



Review of the South African Market for Hospital Cash Plan Insurance

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FinMark Trust

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1. Executive Summary

Background to the South African health insurance market for low income earners¹

The funding of health care in South Africa has a long and complex history. Private medical schemes operate as not for profit trusts and pool members' funds to purchase private health care goods and services. The Medical Schemes Act no. 131 of 1998 is the primary legislation governing medical schemes while the Council for Medical Schemes (CMS) is the delegated administrative body with jurisdiction over these schemes. The majority of the income-rated options as considered in this report provide for benefits at 100% of the scheme rate. As this is below the charging rate of many specialists, income rated options often make use of provider networks and designated service provider (DSP) agreements that facilitate payment in full as long as the member makes use of the applicable networks. Consequently, while medical schemes offer greater protection to members, they are also significantly more expensive and are thus inaccessible to the majority of the population, with only 16% of the population currently being members of these schemes.

In addition to health insurance products offered by medical schemes, long- and short-term insurers also offer health insurance products. Long- and short- term insurers are governed by the Long Term Insurance Act no. 52 of 1998 and Short Term Insurance Act no. 53 of 1998, respectively, and their primary administrative body is the Financial Services Board (FSB). The Insurance Acts do not permit them to be involved in the business of a medical scheme. An agreement reached in 2004 between the CMS, FSB and the Life Offices' Association (LOA), the then industry representative body for long-term insurers, saw the release of a demarcation document to provide clarity to all stakeholders on the definition of the "business of a medical scheme" as defined in the Medical Schemes Act. The aim of the demarcation agreement was to protect medical schemes and ensure that the core principles of solidarity and community rating in the medical schemes environment were not undermined by the risk-rated approach of health insurance products.

The provision of health insurance products by long and short-term insurers is relevant to the demarcation issue on two fronts:

1. In response to increasing prices charged by specialists for in hospital services, short-term insurers have developed Gap cover insurance policies which provide for the shortfalls between medical scheme benefits and rates charged by providers. Membership of Gap cover products is limited to members of medical schemes, thereby providing additional cover for

¹ Low income earners are defined for purposes of this report as the LSM 1-6 market and exclude the unemployed and people whose only income is social grants.

those that can afford medical scheme membership but providing no protection for low income earners that are not members of a medical scheme. Profit margins are relatively high, although this has reduced recently as doctors and patients become more acquainted and aware of Gap cover benefits.

The CMS considered Gap cover products to be non-compliant with the demarcation and in 2006 challenged the validity of these products in court. They considered the fact that Gap cover products offered benefits that were directly related to the cost of treatment to mean that insurers offering these products were conducting the business of a medical scheme. The CMS was concerned that these products encouraged buy-down behaviour by enticing younger healthier members to select cheaper medical scheme options and then to “top up” with insurance products to provide more comprehensive cover. This option is not available to all medical scheme members due to the risk rating and underwriting policies of these products and as such could lead to a de-stabilisation of the medical schemes industry by reducing the cross-subsidies from younger to older members or from healthier to sicker members. Although the lower court ruled in favour of the CMS, the Supreme Court of Appeal in 2008 ruled in favour of the insurer based on the interpretation of the medical schemes Act.

2. In addition to Gap cover products, both long- and short-term insurers offer Hospital Cash Plans (HCPs). HCPs are mainly aimed at that part of the market that does not belong to medical schemes and are dependent on public health care services. Public health care services are billed according to a means test and the tariffs for each income category are set out in the Uniform Patient Fee Schedule (UPFS). Only certain groups (unemployed, those receiving social grants) receive free care while those in higher income categories pay proportionally higher fees with those earning in excess of R6,000 per month (individual income) being charged in full. The result is that charges can be significant for low income earners. These costs, together with the related costs of a health event such as transport, accommodation and lost income, can result in significant out of pocket expenditure.

Under HCPs, premiums are dependent on age and cover level. While hospitalisation is generally the trigger for payout, compensation is unrelated to the cost of the health services but is instead a lump sum benefit based on number of days hospitalised and in some cases type of care. HCPs generally provide cover of between R250 per day and R5,000 per day for premiums of between R100 and R450-R850, respectively. Some HCPs also contain add-ons like disability insurance, cash-back and the like. Given that the payout under HCPs is unrelated to the cost of care, insurers are unable to confirm how these payouts are spent (on covering direct health expenses, on indirect expenses like transport or convalescence, or as a

windfall). It is possible that they are used in many cases to defray the costs of health care, most likely at a public facility.

The effectiveness of HCPs in meeting the cost of health care

The purpose of this paper is to analyse the effectiveness of HCPs in meeting the cost of health care for low income-earners. There are estimated to be between 1 million and 1.5 million policies in effect, with total lives covered estimated to be 27% of those covered under medical schemes, or 2.4 million people. The majority of policyholders are in the LSM² 4-7 brackets³, and more than 55% of HCP beneficiaries are concentrated between the ages of 20 - 40 years. There are between 30 and 40 insurers providing HCPs, versus 99 medical schemes and between 15 and 20 Gap cover providers. While the benefits of a HCP are not comparable to those of a medical scheme, low-income South Africans would likely have no alternative product which they could access due to affordability constraints.

HCP products are less expensive than the cheapest open income-rated medical schemes for most ages and cover levels. The reason for the relative affordability of HCPs is that they have significantly lower benefit levels. HCPs also apply relatively light underwriting conditions, this due to the relative expense of underwriting at such low premium levels.

Our analysis in this paper illustrates that HCPs are able to offer some form of protection against both direct and indirect costs to low income (less than R 6,000 per month) earners that make use of public facilities even at benefit levels as low as R 500 or R 1,000 per day. At income levels as low as R 3,000 per day the higher relative state subsidy would imply that these products would be even more beneficial.

Suppliers' perspective

From a medical schemes perspective, one of the key concerns regarding the HCP market is the risks posed to medical schemes, but while HCPs are significantly less expensive, even high benefit cover levels of R 3,000 to R 5,000 do not come close to covering private sector hospital costs in the same manner as medical scheme products do. Considering that the majority of HCP policyholders also have lower levels of cover (70% to 80% of the market are believed to fall below R 1000 per day), the

² LSM refers to the Living Standards Measure as developed by the South African Advertising Research Foundation (SAARF) and is the most widely used tool for categorising the South African population.

³ According to the FinScope South Africa survey 2012, the average personal monthly income for the LSM 4 category is R975 and that for LSM 7 is R4080, implying that the current user base would be people earning roughly in these bands. Note, however, that the LSM categorisation is not drawn up on an income basis, but reflects various socio-economic variables including asset ownership and geographical spread.

current marketing and disclosure requirements as well as the required up front lump sum deposits required for an uncovered individuals to attend a private facility, it is highly unlikely that the average HCP product offering in this market would be able to draw members away from medical schemes.

As for HCP writers, the market is relatively large and rapidly growing with an estimated 50,000 new policies sold every month. Products seem to be profitable with risk costs assumed to be between 20% to 35% of the total premium and, while lapse rates and initial expenses can be high (20% - 30% first year lapses), this is not out of the ordinary compared to other short term insurance products. Underwriting costs and fraud represent a challenge to this industry and, with limited sharing of information and institutional market data available, this is likely to remain a key concern.

The future of HCPs

As a direct (if delayed) response to the aforementioned court case, on the 2nd of March 2012 the National Department of Health in conjunction with the CMS and FSB released a discussion document for public comment outlining a proposed revised demarcation between medical schemes and health insurance providers. The proposed revised demarcation sets out the changes to the Long Term Insurance Act and Short Term Insurance Act that would directly impact all existing health insurance products. In particular, the demarcation provides that the benefits of health insurance products cannot be related to the cost of treatment (this is not a change per se but rather a re-emphasis and clarification) and that daily HCP benefits are to be capped at 70% of daily income (net of tax) of the policyholder. It further provides for underwriting for health insurance products.

While the majority of HCPs provide benefits that are unrelated to the cost of care and thus would not be significantly impacted by the first requirement, Gap cover products certainly would be. More worrying for low income earners, is the negative effect the cap on daily cash benefits to 70% of the policyholder's income will have on the value that these products are able to offer. While it appears that an attempt is being made to reclassify HCPs as income replacement with the proposed cap being introduced to prevent fraud, our analysis shows that at a monthly salary of under R3,000, the cap would limit daily benefits to a maximum of R105 while at income levels of between R3,001 and R6,000 the cap would limit daily benefits to a maximum of R210. The effect is that these products will be unable to defray the costs of either direct or indirect medical expenses for hospitalisation at state facilities, making them unattractive to low income earners. Further, in order to provide daily cover of over R2,000, a person would need to earn over R57,100 per month while for daily cover of R5,000 income of R142,850 per month would be required. People in these income brackets would be able to afford medical cover, so that there would be little market for HCPs at either the low or higher income levels.

The proposed National Health Insurance (NHI) may also reduce the need for HCPs in that one of the proposals is that patients will not be required to pay for services at the point of treatment. While this is subject to debate, if there are no user fees this would significantly decrease the potential out of pocket burden faced by patients, and in turn decrease the need for HCPs. Similarly, if no co-payments are required for health care services, the need for Gap cover products is limited. The shape that NHI will take is still unclear and rollout may be protracted.

2. Introduction

2.1 Research Goals

The provision and financing of health care in South Africa has long been a contentious issue with many of the current problems having originated in South Africa's troubled and divided past. Although the right to health care was included in the Bill of Rights of the Constitution of the Republic of South Africa as introduced in 1996 (SABOR, 1996), the majority of South Africans still do not have adequate access to quality health care provision. Wealthier South Africans tend to belong to medical schemes and access quality care via the private sector, whereas the poorer majority of the population rely on a struggling public health sector.

Only approximately 16.8% (CMS, 2010) of the population are able to afford and choose to purchase medical insurance via medical schemes. There is however evidence that slightly more than 30% of the population makes use of private health care providers for primary health care services, with those without medical scheme membership incurring significant out of pocket payments (ECONEX, 2010).

Public health care is available to all South Africans and subsidised for low income earners. The size of the subsidy is dependent on the income level of the user, and is determined via the state means test through a tiered subsidy system. The Uniform Patient Fee Schedule (or UPFS) sets out how much patients are charged according to their classification under the state means test.

The aim of this report is to consider the role that Hospital Cash Plan (HCP) insurance products play in the funding of hospitalisation related expenses for low income South Africans, defined as LSM 6 or lower

Key areas that are addressed and analysed in this report include:

- Current market and product structure, including a detailed overview of the size, characteristics and dynamics of the market – Sections 3, 4 and 5;
- The present regulatory environment and the impact of proposed changes - Sections 3 and 7;
- The efficacy of HCP products in servicing the needs of low-income policyholders for both the direct and indirect costs of a major medical event that requires hospitalisation, and the benefit of these products for consumers relative to cost – Sections 6 and 7

The report also briefly considers the effectiveness of alternative health financing options, so-called "low income medical scheme options" which often have income based contribution rates to facilitate access to medical scheme benefits for lower income South Africans.

2.2 Methodology and Process

The data collection phase of this study consisted of desktop research, literature reviews and stakeholder interviews.

We used desktop research to identify the key HCP providers (insurers) and regulatory bodies. Initial interviews were then conducted with reinsurers that were able to provide a macro view on the HCP market and confirm the relevance of the list of insurers and ensure that the sample was representative. Information regarding specific product offerings was obtained via the insurers' respective websites; please see Section 9 for a list of the relevant websites.

The initial research phase of the project also included literature reviews of the relevant research documents and papers. These documents have been referenced under each section where applicable. A complete list can be found in Section 9.

