ACTUARIAL SOCIETY OF SOUTH AFRICA

The Medical Schemes Environment:

An Update from the Regulator

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Council for Medical Schemes

20th May 2009

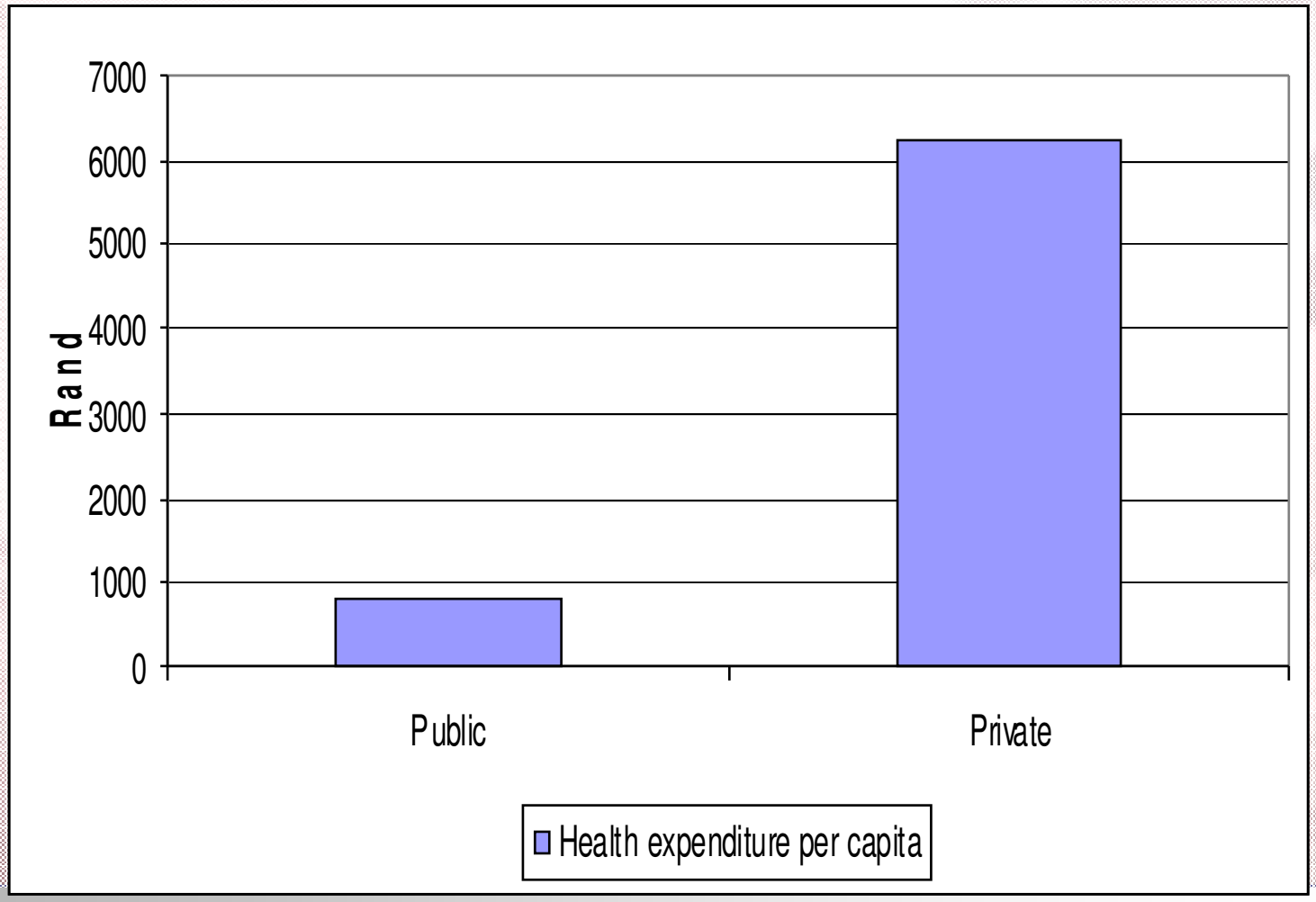
Presentation layout

1. Context for reform
2. The role and function of medical schemes
3. Facts and figures about the Medical Schemes' industry
4. Further initiatives going forward

