and medium schemes are at a disadvantage. Medical schemes are further characterised by sector; the earlier section of the report depicts 11 government-funded schemes which operate on a similar model, with some having a government subsidy benefit for members. The HMI report revealed the following shortcomings in the sector:

- Competition and competitive bargaining pressures from funders have to be increased significantly,
- The vacuum in tariff determination and other market features (such as PMBs at cost) have contributed to scheme expenditure on specialists increasing over time,

- These costs are passed on to consumers through higher premiums, decreasing levels of coverage, and/or balance billing by practitioners and
- Lack of transparency on prices has meant that patients live in a world of price uncertainty.

The Health Market Inquiry (HMI) report recommends that representatives of practitioners, funders, government, and civil society constitute a multilateral forum. However, due to the economies of scale, such a structural design would further need to consider the balancing effect of smaller schemes versus larger schemes. The second challenge facing small schemes is that they are mainly restricted schemes. They also cannot compete with open schemes for membership. One proposed solution is establishing an umbrella fund where similar schemes could operate within such a model and compete with larger schemes. Circular 42 of 2018 outlined some of the benefits of setting an umbrella type of fund as follows:

- This approach would first create an "umbrella medical aid scheme", which would essentially have a uniform set of benefits, rules, and governance team,
- It would then serve as a base fund for each non-state scheme to be amalgamated and
- The ability of such a scheme to negotiate better tariffs with medical service providers for the benefit of the member.

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