After the desktop and literature review phase of the project, interviews were conducted with industry bodies, insurers, hospital groups and reinsurers. The aim of the interview process was to gain a detailed understanding of the market from the different perspectives of all industry stakeholders as well as more clearly defined product information. The process also included submitting detailed questionnaires and data requests to the interviewees. Details of the participants and interviews have been provided in Appendix 5.

The information was then collated and used as a base for the modelling and analysis phase of the project. Details of the modelling approach are provided in Section 6.

3. Overview and Regulation

In this section medical schemes and health insurance products are described with particular attention to the structural and supervisory differences between these two product areas.

An historic overview of the South African market for medical protection is then provided.

Finally this section provides an overview of the regulatory frameworks under which the different health product classes operate and illustrates how the different regulations impact the various product designs. Section 3.5 outlines the proposed revised demarcation released for public comment on the 2nd of March 2012.

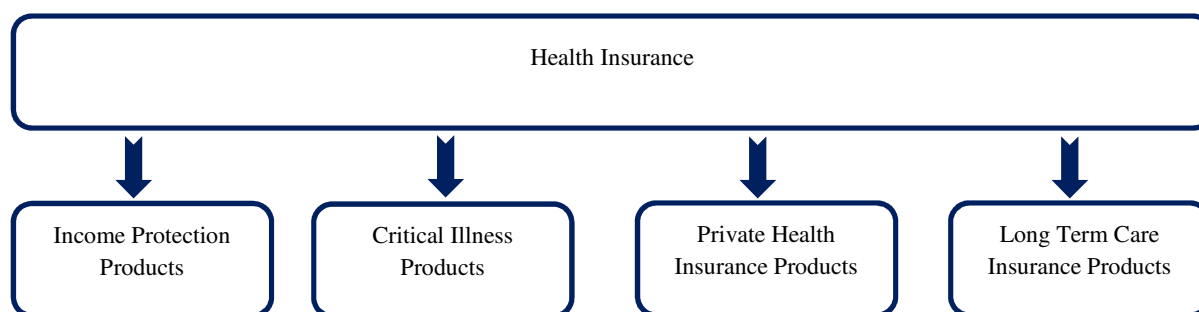
3.1 Health Insurance vs. Medical Schemes – Definitions and concepts⁴

A variety of product structures exist according to which benefits are paid upon the incidence of a health event or occurrence of an expense for the provision of a health care service. This section outlines the main structural forms these products may take.

In general health insurance products represent any and all insurance products designed to provide benefits in the event of a defined medical occurrence. Products vary greatly internationally and local factors such as regulation, state provision, employment and income levels as well as cultural and religious considerations all impact on the product and benefit designs in different countries.

The diagram below illustrates the major categories of health insurance products available in the international market:

⁴ This section is based on (Act no 52, 1998); (Act no 52 1998) and (Act no 131, 1998); Da Silva & Vughs, 2010; Soderlund & Hansl, 2000

Figure 1: Health Insurance General Product Overview

Source: Authors own representation (this applies to the definitions below as well).

Income protection products provide cover for the insured's income in the event that the policyholder is unable to work due to injury or illness. Benefits are usually available for a pre-defined period (usually up to retirement age). Short term variations like accident policies and sickness policies also exist.

Critical illness products provide cash benefits on the diagnoses of a specified list of diseases, or in the event of a specified surgical procedure or on reaching a predefined level of impairment or disability.

Private health insurance generally refers to product offerings aimed at meeting the cost of medical care. Products vary greatly and the more common options relate to dental plans, optical plans, major medical expense plans, excess options, medical cash plans, waiting list plans and personal medical expense plans.

Long-term care insurance refers to policies that provide cover for the cost of care in a residential or care home facility once the insured is unable to care for him/herself. These products usually relate to elderly persons and can provide cover on either an indemnity or cash basis.

South Africa has an unusual structure with regards to private health insurance with a distinction between medical schemes and health insurance products. The results and findings of this report are based on the following definitions⁵ and focus on the following products:

Hospital cash plan products: These are insurance products, registered and regulated by the Financial Services Board (FSB) under the Long Term Insurance Act, No 52 of 1998 (Long Term Insurance Act) and Short Term Insurance Act, No 53 of 1998 (Short Term Insurance

⁵ The definitions are based on the authors interpretation of (Act no 131, 1998), (Act no 52 1998) and (Act no 53 1998).

Act), respectively. They provide a pre-defined benefit to the policyholder in the event of hospitalisation (mainly). Benefits are required to be paid directly to the policyholder and are usually determined by the length of stay in the hospital and are not related to the cost of care. Sums assured per day vary by product and policyholder choice, and daily benefits can differ for different levels of care in hospital. These products would refer to a combination of private health insurance and income protection as defined above but can also incorporate elements of critical illness cover. Though more comprehensive in nature, these products would offer benefits similar to forms of private medical insurance cover in an international setting.

Medical scheme products: A non-profit mutual benefit society of pooled member funds, regulated by the Council for Medical Schemes (CMS) under the Medical Schemes Act, No 131 of 1998 (Medical Schemes Act or MSA). Benefits are indemnity based and are usually paid directly to the service provider (direct payments to members are also occasionally made with the member then having to reimburse the service provider). Products are designed to meet the actual cost of health care treatments for members within the scheme's rules and benefit structure. Medical scheme products function on the principles of inclusion and solidarity and provide benefits similar to a comprehensive form of private health insurance cover in a comparative international setting. Income-rated schemes generally target lower income earners.

Gap cover products: These are short-term insurance products, regulated by the Financial Services Board (FSB) under the Short-Term Insurance Act, designed to provide a benefit to cover the difference between what a policyholder's medical scheme pays and what the health care provider charges. Cover relates mainly to specialist fees for in-hospital procedures and benefits are paid to the policyholder. Gap cover products are akin to a form of excess cover as defined above where the initial part of the claim is funded by the policyholder's medical scheme.

3.2 Market Development and History⁶

3.2.1 Medical Scheme Products

In South Africa medical schemes date back to 1889 when they first operated in the format of informal institutions which pooled money for the funding of health care for their members. In 1956 their status

⁶ The historical information in the section is mainly derived from McLeod & Ramjee, 2007; McLeod, 2005; Kautsy & Tollman, undated; Pearmain, 2000 and HEALTH 24, 2011. Information from other sources has been individually referenced.

was formalised under the Friendly Societies Act (No 25 of 1956). Health care risk pooling and funding regulations were later drafted to form the original Medical Schemes Act (No 72 of 1967).

Amendments to the Medical Schemes Act of 1967 were introduced in 1993 leading to the part-deregulation of the industry and in many cases to the effective exclusion of older and sicker people from cover through the rating of premiums based on health status and other risks. Other changes included:

- The removal of payment arrangements between medical service providers and benefit funders, where one party can contract for set prices with the other;
- Deregulation of benefit structure; and
- Medical schemes were allowed to operate health facilities.

Much of this deregulation was reversed by the new Medical Schemes Act (No 131 of 1998) which came into effect in 2000 in response to the unintended effect of the deregulation on those who needed the protection most.

The new Act introduced the following main changes:

- prescribed minimum benefits (PMBs), to be paid in full – these are a list of health conditions and accompanying treatments that must be covered by all product options for all medical schemes;
- Community rating for all members, with contributions only being differentiable by income, number of dependants and/or beneficiary type (i.e. whether the member is the principal member or an adult or child dependant member);
- Regulations that apply to other industry stakeholders like brokers and intermediaries

This Medical Schemes Act provides for high levels of benefit security and social solidarity as no one can be excluded from cover based on ill-health and PMB benefits ensure a minimum cover level is provided to all members.

Any product that is classified as a medical scheme under the Medical Schemes Act is supervised by the Council for Medical Schemes (CMS) and needs to comply with all the requirements of the Medical Schemes Act. There are however a few low-income industry-based schemes (Bargaining Council schemes) that are exempted from complying with the full Medical Schemes Act and its supporting regulations. These schemes provide less than the prescribed minimum benefits, and it would not be financially viable for them to comply with the full set of regulations (Budlender & Sadeck, 2007).

Since the introduction of the Medical Schemes Act in 2000 there has been one material update which added a list of chronic conditions to the list of PMBs that all product options and medical schemes are required to cover. There have also been a number of proposed initiatives to improve the stability of the industry, such as the Risk Equalisation Fund (REF)⁷, as well as initiatives to investigate ways in which lower income members could be included in the industry risk pool (the Low Income Medical Scheme task team – LIMS). Neither of these initiatives has been implemented.

3.2.2 Health Insurance Products

In addition to medical schemes there are also a number of health insurance products available in the South African market. These products are relatively new and originated from Major Medical Cover that was first introduced in the USA in the 1950's. The first products were offered in South Africa in the 1980's and were in the form of HCP products. By 1989 there were approximately 50,000 active policies (Health 24, 2011).

The market for health insurance grew rapidly due to direct marketing via radio and mail adverts and by 1991 there were roughly 13 insurers in South Africa that sold health insurance policies of this nature.

Insurers in South Africa also proved innovative in the field of health insurance with Dread Disease cover being pioneered in South Africa during the 1980's. Dread Disease cover (also known as Critical Illness cover) provides lump sum cash benefits on the diagnosis of a specified illness. The benefits are not aimed at indemnifying the policyholder against any specific costs and can be used at the policyholder's discretion.

While HCP products can be provided by both long- and short-term insurance companies, they were initially sold by long-term insurance companies on a group basis. These products often included additional benefits such as an endowment benefit. These additional types of cover favoured long-term licence insurers with approximately 80% of policies being sold by life companies. However the mix of business has changed with the introduction of specialised short-term writers that often make use of direct marketing in selling these types of products.

In 2004 the CMS, FSB and the Life Offices' Association (LOA), the then industry representative body for long-term insurers, released a demarcation document to provide clarity to all stakeholders

⁷The REF is a fund mooted by the CMS as a mechanism to equalize the risk profile between schemes. Schemes have widely varying risk profiles which has a significant impact on the overall cost of the scheme. This incentivizes schemes to compete on risk profile rather than on efficient delivery of care. The REF was to be a zero sum fund that sourced net funds from young and healthy funds and paid these monies to older sicker funds based on a predetermined formula.

regarding the definition of the “business of a medical scheme” as defined in the Medical Schemes Act.. The aim of the demarcation agreement was to protect medical schemes and ensure that the core principles of solidarity and community rating in the medical schemes environment were not undermined by the risk-rated approach of health insurance products. This document included a demarcation guideline for long-term insurers illustrating the types of products that could be written within the confines of what is deemed to be outside the role of medical schemes (DMS&HI 2004).