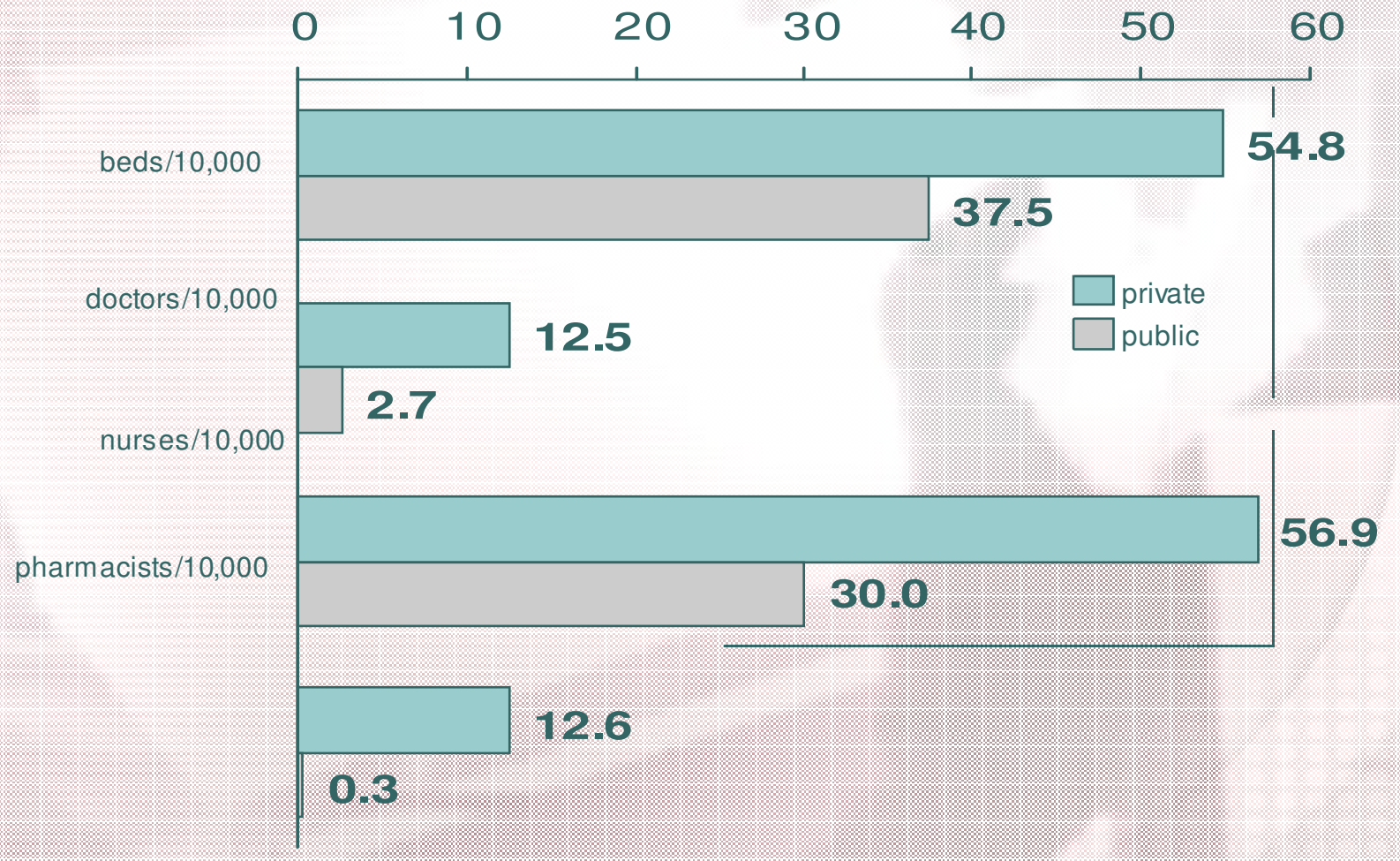
The Health Sector Context

- Inequalities persist
  - Private sector receives 46% of overall healthcare funding, caters for 14.8% of the population
  - Public sector caters for 64.2% of population with 40% of healthcare funding
  - Significant OOP (regressive); 21% of the population spending est. 14% of healthcare funding OOP

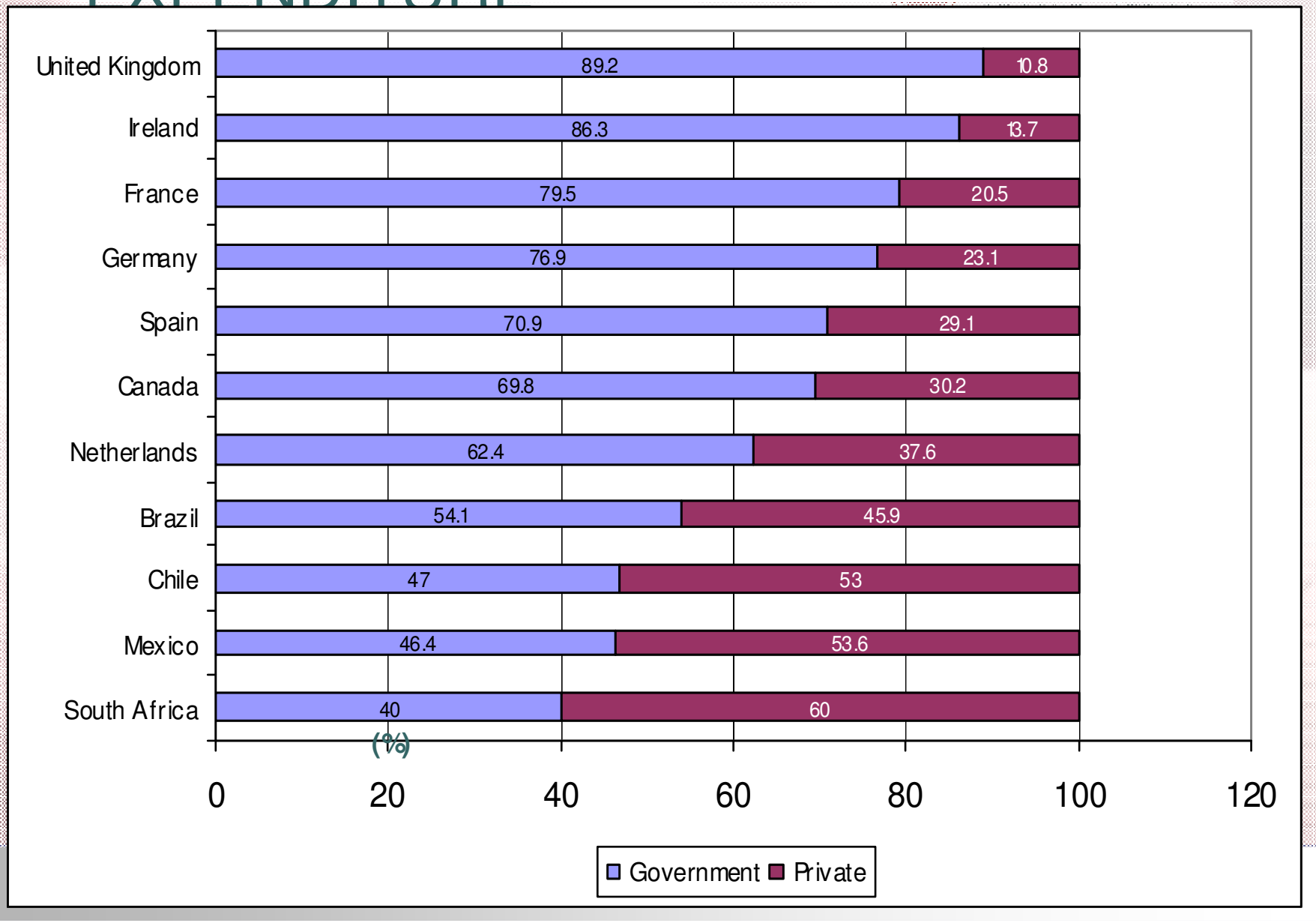
HEALTH EXPENDITURE PER CAPITA



COMPARISON OF PUBLIC AND PRIVATE HEALTHCARE RESOURCES



COMPARATIVE HEALTHCARE EXPENDITURE



On Health Sector Reforms

- "The National Health Insurance, part of its function (is) to try and contain the costs that are spiralling out of control", Health Minister, News 24, 18 May 2009
- "We should also understand that healthcare inflation in SA is no higher than in many other healthcare systems internationally", Adrian Gore, CEO, Discovery Health, Businessday, 18 May 2009

Motivation for reforms

- Medical schemes' population more or less stagnant
- Pressure on public healthcare infrastructure
- Escalating healthcare costs
- "Skewed" allocation of resources between public and private sectors
- Scarcity of healthcare professionals

The Medical Schemes' Role

- Avail access to healthcare through funding by providing the following:
  - Incentives to join and stay in schemes
    - Open enrolment
    - Waiting periods
    - Late-joiner penalties
  - Protection of members in schemes
    - Community-rating [No risk-rating]
    - Non-discrimination on benefits
    - Adjudication of complaints
  - Protection of minimum comprehensive benefits
    - Prescribed minimum benefits
  - Improved governance
    - Medical schemes
    - Industry overall

Medical Schemes' Numbers

	Schemes	Options
Open	33 (41)	178 (220)
Restricted	79 (83)	178 (172)
Total	112 (124)	356 (392)

*Figures in brackets are for 2006

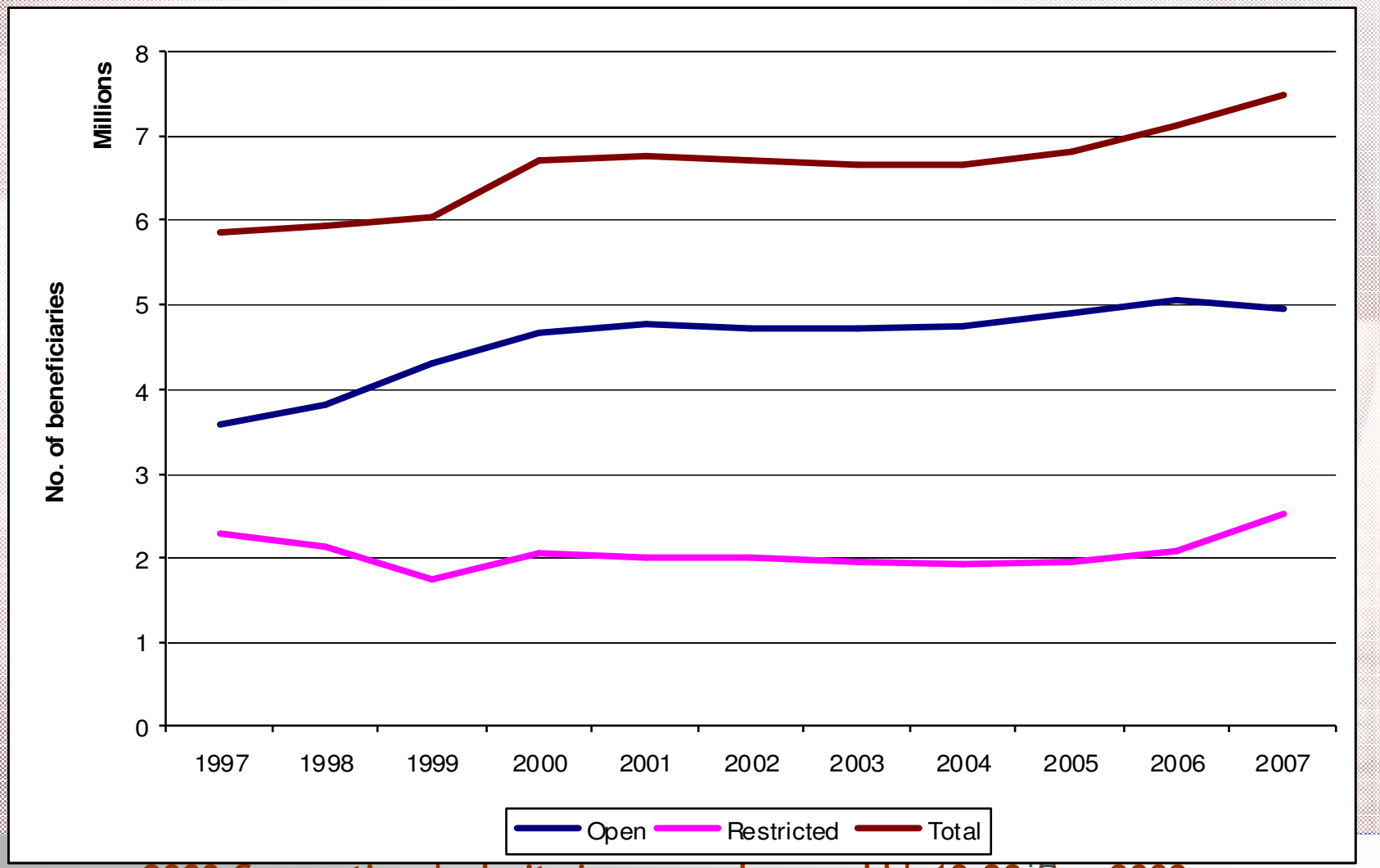
* 2008 Q2 results

Membership

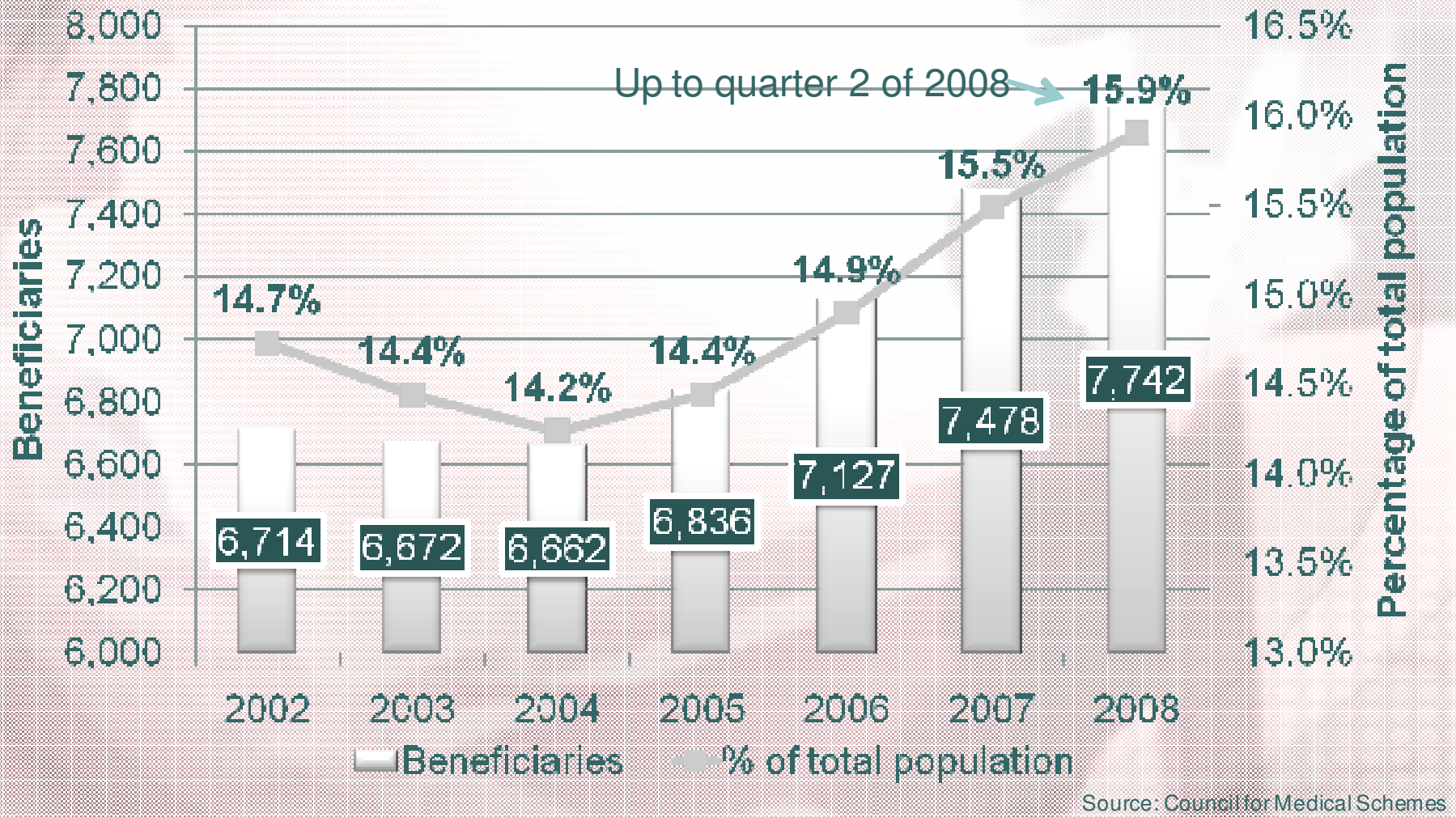
Scheme type		2007	2006	% change
Open	Members	2 114 986	2 099 247	0.7
	Beneficiaries	4 951 317	5 050 438	-2.0
Restricted	Members	1 118 504	886 103	26.2
	Beneficiaries	2 653 919	2 076 905	27.8
Consolidated	Members	3 233 490	2 985 350	8.3
	Beneficiaries	7 605 236	7 127 343	6.7

GEMS and Motohealth are two new restricted schemes that contributed significantly to growth in membership