3.2.3 Gap Cover Products

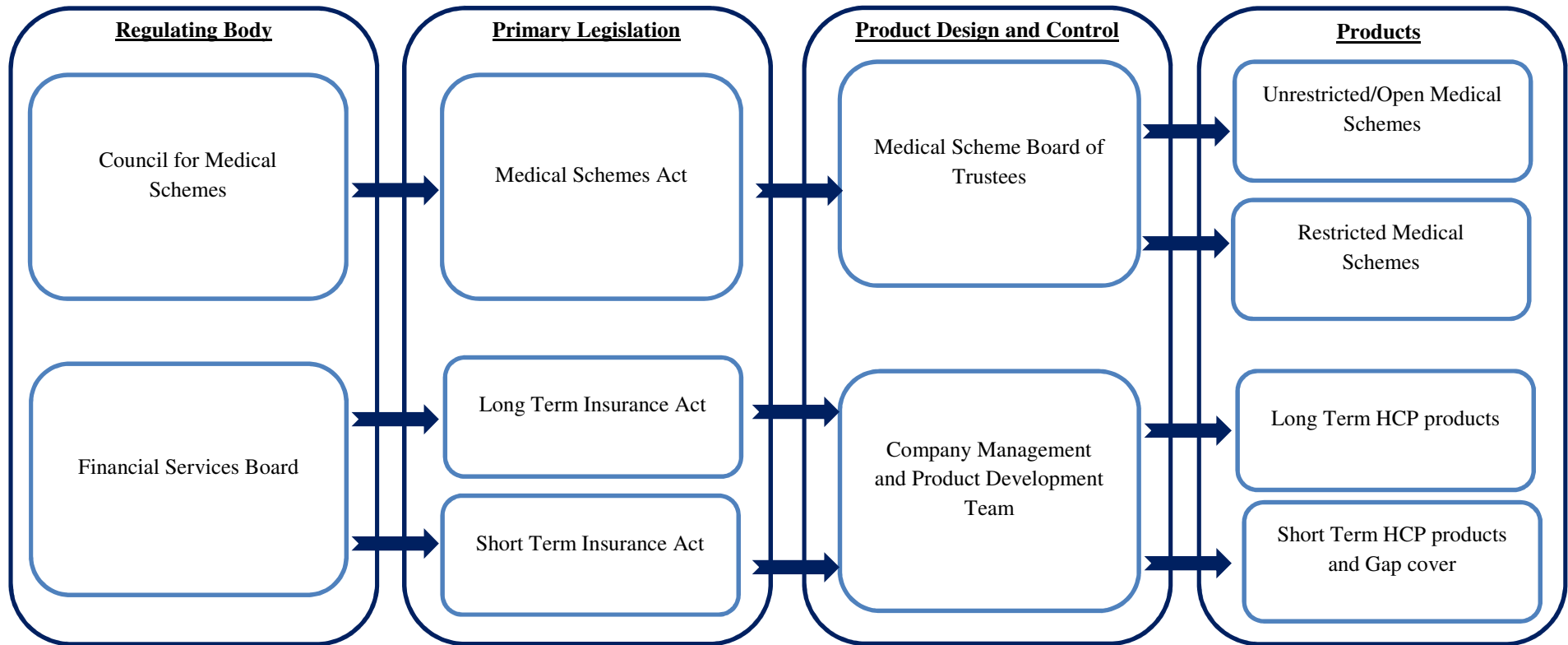
Gap cover products are a fairly new class of short-term insurance product that were launched in the late 90’s and that provide cover for the difference between what a policyholder’s medical scheme would pay and the rates actually charged by the provider. The need to fund this difference has become more pressing in recent years as the difference between what health care providers charge and what a policyholder’s medical scheme pays for the service has been increasing, particularly for specialist services.

Gap cover products have been a point of contention in the recent past with industry associations and particularly the CMS deeming those selling these products to be conducting the business of a medical scheme. This led to a protracted legal battle that saw the Supreme Court of Appeal side with the insurers, thus allowing these products to be sold by non-medical scheme insurers in the market (Case No. 168, 2008). Please refer to Section 3.4 for more details on these legal proceedings and outcomes of the dispute.

3.3 Regulatory Structure

The figure below illustrates the current regulatory structure for medical protection products.

Figure 2: Current Regulatory Structure



Source: Adapted from (Act no 52, 1998), (Act no 52, 1998) and (Act no 131, 1998).

Currently there are three acts and their supporting regulations which constitute the regulatory framework for medical protection products:

- The Long-Term Insurance Act;
- The Short-Term Insurance Act; and
- The Medical Schemes Act.

Medical schemes are subject to strict requirements regarding benefit design and pricing to comply with the MSA. The CMS aims to ensure that the interests of medical scheme members are protected. Each medical scheme is required to be managed by a board of trustees who have a fiduciary duty to ensure the effective management of the scheme, including compliance with the MSA.

In terms of Section 1 of the Medical Schemes Act :

The “business of a medical scheme” means the business of undertaking liability in return for a premium or contribution

- to make provision for the obtaining of any relevant health service;
- to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.”

Medical schemes can be grouped into two main categories: *restricted* medical schemes that are only accessible via membership of a specified/closed group (usually employer based) and *open* medical schemes that offer membership to all individuals able to afford membership.

Protection against anti-selection for open schemes is limited. A defined set of waiting periods, exclusions and premium loadings are permitted, but only in defined circumstances and the restrictions are not generally applicable to PMB’s, though some can be applied in certain circumstances.

The current forms of the Long Term Insurance Act and Short Term Insurance Act that apply to health insurance products were drafted as part of the process to clearly define the demarcation between the business of a medical scheme and other health insurance business, and to re-align the legislative landscape to ensure that the interests of medical scheme members are protected. Consequently the current legislation was drafted in tandem with the MSA of 1998 and also came into force in 2000.

The Short Term Insurance Act sets out the structure of short term insurance products and defines an accident and health policy as follows:

“Accident and health policy” means a contract in terms of which a person, in return for premium, undertakes to provide policy benefits if a:

- *Disability event;*
- *Health event; or*
- *Death event.*

Contemplated in the contract as a risk, occurs, but excluding any contract:

in terms of which the contemplated policy benefits:

- *are something other than a stated sum of money;*
 - *are to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and*
 - *are to be provided to any provider of a health service in return for the provision of such service; or*
-
- *of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act No. 72 of 1967)*
 - *which relates to a particular member of the scheme or to the beneficiaries of such member; and*
 - *which is entered into by the scheme to fund in whole or in part its liability to such member or beneficiaries in terms of its rules and includes a reinsurance policy in respect of such a policy.*

Some short-term insurers have designed products that are directly aimed at meeting the costs of medical expenditure. Though this is likely outside the scope of allowable products as outlined above, insurers have relied on the Supreme Court ruling referred to in 3.2.3. above in favour of the short-term insurer Guardrisk to justify the sale of these products. Please see Section 3.4 below for more details regarding the case and dispute.

The Long Term Insurance Act governs all long-term insurers and a health insurance product would fall under the category of a health policy as defined by the Act. We include the definition below:

“Health policy” means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event, but excluding any contract of which the contemplated policy benefits:

- *Are something other than a stated sum of money;*
- *Are to be provided upon a person having incurred, and to defray, expenditure in respect of any health service obtained as a result of the health event concerned; and*
- *Are to be provided to any provider of a health service in return for the provision of such service; or:*

of which the policyholder is a medical scheme registered under the Medical Schemes Act, 1967 (Act No. 72 of 1967)

- *which relates to a particular member of the scheme or to the beneficiaries of such member; and*
- *which is entered into by the scheme to fund in whole or in part its liability to such member & or beneficiaries in terms of its rules and includes a reinsurance policy in respect of such a contract;*

All sales of health insurance products should adhere to the marketing requirements as set out in the demarcation agreement regarding how the products are described, sold and benefits communicated, with no reference permitted to be made to medical schemes or to products being sold conditional to the policyholder being a member of a medical scheme.

The regulating body for health insurance products is the FSB with the two industry bodies, the Association for Savings and Investments in South Africa (ASISA) and South African Insurance

Association (SAIA) representing the long term/life licence and short term insurers respectively. ASISA fulfils a more formal self-regulatory role and strongly encourages its members to adhere to the demarcation code of conduct (ASISA, undated). SAIA on the other hand applies a less formal form of self-regulation and allows its members to test their products based on market forces. SAIA have issued a code of conduct, but the onus is on the insurer to ensure that it adheres to the code and measure its own compliance (SAIA CC, 2010). Should a dispute arise an insurer would likely rely on court rulings and past precedent to determine if a product is deemed to be in conflict with the demarcation (Case No. 168, 2008).

HCP and Gap cover products function as insurance products and the design of individual offerings is largely driven by market forces (given the offering remains within the bounds of the demarcation agreement). There are a wide variety of product offerings. Long-term health insurance products are usually restricted to traditional HCP products, while short-term health insurance products vary from HCP offerings to Gap cover and other products that provide cover similar to medical scheme benefits.

3.4 Demarcation Disputes⁸

Coinciding with the introduction of the MSA in 2000, the regulators and industry bodies deemed it necessary to clearly distinguish between medical schemes and health insurance products. An agreement was reached between the Life Office Association (LOA) and the CMS setting out a clear demarcation between medical schemes and health insurance products. While this demarcation agreement does not have full legislative standing, it does set out the proposed conditions under which health products are classified, to ensure that they are not in contravention of the Medical Schemes Act by providing benefits that would be viewed as the business of a medical scheme.

The demarcation between health insurance products and medical schemes is dependent on the interpretation of the business of a medical scheme versus the definition of an accident and health policy as set out in the Long Term Insurance Act and Short-Term Insurance Act. It was generally accepted that the MSA would be interpreted to mean that all products aimed at meeting the cost of health care would fall within the business of a medical scheme.

The CMS considered Gap cover products to be non-compliant with the demarcation and in 2006 challenged the validity of these products in court. It considered the fact that Gap cover products offered benefits that were directly related to the cost of treatment to mean that insurers offering them were conducting the business of a medical scheme. The CMS was also concerned that these products encouraged buy-down behaviour by enticing younger healthier members to select cheaper medical scheme options and then to “top up” with insurance products to provide more comprehensive cover.

⁸ The information in this section is based on Case No. 168, 2008 as well as interviews Insurers.

This option is not available to all medical scheme members due to the risk rating and underwriting policies of these products and as such could lead to a de-stabilisation of the medical schemes industry by reducing the cross-subsidies from younger to older members or from healthier to sicker members.

In the now almost infamous court case (Case No. 168, 2008) referred to in this document as the Guardrisk case, a short-term insurer providing Gap cover products, Guardrisk, was taken to court by the CMS on the grounds that it was contravening the demarcation agreement. Guardrisk countered by arguing that because policyholders had to belong to a medical scheme in order to buy the Gap cover product, this would in fact encourage medical scheme membership. They further argued that the benefits offered by Gap cover products do not compete with the benefits of any existing medical scheme and as such those offering Gap cover products cannot be viewed as conducting the business of a medical scheme.

In December 2006 the High Court ruled in favour of the CMS and Guardrisk was ordered to stop all marketing and sale of policies. Guardrisk would not have been allowed to renew the 130,000 existing policyholders contracts, but was allowed a period of 3 months to apply for leave for appeal.

Guardrisk appealed the judgement and the case was heard by the Supreme Court of Appeal. On 28 March 2008 the Supreme Court ruled in favour of Guardrisk and the company was able to resume the operations and marketing of its two lines of Gap cover products, Admed Pulse and Admed Gap.

The ruling turned on a literal interpretation of the definition of a business of a medical scheme in the MSA, in particular on the use of the word “and”. Recall the definition of a business of a medical scheme as follows:

The “business of a medical scheme” means the business of undertaking liability in return for a premium or contribution

- to make provision for the obtaining of any relevant health service;
- to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.”

The court stated that the word “and” between bullets 2 and 3 meant that all three conditions had to be met for a business of a medical scheme to be carried out and that, since Gap cover products did not meet all three conditions, they could not be deemed medical scheme products and so were not subject to the MSA. The ruling led to a mix of outcomes. Certain insurance companies closed their health insurance products to new business based on discussions with the CMS. But the ruling also led to a number of new Gap cover products being launched by a number of firms.

3.5 Proposed Revised Demarcation⁹

As a direct (if delayed) response to the Guardrisk case, on the 2nd of March 2012 the National Department of Health in conjunction with the CMS and FSB released a discussion document for public comment outlining a proposed revised demarcation between medical schemes and health insurance products.. The proposed revised demarcation sets out the changes to the Long Term Insurance Act and Short Term Insurance Act that would directly impact all existing health insurance products.