Trend analysis of coverage

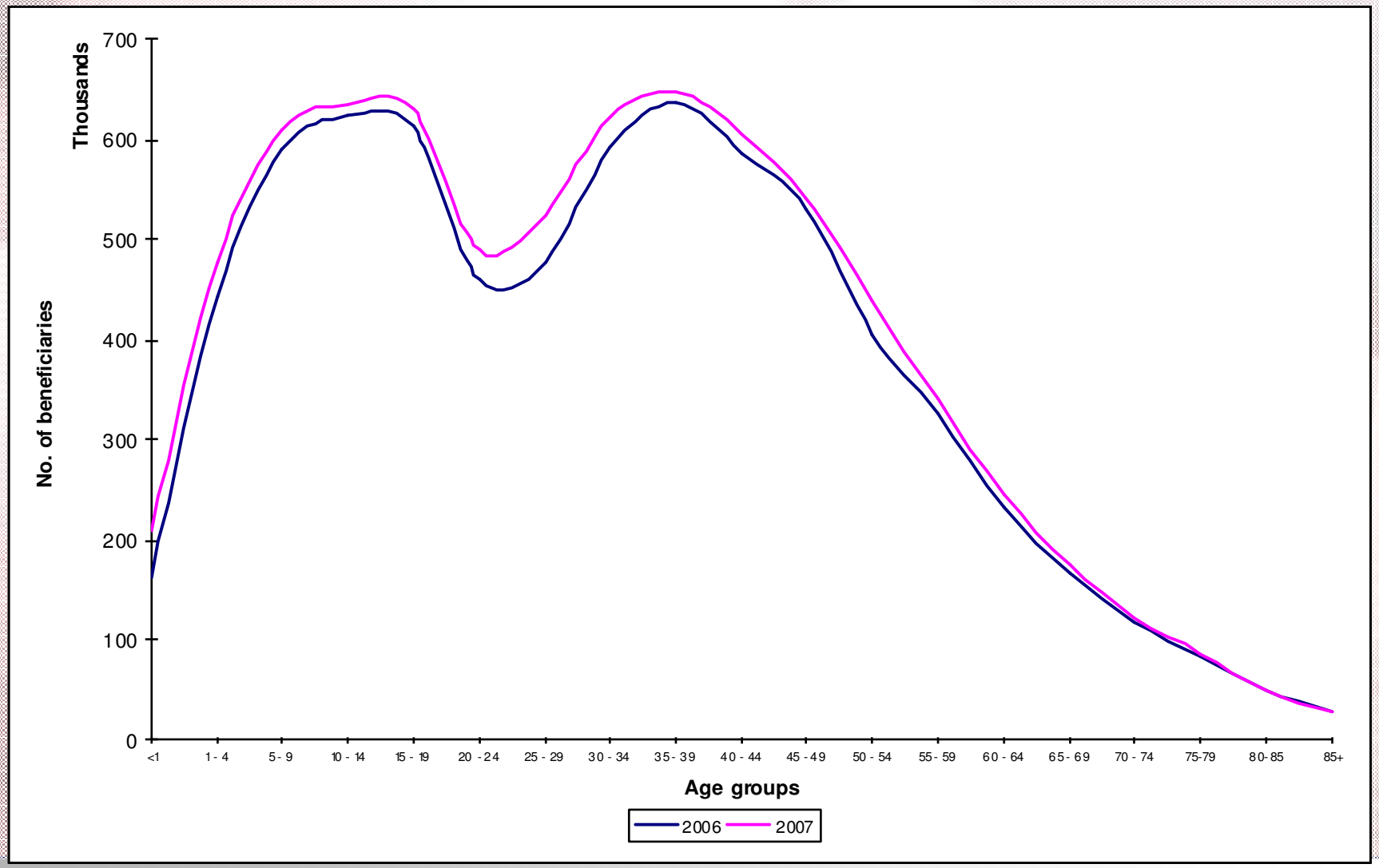


Medical Scheme beneficiaries



Source: Council for Medical Schemes

Age distribution



Contributions and claims

Total contributions:*

- Total contributions increased by 12.3% to R64.7 billion
- Total gross relevant healthcare expenditure incurred increased by 10.2% to R56.3 billion

Risk contributions

- Risk contributions grew by 13.5% to R58.3 billion
- Risk claims increased by 11.5% to R50.4 billion

Medical Savings Accounts

- MSA contributions grew by 2.1% to R6.3 billion
- MSA claims decreased by 0.2% to R5.9 billion

*contributions excludes out of pocket expenditure: copayment, uncovered benefits, depleted benefits, deductibles and self payment gaps

Contributions and claims
(pabpm)

Total contributions:

- Total contributions increased by 7.2% to R736.6 from R687.1
- Total gross relevant healthcare expenditure incurred increased by 5.2% to R641.6 from R610.0

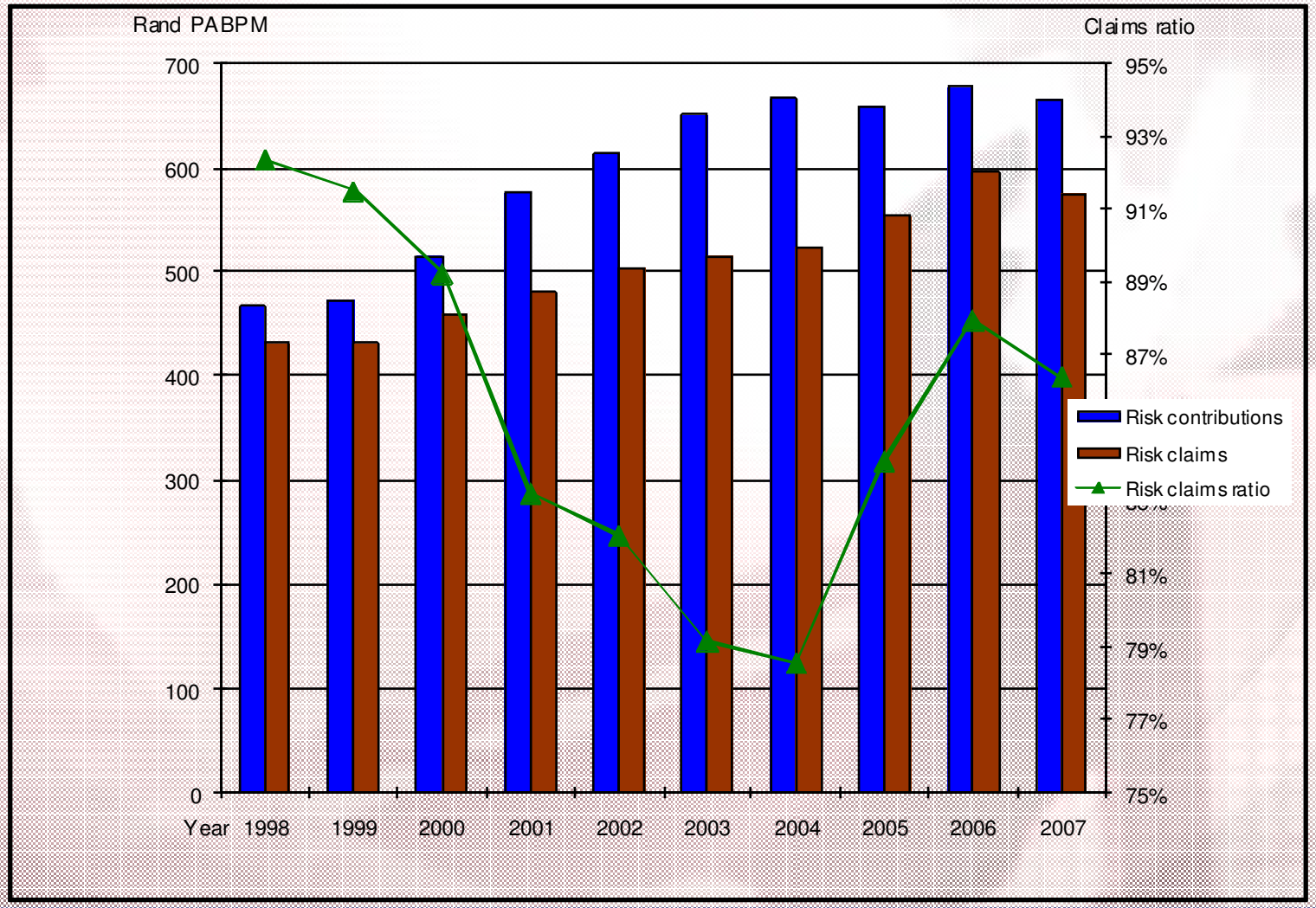
Risk contributions

- Risk contributions grew by 8.4% to R664.8 from R613.4
- Risk claims increased by 6.5% to R574.5 from R539.6

Medical Savings Accounts

- MSA contributions decreased by 5.3% to R94.5 from R99.8
- MSA claims decreased by 7.4% to R88.2 from R95.3

Risk claims ratio for all schemes



Utilisation of services

(per 1000 beneficiaries)

	2007	2006	% change
Outpatient			
GP	718.0	784.6	-8.5
Dentists	218.3	242.9	-10.3
Pathologists	802.1	1003.8	-20.1
Radiologists	386.2	392.6	-1.6
Paediatricians	196.6	201.4	-2.4
Physicians	261.3	258.5	1.1
Gynaecologists	222.4	209.0	6.0
Private Hospitals			
Admitted	180.6	170.7	5.8
Admissions	293.9	274.0	7.0

Benefits paid to healthcare providers

	Amount (R)	% of total	% change
• Hospital services	19,9 bn	36,3%	12,5%
• Med Specialists	12,2 bn	21,7%	11,0%
• Medicines	9,4 bn	16,7%	8,2%
• GP's	4,3 bn	7,7%	-1,5%

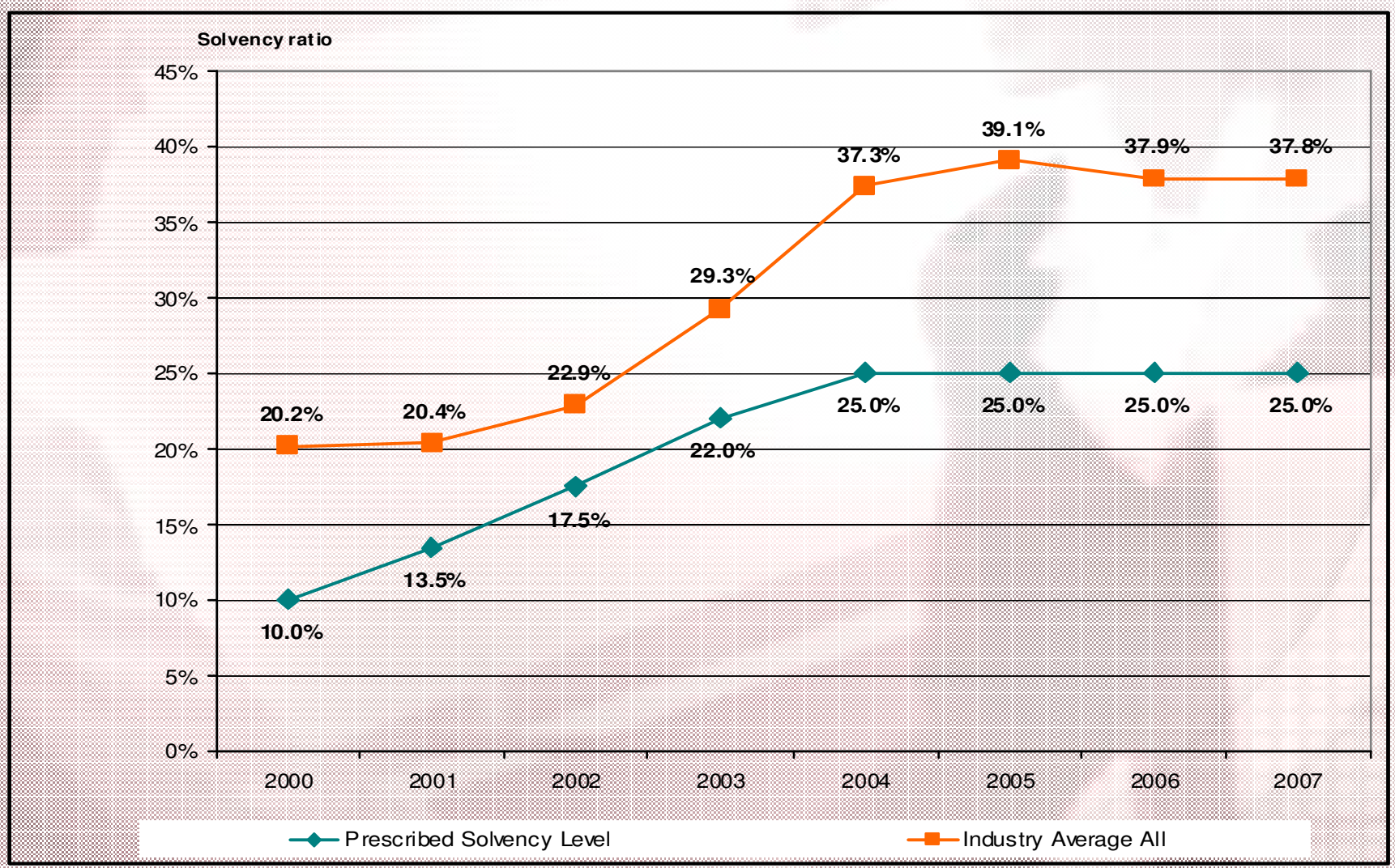
Non-healthcare expenditure

- **Consists mainly of :**
  - Administration (fees and costs)
  - Managed healthcare (value proposition)
  - Brokers fees
  - Impaired receivables