The headline changes that are applicable to the products considered in this report are as follows:

- The benefits of health insurance products cannot be related to the cost of treatment. This is not a change per se but rather a re-emphasis and clarification in the proposed draft;
- Daily HCP benefits are to be capped at 70% of daily income net of tax of the policyholder;
- Additional regulatory requirements to be introduced and CMS to be directly involved in the vetting and launching of new and existing health related product offerings to ensure compliance with the proposed revised draft demarcation; and
- Updated marketing and distribution requirements requiring insurers to be more explicit regarding the cover provided and the fact that these products are not designed to meet the cost of health care.

Impact of the proposed changes

The majority of HCPs provide benefits that are unrelated to the cost of care and thus would not be significantly impacted by the first requirement.

The cap of daily cash benefits to 70% of the policyholder's income will however have a significant impact on policyholders and the value that these products are able to offer. Section 6 outlines the ability of HCP products to defray the direct and indirect cost associated with a major medical event for low income policyholders. The results presented in this section show that even people categorised as H1 and H2¹⁰ under the means test applied to users of the public hospital system can incur significant health care-related costs and that even relatively low daily HCP benefits would be able to assist in covering these costs. Capping the daily benefit at 70% would severely limit the ability of

⁹ The information in this section relates mainly to Proposed Revised Demarcation Agreement, 2012

¹⁰ (UPFS AH, 2012) - H1 would imply an income of less than R 3 001 per month, while H2 would imply an income of between R 3001 and R 6,000 per month.

these products to defray both the direct and indirect costs of a major medical event. Please refer to Section 7 for a detailed analysis regarding the financial impact of this proposed change.

It is also envisaged that the CMS will play a more significant role under the revised demarcation and will fulfil a regulatory and supervisory role for both medical schemes as well as insurance products. There is some concern that the requirement for the CMS rather than the FSB to approve all health insurance products may lead to the suffocation of existing and new products.

An updated set of marketing and distribution requirements have been proposed so as to ensure that policyholders better understand the differences between products and do not underinsure themselves when they could afford a medical scheme. This would imply that all marketing material such as brochures, websites and the like would have to be updated to ensure that the communications adhere to the revised requirements.

The impact of the revised demarcation on Gap cover products will be significant and it is likely none of the products will be able to function in their current form. This will necessitate insurers either updating their offering to provide a pre-defined set of stated benefits or remove their products from the market.

Given the history of the court case involving Guardrisk and the opinions of Gap cover insurers polled during interviews for this report, these insurers may be willing to contest this legislation in court should it be implemented in its current form.

3.6 Chapter Summary

The table below summarises the key concepts of the different regulatory frameworks relating to medical schemes and health insurance products.

Table 1: Regulatory Overview

Key Principles	Categories of Health Products		
	Medical Schemes	Long Term Insurance	Short Term Insurance
Origin Date	1880's	1980's	1990's
Aim	Indemnity Cover	Cash benefits (income protection)	Cash Benefits /Indemnity Cover
Regulator	CMS	FSB	
Key Legislation	Medical Schemes Act	Long and Short Term Insurance Act	Short Term Insurance Act
Products	Medical schemes	HCP*	HCP and Gap cover*
Date Effective	2000 (drafted in 1998)		
Benefits	Based on cost of care	Pre-defined cash	Pre-defined cash or cost of care
Regulatory Aim	Regulate medical schemes	Regulate long-term insurers	Regulate short-term insurers
Latest Amendments	2003	Currently proposed	
Impact of Regulation and Governing Body	High	Medium - High	Medium
Disputes	Interpretation MSA regarding the payment of PMB benefits at cost.	Few as providers have clear guidance as to adherence via the demarcation agreement.	Demarcation between HCPs and medical schemes have resulted in court cases.

**The Short Term Insurance Act and the Long Term Insurance Act apply to a number of different products including other health products (dread disease, etc.) but for the purposes of the report and as applies to the table above only HCP and Gap cover products have been considered.*

4. Market Structure and Product Types for HCPs

This section outlines the key features of the market for hospital cash plan insurance and describes different hospital cash plan product categories.

The aim of the research and report is to determine how well HCP products service the needs of low income policyholders in defraying the direct and related costs of a major medical event. The results below thus focus on HCPs but comparisons are drawn to other “low-income” products (income-rated medical scheme options and Gap cover products) to clearly illustrate all available options to low-income individuals.

4.1 Market Size and Growth

The market for HCP products has expanded rapidly in the last 12 to 18 months. A number of industry stakeholders have estimated that there were 50,000 to 75,000 policies sold monthly¹¹ in the last year or so. The growth in the market coincides with the rise of direct marketing as a number of large insurers have invested heavily in radio, telemarketing, television advertising and other direct marketing campaigns. The actual number of policies sold in the industry is difficult to determine due to the lack of comprehensive industry level data and the unwillingness of competing insurers to share this information.

Policyholders can take out multiple policies. These figures will be partially inflated in terms of individual lives covered as policyholders can take out multiple policies, often with the same insurer. The combined benefit level for multiple policies with the same insurer is usually capped at the maximum daily cover available from the insurer or as referenced to the policyholder’s salary if this information is available, to avoid over-insurance or policy “farming”, but there is currently no way to monitor policyholders taking out multiple policies with different insurers.

The HCP market could equal 27% of the size of the medical schemes market if measured by lives covered. Even with high lapse rates and the purchase of multiple policies by the same policyholders, the market has gone through a period of rapid growth in recent years with the total number of current policies estimated to be between 1,000,000 and 1,500,000. This estimate is based on historical figures, relative industry growth rates and information provided during interviews. There is currently no hard data available from any source that provides an exact number of policies in force. The number of lives

¹¹ These figures are based on information provided in interviews conducted with several industry stakeholders that are able to take an informed view on the growth of the market in general.

covered under HCPs can be approximated by assuming¹² a conservative number of dependants covered by the policies. If we multiply the upper bound and lower bounds of the estimate by 2, it is possible that the number of lives covered equals approximately 24% - 27% of the number of lives covered by medical schemes. The medical schemes market currently caters for 8.3 million lives, (CMS, 2011) so that 2.24 million lives could be covered under HCPs.

The market for Gap cover is significantly smaller than the HCP market. Gap cover is estimated to be no bigger than 250 000 policies and service approximately 300,000 – 400,000 lives that would also have medical scheme coverage.

The table below illustrates the different estimated market sizes.

Table 2: Estimated Market Size

	HCP	Medical Schemes	Gap Cover
Number of Policies	1.0 – 1.5 Million	3.6 Million	Up to 250 000
Overlap with HCP	-	Information not available	Likely very small
Overlap with Medical Schemes	Information not available	-	100%
Overlap with Gap Cover	Likely very small	100% of Gap cover policy holders are also members of medical schemes	-

Source: CMS, 2011 and interviews with insurers.

4.2 Product Providers

Products are sold by both long-term and short-term insurers. The majority of current health insurance products are provided by the following categories of insurers:

- long-term insurers that sell HCP products as an additional product alongside their more traditional life insurance product portfolio;
- short term insurers that tend to specialise in low premium policyholder benefit products of this nature (HCP's, Funeral Cover, limited underwriting life cover etc.); and/or
- insurers that offer products under a combination of both their short and long term licences.

Though HCP products appear to be profitable in their own right, the relative size of the market and low premium values would likely imply that these products do not contribute a significant proportion

¹² Again there is no hard data on the number of lives covered per policy on an industry level.

to profits of large long-term insurers. Short-term insurers that invest heavily in marketing and development may be more dependent on this line of business.

Long-term insurers sell life insurance contracts whose term endures for *an extended period*. The policies are not normally annually reviewable and will usually only terminate due to death, policy lapse by the policyholder or breach of the policy rules. This implies that the insurer will likely not be able to vary the premium per the individual experience of the policyholder and requires a large client base and additional margins to ensure protection against anti-selection and adverse experience.

In contrast, short-term policies are generally sold on an individual basis so that the premium reflects the particular risk of the policyholder. They are annually reviewable and the insurer can adjust the rates and/ or terms offered on the policy anniversary according to the individual policyholder experience, though these interventions can be expensive. Group experience rating is also done. This implies that policyholders could experience volatile premiums or benefit changes from year to year. Products are mainly marketed via direct marketing.

There are approximately 99 medical schemes (CMS, 2011) active in the market compared to an estimated¹³ 30 – 40 HCP products and 15 – 20 Gap cover products actively being offered in the market.

4.3 Product Features

The table below illustrates the main benefit characteristics of the different product classes. There are a number of insurers that offer benefits that deviate from the structure below, but the information as presented in

¹³ These estimates are based on the information obtained from interviews with insurers and reinsurers.

Table 3 represents the majority of the products in the industry.

Table 3: Benefit structure for HCP, medical scheme and gap cover products

Product Class	HCP	Medical Schemes	Gap Cover
Benefit type	Stated benefits	Benefits linked to cost of care and scheme rules	Benefits linked to cost of care and medical scheme benefits
Major Medical Benefits	Daily benefits range between R 250 and R 5,000 and the pay-out will depend on cover level, days hospitalised and care ward	PMB benefits paid at cost, other benefits per benefit schedule	Cover applies mainly to non PMB, in - hospital procedures
Day to Day benefits	No cover*		Limited cover for certain specified conditions
Chronic/Dread disease benefits	No direct cover, can be in the form of tied products		
Possible Additional or Ancillary benefits	Benefits for accidents or public transport incidents, premium holidays and death benefits	Maternity programmes and loyalty programmes for some of the options	N/A
Cash Back	Policyholder retention incentive	N/A	
Loyalty Program	N/A	Incentive for members to remain healthy, only available on some products	N/A
Number of Providers	30-40**	99	15 – 20**

Source: Product brochures and stake holder interviews.

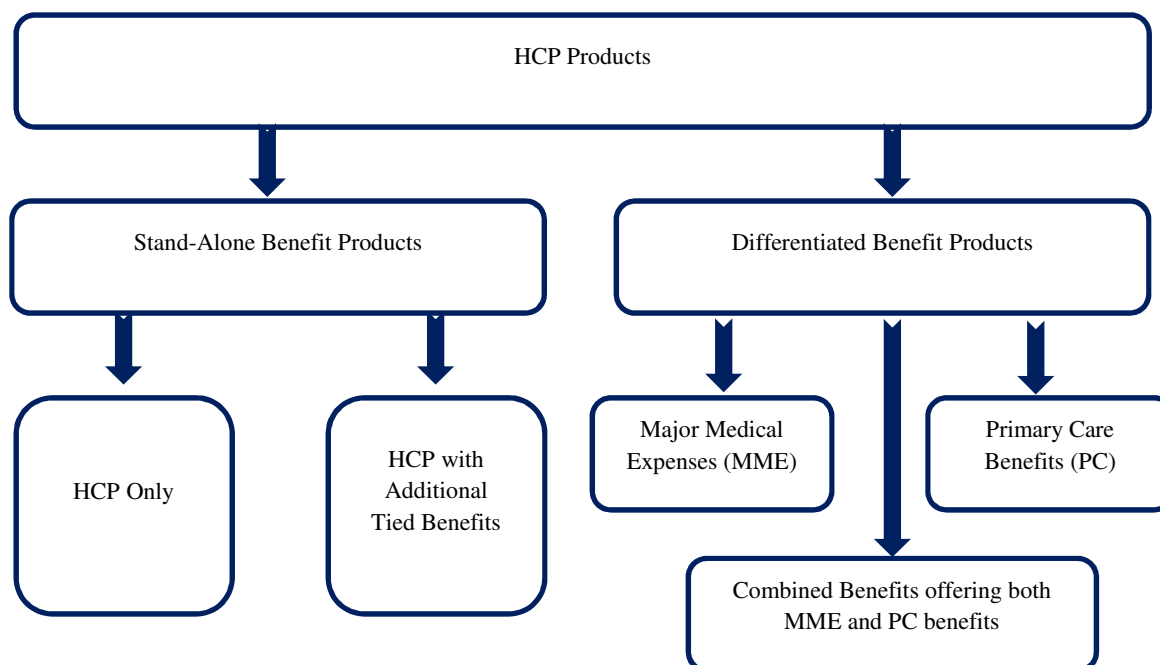
*There are a few products that do provide day to day benefits via provider network arrangements, but the majority of standard HCP do not provide benefits for day to day benefits.

**Estimated figures.

HCP Products

During the research, two main informal categories of HCP products emerge as illustrated in Figure 3:

Figure 3: HCP Benefit Classification



Source: Stoker, 2011 and authors own impression from analysis of different product offerings.

Stand-alone HCP benefit products are products that provide standalone benefits in the event of hospitalisation only, unrelated to the cost of care. Stand-alone benefit products can be subdivided into products that are pure hospital cash plans that offer only cash back benefits in the event of hospitalisation or products that offer other tied lump-sum benefits like accidental death benefits as well as dread disease benefits.

HCP products can service a wide variety of needs, but these are unclear as payment is made directly to the policyholder. Based on interviews and reviews of product information and advertising material, it can be concluded that clients do not purchase HCP products with the intention of meeting a specified financial need. HCP products are likely purchased to provide the insured with peace of mind in the event of a significant unexpected major health-related expense and the payout used to fund benefit shortfalls, replace or subsidise income, repay financial obligations (loan repayments, car instalments) or provide access to higher cover levels (private rooms etc.)

Given the average benefit pay out levels, assumed demographic and opinions of insurers and hospital groups, the benefit usage appears to depend on the cover level with lower income policyholders likely utilising the compensation to fund the cost of treatment (even if just partially) and related expenses of hospitalisation (travel, day care, recovery etc.) and higher earning policyholders that are also members of a medical scheme using the pay-outs to fund shortfalls in medical scheme payment or simply as a windfall pay-out unrelated to a specified financial need.

Differentiated benefit products are products that offer differentiated benefits that are likely aimed at meeting the cost of care. Table 4 compares the offering of 6 HCP providers.

Table 4: HCP Benefit Comparison

Benefits	Clientèle		Hollard	Sanlam	Old Mutual	Prime Meridian		Day 1*
	Standard Options	Premium Option	Day - Aid	All Plans	Both Options	Standard Options	Plus Option	Option 2
Daily Cash	Cover from 3 rd day	Backdated to day 1 if hospitalised for 3+ days			Cover from 2 nd day (not backdated)	Cover from 3 rd day		From 1 st day
Accidental Disability Benefit	Per defined schedule, no children		R50 000 + R10 000 (public transport)	Plan specific, no children, "No more premiums" benefit	N/A	Up to age 75, no children	Up to age 65, no children	R 250,000 (Principal Member Only)
Accidental Death Benefit	N/A	Up to age 80, no children	R50 000 + R10 000 (public transport)	Plan specific, "No more premiums" benefit	N/A			R 15,000 (Principal Member Only)
Dread Disease Benefit	N/A	5 Categories	N/A					Separate Benefit. Up to R 185,000 per annum
Maternity Benefit	12 month waiting period			Premium (and cover) holiday	12 month waiting period			N/A
Cash Back	Loyalty reward		1 years prem for every 5 years (regardless of claims)	No claims bonus, 1 years premiums every 5 years	Independent of claims, 15% of premiums every 5 years	Loyalty reward (25% if no claim)	Loyalty reward (50% if no claim)	N/A

Source: All information above is publically available. Please see the "Providers and Products" section in the References.

*Day 1 also offers a separate day to day benefit option (Option 1) with specified benefits for consultations, medication, HIV/Aids, radiology, pathology, dentistry and optometry. Option 1 and Option 2 can also be combined to provide a more comprehensive offering to members.

**N/A above implies that it was not noted on the benefit schedule.

Benefits are usually dependent on a minimum hospital stay (usually 3 days) with the majority of providers backdating benefits to the first day of hospitalisation. This serves to limit small claims and reduces the volatility of claims (similar to the use of an excess on motor vehicle insurance).

Additional benefits like accidental disability benefits, accidental death benefits and dread disease benefits are included in a number of products and act as tied products with cash sums being paid in the event of a valid claim regardless of the policyholder incurring a hospital claim as well. These benefits are usually fixed according to a stated schedule.

Nearly all the products apply a waiting period of 12 months for maternity cases to limit anti-selection. The vast majority of products also apply some form of cash back/loyalty reward program where the policyholder receives a cash back benefit or portion of his/her contributions in return for continued membership (usually 5 years). This benefit can be dependent on claims history for some products. Other ancillary benefits include premium “holidays” in the event that the insured becomes incapacitated /unable to work for a period.

It is clear that there is a wide range of products available with many insurers making use of different benefit structures to ensure they are sufficiently differentiated. This is often the case with a new and expanding market as insurers compete to find innovative offerings that will attract consumers.

Gap cover products

Gap cover products generally offer benefits that are directly related to both the cost of care and the benefits provided by the policyholder’s medical scheme, with the pay-out amount being the difference between what the medical scheme pays and what the provider charges up to a fixed multiple (usually 4 or 5 times) of an applicable rate (an annually inflated figure from the Reference Price List – RPL, is often used). Some insurers also offer stated benefits or a combination of the two. As with HCP products, benefit payments are made directly to the policyholder.

Medical Scheme Products

Medical schemes offer benefits directly related to the cost of care and aim to indemnify the member for these costs. The majority of the income-rated options as considered in this report provide for benefits at 100% of the scheme rate. While this is below the charging rate of many specialists, income rated options often make use of provider networks and designated service provider (DSP) agreements that facilitate payment in full as long as the member makes use of the applicable networks.

This is in contrast to the principles that guide the design of insurance products and consequently while medical schemes offer greater protection to members they are also significantly more expensive and are thus inaccessible to the majority of the population.

Both HCP and Gap cover are insurance products and apply insurance principles in their design and administration. Insurers can apply strict underwriting principles and can also stipulate a number of exclusions, both in access to the products and the level of benefits offered. For HCPs contributions are typically age-rated with limiting ages for entry and maximum ages after which cover ceases. Limiting ages for new principal policyholders range from 18 – 65. Minimum income requirements also apply to higher cover levels.

4.4 Premiums and Persistency

Lapse rates are a key concern for insurers. A number of insurers mentioned significant first year lapse rates for HCP products. Some of the interviewed stakeholders noted first-year lapse rates as high as 50% though the industry average seems to be in the region of 25% to 35%¹⁴. In general those insurers who sell through direct marketing have higher lapse rates as lapse rates are partly a reflection of the appropriateness or otherwise of the sales channel or process or the degree of sales ‘push’. High lapse rates could indicate overly “pushy” sales and buyer’s remorse.

Given the nature of the products and the benefits of persistency offered to members in the form of cash back benefits and the like, lapse rates after the first year are likely significantly lower than the initial high rates noted.

HCP products are significantly cheaper than medical scheme offerings. Income-rated medical scheme contributions (these are typically products aimed at lower income groups) are between 2 to 6 times higher than the average HCP contribution (from a comparison of a variety of product brochures). This is due to HCPs having significantly lower benefit levels and lighter underwriting conditions, and also to the difference between the product structures. HCP contributions vary widely which is attributable to the rating factors applied and benefits offered. Very low levels of cover (R250 per day) are available for approximately R100 per month while the cost of R 5,000 per day cover ranges between R 450 and R850 per person depending on age (see Table 6 below). .

Gap cover products have low premiums due to the narrow benefits offered and are usually priced on a family basis. However, the typical condition of having to belong to a medical scheme implies that these products would likely be inaccessible for low to middle-income policyholders.

Contributions for both Gap cover and HCP products are also dependent on the sales channel. Products that are sold to individual policyholders can be priced 20% - 50%¹⁵ higher than products that are sold as on a group basis. This price difference reflects the inherent risks of anti-selection on individual business. Individual policyholders that actively seek cover have higher claiming propensities and as such represent a higher risk group. Gap products are often sold on a group basis.

Employer subsidies can serve to reduce the burden of the employee. The policyholder’s portion of contributions under group HCP policies which have significantly reduced premium rates due to group discounts can often be further reduced by employer subsidies. Products sold under this arrangement could be a more affordable option to members seeking some form of cover.

In contrast, medical scheme contributions are not influenced by whether the product is sold on an individual or group basis, though employers can subsidise contributions.

¹⁴ These figures were quoted in interviews with insurers and confirmed by reinsurers.

¹⁵ These figures were quoted by two larger insurers that offer both group and individual offerings.

Tables 6 and 7 below illustrate the average monthly principal contributions for each of the different product classes. These amounts are based on the contribution tables of 5 of the main HCP writers in the industry and represent an accurate estimate of the average contributions in the industry. The average monthly medical scheme contributions are based on the 6 different options for 5 open medical schemes that offer income rated options, and these represent approximately 5% of the total medical schemes industry by membership (CMS, 2011).

Table 5 illustrates the insurers and medical scheme options used for the comparison. Details of the different policy documents and rates can be found by making use of the links as included in the “*Products and Providers*” section under References.

Table 5: Providers

HCP	Medical Schemes	Gap Cover
Clientèle	ProSano Procedure Option	Admed Gap&Admed Pulse
Old Mutual	Discovery Key Care Core Option	Ambeldon
Hollard	Discovery Key Care Plus Option	Old Mutual
Sanlam	BonitasBoncap Option	
Prime Meridian	Resolution Foundation Option	
	Momentum Ingwe Network Option	

Table 6: Hospital Cash Plan Principal Policyholder Average Monthly Contributions

Age	Cover Level –Daily benefit amount						
	R 250 (\$ 32)	R 500 (\$ 64)	R 750 (\$ 96)	R 1000 (\$ 129)	R 2000 (\$ 257)	R 3000 (\$ 386)	R 5000 (\$ 643)
18 - 24	R 96 (\$ 12)	R 106 (\$ 14)	R 129 (\$ 17)	R 156 (\$ 20)	R 238 (\$ 31)	R 261 (\$ 34)	R 450 (\$ 58)
25 - 34	R 98 (\$ 13)	R 109 (\$ 14)	R 132 (\$ 17)	R 162 (\$ 21)	R 257 (\$ 33)	R 273 (\$ 35)	R 510 (\$ 66)
35 - 44	R 98 (\$ 13)	R 116 (\$ 15)	R 137 (\$ 18)	R 170 (\$ 22)	R 269 (\$ 35)	R 333 (\$ 43)	R 550 (\$ 71)
45 - 54	R 99 (\$ 13)	R 121 (\$ 16)	R 137 (\$ 18)	R 182 (\$ 23)	R 303 (\$ 39)	R 377 (\$ 48)	R 730 (\$ 94)
55 - 65	R 100 (\$ 13)	R 153 (\$ 20)	R 177 (\$ 23)	R 205 (\$ 26)	R 340 (\$ 44)	R 445 (\$ 57)	R 850 (\$ 109)

\$ Equivalent amount in brackets. Exchange rate as per Oanda currency converter

(<http://www.oanda.com/currency/converter/>) as at 7 May 2012.