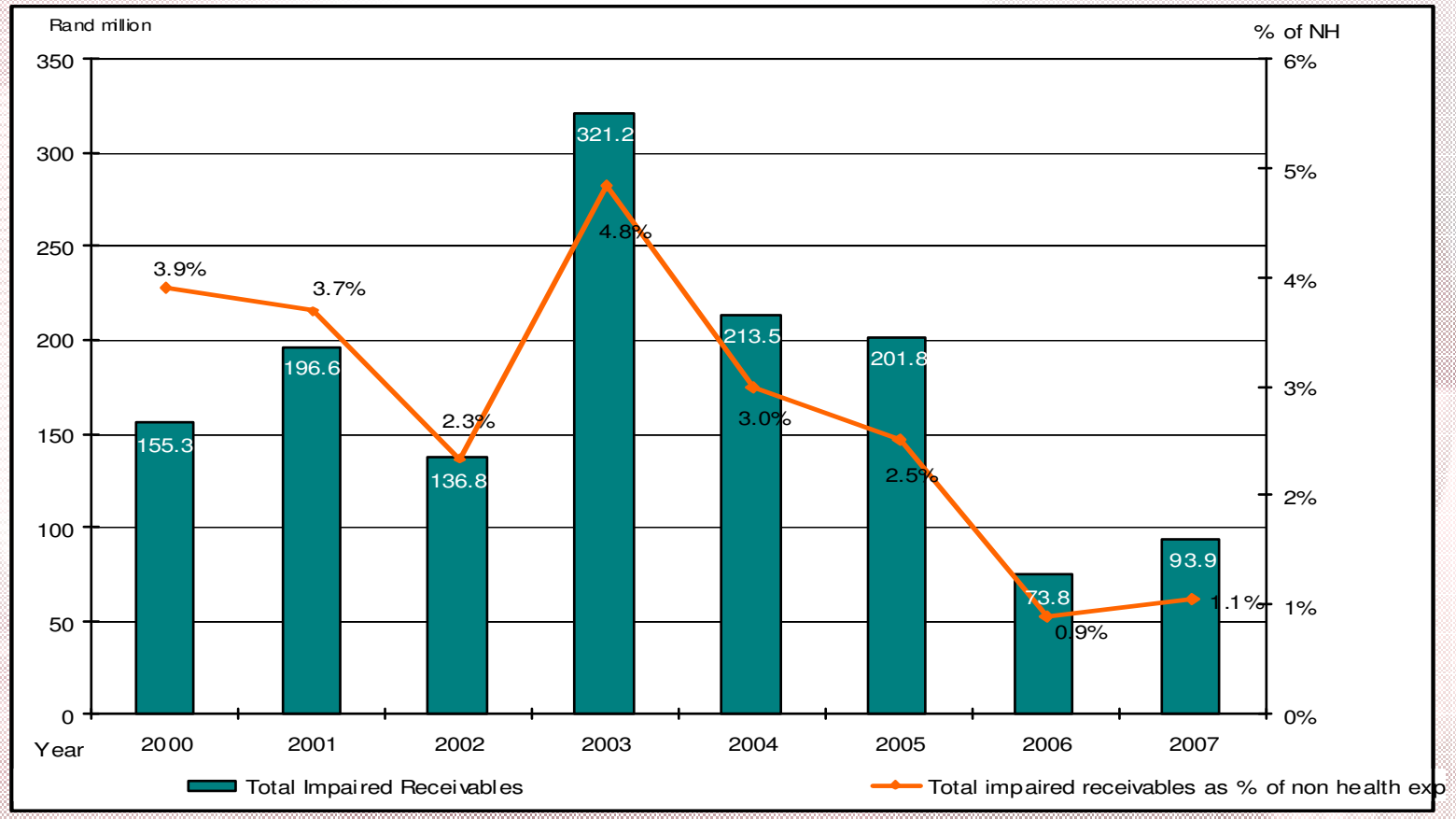
Non Healthcare Expenditure

- Total NHE increased by 7.3% to 8.3 billion. This was high compared to 3.7% increase in 2006.
  - After adjustment for membership and inflation, NHE decreased by 3.8%

Solvency level of all schemes



Impaired receivables



It took an average of 13.1 days to collect debts in 2007

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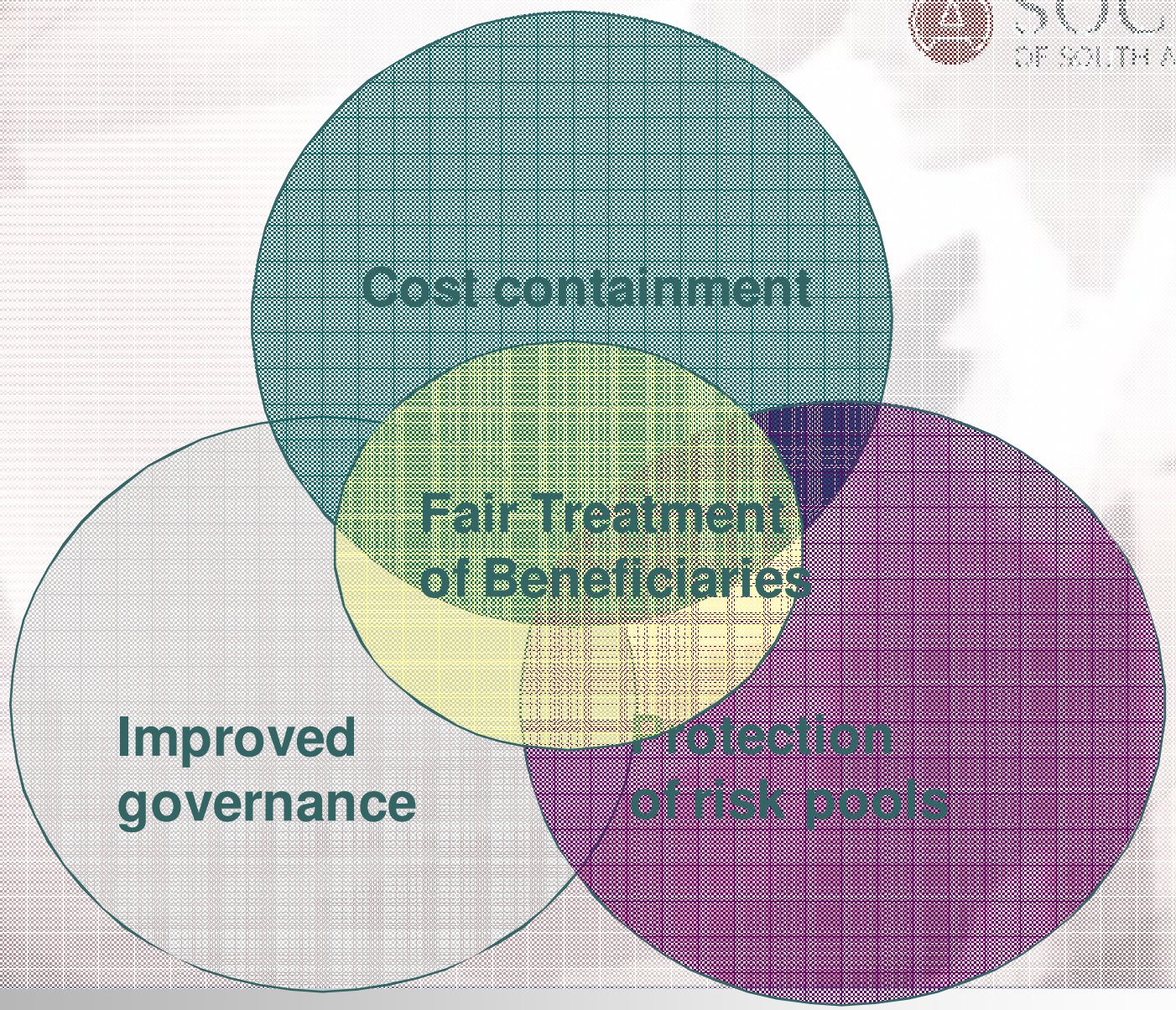
THE REGULATORY APPROACH GOING FORWARD