Table 7: Income-rated Medical Scheme Principal Policyholder Average Monthly Contributions

Monthly Income	Average Contribution	Average Contribution including Gap cover*
0 – R 4 000 (0 - \$514)	R 491 (\$ 63)	R 591 (\$ 76)
R 4 001 – R 6 000 (\$ 515 - \$ 771)	R 603 (\$ 78)	R 703 (\$ 90)
R 6 001 – R 8 000 (\$ 772 - \$ 1028)	R 723 (\$ 93)	R 823 (\$ 106)
R 8 000+ (\$ 1029+)	R 1051 (\$ 135)	R 1151 (\$ 148)

*Gap cover is family-rated and dependants will be covered at no additional cost.

\$ Equivalent amount in brackets. Exchange rate as per Oanda currency converter

(<http://www.oanda.com/currency/converter/>) as at 7 May 2012.

While the benefits of a HCP are not comparable to that of a medical scheme, low-income South Africans would likely have no alternative product which they could access due to affordability constraints (LIMS Ministerial Task Team, 2005). The additional cover provided by a Gap cover product would be even less accessible to low-income persons due to the additional contributions required above a medical scheme contribution.

As can be seen from the above tables, HCP products are less expensive than the lowest medical scheme contribution level for all ages and cover levels up to the R 3,000 per day benefit level. To access benefits of R 5,000 per day or more, a person would be required to be earning a higher salary and someone earning this much would likely be able to afford medical scheme membership.

HCPs often also only apply one additional reduced contribution for a full family compared to medical schemes that usually charge an additional contribution for each dependant, sometimes up to a pre-defined limit of 3 or 4, although there is often no limit on the lower income options.

Underwriting is usually light in the South African HCP market. The reasons for the low HCP premiums relative to medical schemes are that benefits are lower and underwriting is light. During the interview process it emerged that underwriting criteria in the South African HCP market are often limited to age, exclusion of certain conditions (pre-existing dread diseases etc.) and for policies with high daily cash benefits, income. The majority of insurers interviewed cited the cost of underwriting as well as the small required reserves as the main drivers for the slight underwriting. HCP products have low reserve levels due to low expected benefit values and claim rates. They are also not required to abide by the same regulatory solvency and investment restrictions as medical schemes.

Similarly, Gap cover products usually apply very little underwriting with the only requirements for most products being medical scheme membership and benefits being subject to certain limiting ages. Gap cover products are most often offered on a group basis and as such could also include a condition of employment in the underwriting requirements. Gap cover products are also likely to benefit from the complex and detailed claims management and control measures implemented by medical schemes.

Detailed underwriting can offer benefits to insurers but is costly. Detailed underwriting can be a very successful tool to control claims and is an important part of the development of sustainable product offerings. However, detailed underwriting is expensive. This, coupled with high lapses, which are typical on directly sold HCP products, will increase the proportion of un-recouped initial expenses. Detailed underwriting also requires a well-trained and efficient sales force. The likely result of a requirement for more detailed underwriting will be higher premiums, slower rates of new business, increased liquidity strain on insurers and pressure on profit margins.

Moreover, policyholders often do not like to provide detailed information about their medical history or financial status and as such a comprehensive questionnaire or detailed assessment could be a hindrance to the growth of new business. Underwriting requirements is one of the factors that have been addressed in part by the proposed revised demarcation via the income-related benefit limits and vetting requirements. Please see Section 7 for more details of the impact of these proposed changes.

Some insurers writing individual policies apply a number of exclusions and waiting periods to policies. These interventions serve to prevent anti-selection and reduce the number and volatility of claims. Typical exclusions and waiting periods include:

- Confinement to rest or convalescent homes, hospices, frail care;
- Abortion, miscarriage, or complications arising from childbirth;
- AIDS or HIV infection;
- Pre-existing conditions (can be applied only for a defined period);
- Non-essential surgical procedures;
- A waiting period can be applied for all non-accidental claims;
- A set waiting period on all claims; and
- Exploratory surgery.

4.5 Target Market and distribution

HCP products do not meet a clearly defined need and are “sold” rather than “bought”. This is usually done by creating awareness of the products and increasing the perceived need for cover. HCP products are targeted at low-to middle-income individuals. Most insurers confirmed this mentioning that they view LSM 4 - 7 as their primary target market. We are unable to access accurate client income data as insurers were generally unwilling or unable to provide this information. Cover level was used as a proxy for income and from industry information from 2009 and 2012 conclusions were drawn regarding the likely income distribution of the HCP market. The results show that the majority of HCP clients purchased low-cover HCP options (cover of R600 (\$ 77) a day or less) costing no more than R150 (\$ 19) per month which supports our view of a target market group of LSM 4 – 7. In contrast, the majority of medical scheme members would fall in the highest earning proportion of the country and can be classified as falling into LSM 8 – 10 (ECONEX, 2010).

The distribution method seems to be dependent on whether the product is offered on a group or individual basis with most group policies being sold via worksite marketing, often in conjunction with the company’s own in-house HR staff or telemarketing to members of a particular employer group. Sales to individuals rely mainly on direct marketing which solicits potential policyholders to contact the insurer after being exposed to the advert.¹⁶

See Section 5 below for a more detailed analysis of the demographics of members.

¹⁶ The distribution channels were discussed at length with many of the insurers and this paragraph is based on the information provided during the interviews. As with other market related information discussed, there is unfortunately no comprehensive hard data.

4.6 Profitability, Costs and Premium Breakdown

One of the key concerns regarding the funding of health care through a commercial insurance vehicle is the drive for profits at the expense of benefits for policyholders, especially vulnerable persons like lower income clients, the elderly and the sick.

HCP and Gap cover products, like all insurance products, are for-profit products with the majority of insurers seeking ways to improve profitability by balancing higher volumes with competitive pricing as opposed to increasing prices and margins per policy. Conversely, medical schemes are not-for-profit mutual benefit societies aimed at meeting the needs of members while ensuring the scheme remains sustainable and self-funding. Profits may be made by the medical scheme's appointed administrator and managed care service providers. The CMS has encouraged schemes to keep so called non- health care costs of schemes to around 10% of contributions.

The table below provides an indication of the average premium breakdown of the three different product classes.

Table 8: Premium Breakdown per average policy

Factor	HCP	Medical Schemes	Gap Cover
Cost of benefits	20% – 35%	75% - 90%	35% - 50%
Administration Expenses	25% - 35%	7% - 10%	20% - 30%
Managed Care Expenses	N/A	5% - 7%	N/A
Commission	Variable**	3% (open schemes)	15% - 20%
Profits/Reserves	25% - 35%	Scheme Dependants (often times negative before investment income)	10% - 20%

* Note that for medical schemes any surplus funds either from investment income or operating surplus would revert to the communal pool of funds and would be used for the benefit of members via lower contribution increases or increased benefits.

**A large proportion of HCP products are sold via direct marketing and distribution channels and as such would likely not have a significant commission component.

The table below illustrates the magnitude of the percentages above on a per policy bases, using the average contributions per policy (assuming HCP members are concentrated in the lower cover levels).

Table 9: Premium Breakdown per Average Policy

Factor	HCP	Medical Aid	Gap Cover
Total Monthly Premium	R 130	R 723	R 100
Cost of benefits	R 26 - R 46	R 542 - R 651	R 35 - R 50
Administration Expenses	R 33 - R 46	R 51 - R 72	R 20 - R 30
Managed Care Expenses	N/A	R 36 - R 51	N/A
Commission	Variable**	R 22	R 15 - R 20
Profits/Reserves	R 26 - R 46	Scheme Dependant (can be negative)	R 10 - R 20

The results above indicate that on average medical schemes provide the highest benefit per Rand spent, while Gap cover and HCP products deliver relatively low benefits per Rand spent. While this could be interpreted to imply that these products offer low value to consumers, one would need to

consider the relative absolute values of premium and benefits; the inherent comprehensiveness of benefits make medical schemes too expensive for the majority of low-income earners and they also do not provide the policyholder with the opportunity to incur windfall claims. Section 6 provides a more detailed analysis regarding the value comparison of these products.

Risk premiums of HCP products are relatively low. The costs of benefits are directly related to the proportion of the premium that is directed towards benefit payments. This is referred to as the risk premium. HCPs have relatively low risk premiums and it has been estimated that only 20% - 35% of the premium is spent on actual benefit payments although insurers indicated that this is increasing. The risk premium ratio for Gap cover has increased recently from 20% to 35% - 50% (as indicated during interviews with insurers). In contrast, the risk premium for medical schemes is significantly higher at 75% - 90% (CMS, 2011) as these products do not carry loadings for profits and expenses are regulated.

Expenses are a significant factor in product development, distribution and pricing. Fixed expenses as a proportion of premium income are relatively high for HCP and Gap cover products versus medical schemes due to the relatively low levels of premiums. The main expense categories relate to administration expenses (covering all fixed and variable costs of administering the policies, from IT and staff salaries to call centre costs and claims administration), managed care expenses (only applicable to medical schemes) and commission (directly related to the distribution channel). The administration spend for HCP and Gap cover products is estimated to be 25% - 35% and 20% - 30%, respectively, of premium income while administration costs amount to only 7% - 10% of premium income for medical schemes (CMS, 2011). Commission will vary greatly between the different insurers and the chosen distribution channel.

The market has expanded in terms of cover levels offered with the maximum level of cover in 2008 ranging up to approximately R 1,000 per day compared to cover of up to R 5,000 per day available today. One possible motivation for the increase in maximum cover levels is the relatively high proportional fixed expenses for HCP products at lower premium values.

Profitability. Interviews with insurers and reinsurers revealed that HCP products are a reasonably profitable line of business, with profit levels likely ranging between 25% - 35% of premiums, and could be considered a lucrative market to an insurer that can secure at least moderate sales volumes.

Interviews with insurers revealed that the cost of benefits of Gap cover products have increased markedly from 2008 leading to average benefit loss ratios (ratio of benefit payments to contribution income) to increase from approximately 50% to 90% in 2011. This is due to increased propensities to claim for specialist care as a result of increased awareness of the benefits and has led to the erosion of the profit margins on these products. Gap cover insurers have also cited increased fraudulent activity by doctors as possible cost drivers. Consequently profit margins for gap cover products are estimated to be 10% - 20% currently compared to the much higher profits of 25% - 35% for HCP products.

Fraud is a significant risk in the South African market. One of the biggest threats to the industry is fraud, with one insurer stating: "The key to success in the HCP market is distribution and fraud prevention...". Interestingly nearly all the insurers interviewed for this study cited the province of Kwa-Zulu Natal as one of their biggest fraud risk areas and have cited instances of fraud ranging from multiple claims under one admission, falsifying claims to collusion between policyholders and doctors. This is apparently true for other lines of insurance as well and some insurers have suggested launching enquiries into and restrictions on products sold in this area. It is possible that more

comprehensive underwriting could assist in reducing fraud but, as stated above, the benefits may be outweighed by the increased costs translating into reduced profits or lower benefit levels that can be accessed by policyholders.

4.7 Chapter Summary

The table below provides an illustration of the key traits of the different products.

Table 10: Product Classification

Product Classification	HCP Insurance Products			Income Rated Medical Aid Products		Gap Cover Insurance Products	
	Stand-alone benefit offering	Combination benefit offering	Differentiated benefit offering	Restricted Medical Scheme	Open Medical Scheme	Pure Gap cover product	Hybrid Gap cover product
Benefits	Stated Benefits		Stated or related benefits	Benefits differentiated on cost of treatment			Combination of stated benefits and cost of treatment
Pay-out on	Hospitalisation		Hospitalisation and day to day events	Incurring costs for a medical event within the schemes rules and benefit structure		In hospital procedures (limited additional benefits)	
Needs met	Unspecified		Most likely cost of treatment	Cost of treatment			Cost of treatment and unspecified
Underwriting	Age, income and family size		Family size	Income and family size		Medical scheme membership and age	
Contribution Ranges*	Low to Medium		Medium	Medium to high		High given medical scheme membership requirement	
Target Market:	LSM 4 - 6			LSM 7 - 9		LSM 7 - 10	
New principal member age at entry restrictions	18 - 65		18 – 65, elderly specific products for persons above age 65 also available	18+		18 - 65	
Profitability	30% – 40%			Not for profit		Historically similar to HCP but has declined in recent years to 10% to 20%	
Benefit Overlap with other products**	Low		Medium to High	Low (Comprehensive offering)		Low (top up benefits)	

Source: Product brochures, insurer and stakeholder interviews and authors own calculations and analysis.

*Please note that contributions are considered from a low income perspective and unrelated to the value of benefits purchased.

**Benefit overlap represents the overlap in benefit structure within the products considered above for the purposes of this research only.

5. Membership

This section outlines the key features and membership demographic characteristics of the different product classes.

A detailed understanding of the profile of the membership base for these products is important in ascertaining how effective they are in servicing low-income policyholders.

This section relies mainly on data from industry representative bodies, but information from both the medical scheme industry and insurance providers was also incorporated.

5.1 The Battle for Members

Health insurance products are viewed as a possible threat to the stability of the medical schemes market. The principal demographic characteristics of HCP policyholders has been a point of debate in the past and is a key concern to policy makers and regulators as well as to insurers and medical schemes. Medical schemes representatives believe that if health insurance products are allowed to provide benefits that compete with the benefits of medical schemes without the same regulatory restrictions and requirements, the medical schemes industry could be destabilised. It is possible that age and medical underwriting of health insurance products could act as a disincentive for older or unhealthy persons to take out these products, requiring these persons to make use of medical schemes while their younger, healthier counterparts would be able to make use of health insurance products at much reduced rates. It is believed that this drain of young and healthy lives from the medical schemes industry would undermine the community-rating system and cross-subsidisation present in medical schemes, leading to ever increasing costs as the medical schemes industry will be left to cover higher risk members.

Whether young and healthy members actually see these products as viable substitutes to medical scheme products depends on their understanding of the difference between the two products (with the complexity of medical schemes perhaps forcing the less knowledgeable into HCPs) and their expectation of the actual costs of a major medical event relative to the pay-out under the two products. The revised proposed demarcation document includes additional requirements as outlined in Section 3.5 aimed at making policyholders more aware of the differences between the two classes of products.

Low-income persons would likely base decisions on affordability considerations and have no other alternative than to take out a HCP to provide some form of protection.

5.2 Membership Overlap

Exact numbers regarding the overlap between medical schemes and health insurance products are not available. Due to the small size of premiums significant underwriting is not applied to all but the highest health insurance cover policies and even in these instances data on medical scheme membership is not collected.

Insurers that offer differentiated benefit HCP products seem to aim to provide cover to uncovered individuals that cannot afford medical scheme membership. Providers of these products suggested that medical scheme membership was limited to less than 3% of their total client base, though this could not be independently verified.

Some industry stakeholders have suggested that historically a number of HCP products were sold as add-ons to medical schemes and so there might be a proportion of historical overlap, but given the significant growth rates in the industry and the rising cost of medical schemes together with the introduction of Gap cover that is specifically aimed at meeting the shortfall on medical schemes, it is likely that the overlap with HCPs is limited.

Determining the exact level of overlap and perceived substitutability would provide significant insights into this market and the exact threat that HCPs pose to medical schemes. Though this information might not be available from insurers an investigation into the membership and overlap of one of the larger insurers in the industry could well form part of a follow up project to further inform the debate.

5.3 HCP Policyholder Demographics and Trends

Information regarding HCP membership demographics was obtained directly from insurers for 2012 as well as ASISA on a summarised level for 2009. In considering this data, it is important to keep in mind that the information does not represent the entire industry in the same sense as medical scheme data does and the actual totals for the industry could well be different. The data represents the characteristics of approximately 216,418 policies and relates to total of 408,098 lives (on a combined level). While this sample of lives represents a relatively small part of the estimated total market size, the data confirms the impressions of the market demographics from the interviews held.

The graph below sets out the likely proportion of lives covered per age band for HCP products in comparison to medical schemes (via ASISA 2009 information and CMS, 2009).

Figure 4: Total Number of Lives Age Analysis

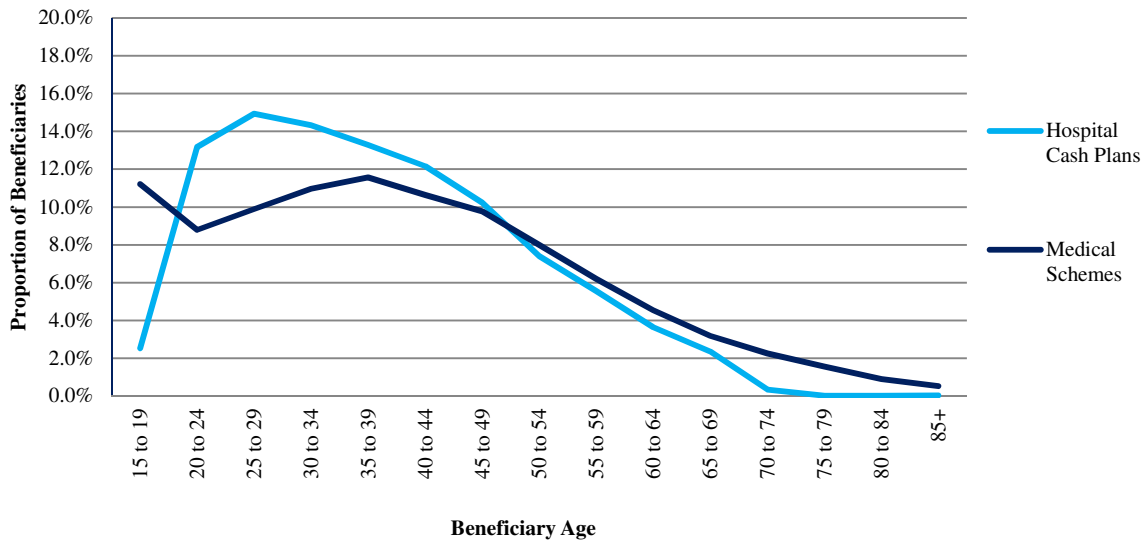
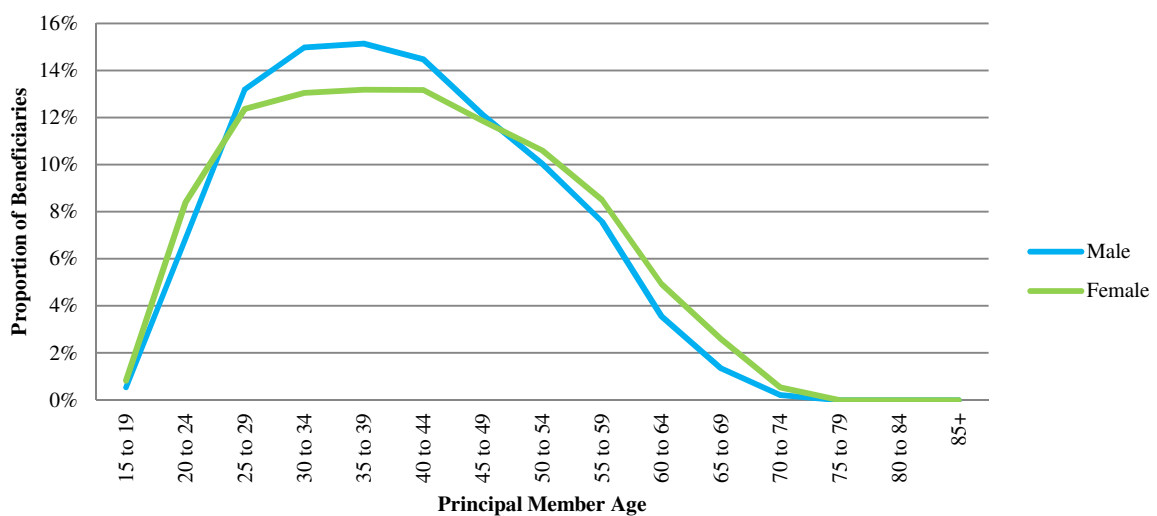


Figure 4 above clearly illustrates the differences in membership profiles between the two markets with more than 55% of HCP beneficiaries concentrated between the ages of 20 - 40 years. These estimates tie in to the information provided during the interview process of the average age of policyholders. By comparison, the same age band for medical scheme members only contains about 30% of members.

The peak of HCP membership lies between the ages of 20 and 30. This indicates that there may well be demand for health insurance or medical scheme products in these age bands, provided that the costs are adequately low so as to give perceived value for money.

The graph below is based on information provided by an insurer and illustrates the distribution of principal lives on HCP offerings split by gender.

Figure 5: Principal Member Age Analysis by Gender



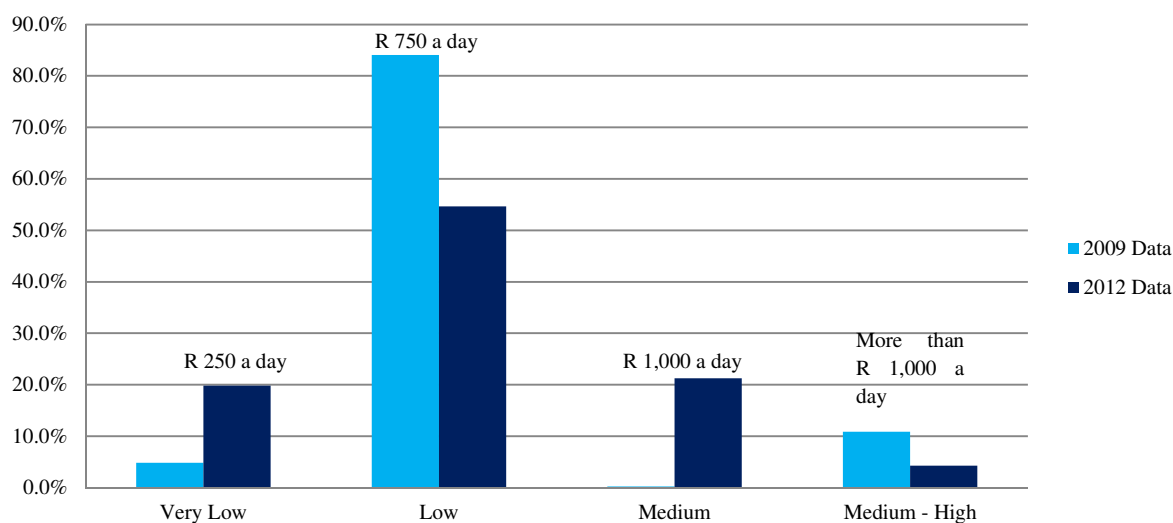
It is interesting to note the distribution of policyholders of both genders peaks markedly between ages 20 – 30 with a significant drop towards older ages. The trend for females seems to be less pronounced with a slightly lower peak at younger ages and a more gradual taper effect towards older ages compared to males.

The reduction in membership as age increases may be due to the age-rated contribution structure of these products. The slight increase in female membership at older ages could indicate the presence of widows. It should be noted that the graph could be skewed due to limited data.

Figure 6 below illustrates the distribution of policyholder income levels based on the level of cover purchased and how this compares to the information submitted by ASISA in 2009 and the insurer data provided in 2012.