Strategic Priorities



Cost Containment

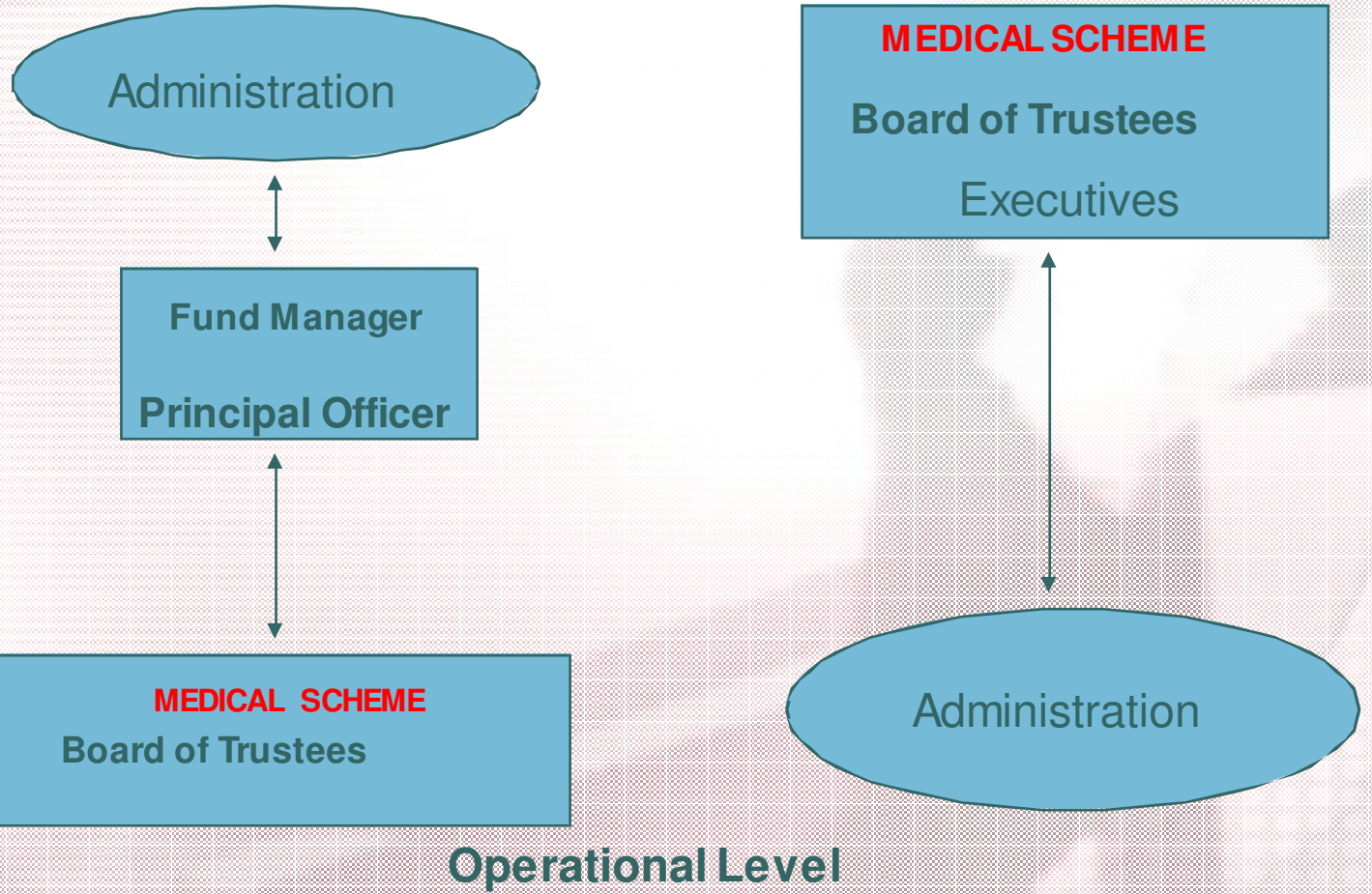
- **Supply side management**
  - Market structure
  - Health Technology
  - Human Capital
  - Provider incentives
    - Activity-based systems (FFS)
    - Capitated systems (Alternative reimbursement)
- **Demand side management**
  - Demographic shift
  - Epidemiological shift
  - Consumer incentives
  - Moral Hazard
  - Asymmetry of information
- **Harmonisation of legislations**
  - Competition Commission; HPCSA, MSA, etc

Protecting Risk Pools

- **Policy Priorities:**
  - Product development and pricing
  - Evidence based and cost effective interventions
  - Preventative care
  - Clinical governance

- **Scheme Priorities:**
  - Benefit structure
  - Income cross subsidies
  - Risk cross subsidies
  - Policy options for the employed but uninsured
  - Review of prescribed minimum benefits

Scheme Governance



Strategic Focus

- Education and training strategy
- Risk equalization fund
- Prescribed minimum benefits
- LIMS
- Demarcation
- Cost containment
- Governance
- Efficiency discounts
- NHI and
- Roadmap for health system reform

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Establish the RISK EQUALISATION FUND

Restructure benefits to reduce complexity and promote cross-subsidisation

Amendments to MSA Key Objectives

Promote improved corporate governance among medical schemes

Facilitate emergence of medical scheme products for low income beneficiaries

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QUESTION? COMMENTS?

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2009 Convention Lite and the Pensions, Health and Life Seminars

19-20 May 2009

Sandton Convention Centre
Johannesburg, South Africa