During the interview process a number of insurers noted that policyholders purchase HCP cover based on affordability considerations and it was noted that more frequently policyholders would seek the highest level of cover they could afford rather than trying to match their needs to a specific level of cover. This implies that cover level and the distribution of policies across cover levels could form a reasonable proxy for the distribution of income and that the level of cover purchased would represent a relatively accurate proxy for affordability.

Figure 6: Income Distribution Comparison (Cover Level as Proxy)



From Figure 6 it is clear that the majority of policyholders make use of cover levels that could signify a low level of income in both sets of data. There does seem to have been a slight shift to higher cover levels which may be attributable to the growth in the market. Nonetheless the vast majority of members are still concentrated in the low income cover categories and would most likely fall in the SLM 4-7 classification for the purposes of this report (see section 6 below and the Appendices for a more in-depth analysis of income relative to premiums and benefits).

Cover levels of approximately R1,000 per day represents medium income earners while cover levels of more than R1,000 per day indicate middle to high income earners.

5.4 Chapter Summary

The data above represents a proportion of HCP membership at the time and provides insights into the key demographics of policyholders that purchase these products. Even given the rapid growth of the industry in recent years and taking into account the growth in the higher cover levels, the market for HCPs is still primarily made up of people that would not be able to afford a medical scheme.

Policyholders of HCPs are likely purchasing the insurance cover either as a form of additional insurance or due to the inability to access medical schemes owing to affordability constraints. It is unlikely that policyholders would see HCP products as replacements for medical schemes, but this will depend on their understanding and perceptions.

The table below provides a summary of the likely demographic profile of HCP policyholders.

Table 11: Membership Demographic Summary

Demographic	Likely Profile
Age	20 - 40
Income Distribution	LSM 4 – 7 (possibly higher)
Gender	No distinction
Disease Profile	Likely low due to age profile and underwriting
Needs	Wide variety, possibly cost of care and related costs

Source: ASISA, insurer data and interviews.

6. Analysis and Comparison Modelling¹⁷

This section provides a comparative analysis of the costs versus benefits of HCP and medical scheme products, in real financial terms.

*The benefits of an HCP product are **not** directly comparable to those of a medical scheme. A comparison model (LAC Signal benefit comparison model) has been used to illustrate the trade-offs to policyholders and quantify the risk of underinsurance should policyholders purchase the HCP products to defray medical expenses.*

6.1 The Reality – An Affordability Comparison

Medical scheme benefits and HCP pay-outs do not provide comparable benefits and are not designed to service the same needs, but low-income persons may make a decision to purchase the former based on affordability rather than benefit structure considerations.

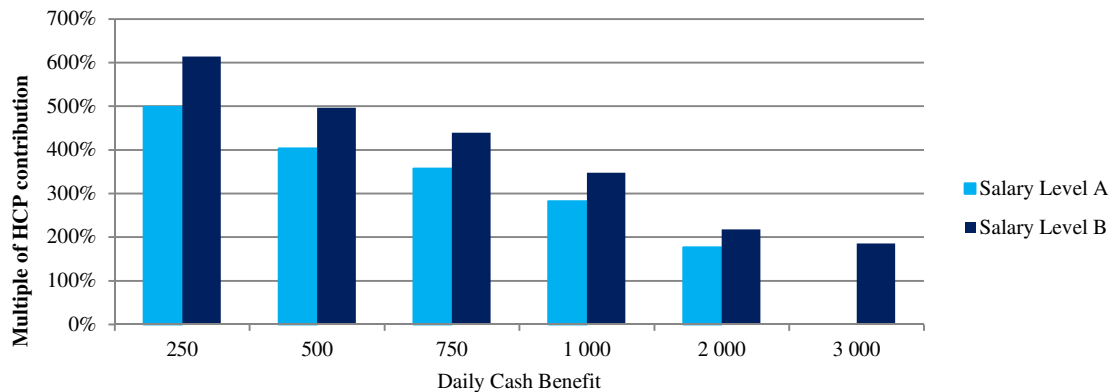
In this section we illustrate the affordability constraints faced by low-income persons and the contribution differences between HCP product and medical schemes. For illustrative purposes the contribution comparison below is based on two income levels both below R6,000 per month:

- Example salary level A would represent a person who earns less than R3,000 per month (LSM 1-5). This would imply that the person would qualify as H1 in the state means test and be able to access public facilities at significantly reduced rates (UPFS, 2012). Section 6.3 provides more details on the state means test and the potential of HCPs to meet the direct costs of hospitalisation when care is supplied via a state facility. A person in this income category would also generally be able to access the lowest income-rated contributions in the medical schemes industry.
- Example salary level B would represent a person who earns between R 3,000 and R 6,000 per month (R 5,000 for illustration). This would imply that this person would qualify as H2 in the state means test and be able to access public facilities at partially reduced rates (UPFS, 2012). A person in this income category would also be able to access the second lowest income band for income-rated medical schemes.

¹⁷ Concepts in this section relate to Padarah & English, 2011; Adam, Evens and Murray, 2003; Van den Heever, undated and World Health Report, 2011.

The graph below illustrates the affordability trade-offs faced by a low income person and shows the average medical scheme contributions as a multiple of HCP contributions per daily HCP cash benefit level for both salary level A and salary level B.

Figure 7: Contribution Comparison



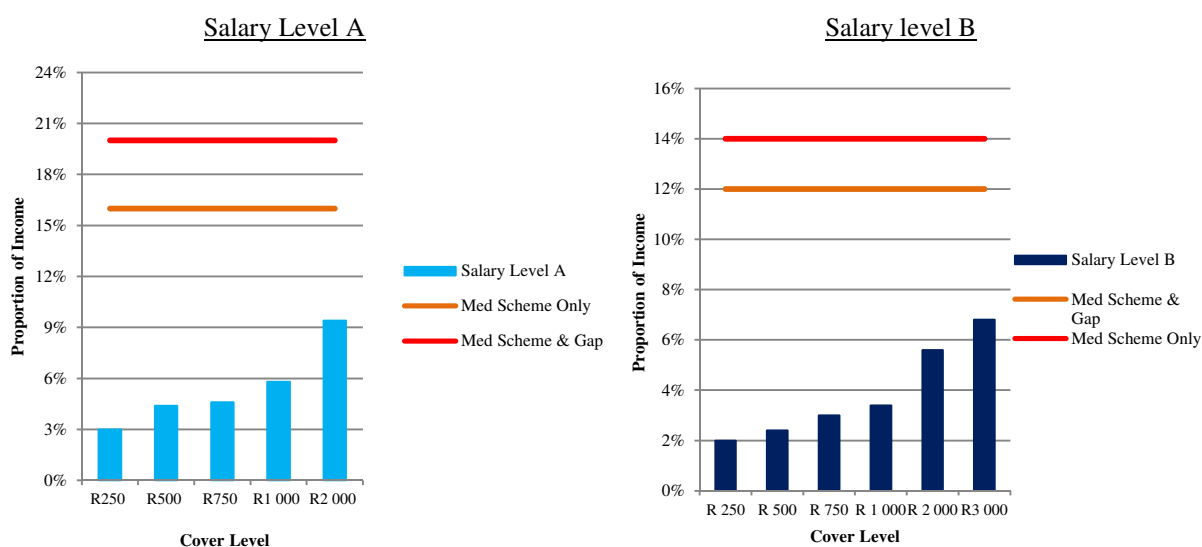
Source: Product brochures and marketing material.

Medical scheme products are 2-6 times more costly than HCP products at lower income levels. From Figure 7 it is clear that members who would qualify for the two lowest income bands on income-rated medical scheme options would have to contribute a much higher portion of their income to secure medical scheme membership, while HCP products are available for significantly lower contribution levels. Details regarding the relationship between HCP, medical scheme and Gap cover contributions are provided in the tables in Appendix 1.

A person in salary level A would be able to afford HCP cover providing maximum daily benefits of R2,000, and those in salary level B would be able to afford HCP cover providing maximum daily benefits of R3,000.

For Salary Level A the average income-rated monthly medical scheme principal member contribution would be approximately R 490 without Gap cover and R 590 including Gap cover. A person in Salary level A would likely only be able to purchase HCP cover up to R 1,000 or R 2,000 per day due to affordability constraints and income vetting at higher cover levels. A person in Salary Level B would pay approximately R 600 without Gap cover and R 700 including Gap cover and would likely be able to access HCP cover up to R 2,000 or R 3,000 per day. HCP contributions are not income rated and contributions would depend on the age of the principle member and the cover level selected.

The graph below illustrates the proportion of income spent on HCP contributions per salary level and how this compares to the relevant medical scheme contributions for each salary band.

Figure 8: Contributions as a Proportion of Salary

HCP products are significantly more affordable for both income levels. From Figure 8 it is clear that HCP cover at relatively high daily benefit levels can be bought for less than 10% of a person's monthly income for both salary levels. Medical scheme contributions are above this threshold level for both income categories and would be unaffordable to these persons without the benefit of a significant employer subsidy. This ratio of contribution to salary would be even higher if the member had non-income earning dependants. Though the benefits would likely be too low to fund the cost of care in a private facility (see Section 6.1), the policyholder would be able to fund a significant proportion of the direct and related expenses if state facilities were used (see Section 6.3).

Income rated medical scheme contributions are regressive in nature. The results of the analysis above illustrate one of the primary constraints of medical scheme membership that is prevalent even in income-rated options. Lower income members need to contribute a significantly larger proportion of income for membership and while the same would be true for a HCP, the latter does not differentiate price based on income, so this would be expected. **Error! Reference source not found.** in Appendix 1 clearly illustrates how the design of income rated medical scheme options fall short of allowing improved access to members and while low income members would be able to access cover at a significantly reduced rate, proportionally the contributions are still too high to make it a viable option for these consumers. Income-rated options seem to be aimed at people in the second to higher income bands.

From the results above we can draw the following conclusions:

- *Medical Schemes up to 5/6 times more expensive than HCP products.* As expected the results above illustrate that medical schemes are significantly more expensive than HCP products with contributions up to 6 or 5 times higher for the lowest cover level (R 250 per day) depending on salary. While this result is expected it is interesting to note that a relatively high

daily cash benefit can still be purchased for a relatively low level of contribution under HCP plans.

- *Medical Schemes would likely be unaffordable to a person in Salary Level A or B.* Medical scheme contributions represent a significant proportion of income at these salary levels and a person earning an income equivalent to Salary Level A or B would be unable or unwilling to take up medical scheme membership that would constitute such a significant proportion of his/her disposable income. This proportion would be even higher if the member needed to add dependants to the medical membership or was to take up Gap cover.
- *HCPs likely the only option for low-income members.* Comparatively a HCP can be bought for a significantly lower proportion of income with cover of up to R 1,000 available at a monthly cost of the approximate daily wage in salary level A and less for salary level B.

6.2 Benefit Quantification (Private Facility)

HCP products are not designed to meet the needs of care and the benefits are significantly lower than those offered under a medical scheme. Although we were unable to find concrete evidence, interviews with insurers revealed that policyholders likely do use the benefits of a HCP to pay for hospitalisation costs and some of the higher cover options would provide benefits that would actually meet private health care costs in some instances.

In order to value the benefits offered by HCP products in funding the cost of private care the LAC Signal benefit comparison model was used. This model clearly defines the percentage of claims covered for each cover level and allows us to understand how this would compare to an income-rated medical scheme offering.

The results of the modelling exercise are based on data for more than 1,000,000 private hospital admissions during 2010 and 2011. This information was provided by the Metropolitan Health Group. The Signal model uses the actual cost of claims for a hospital event and compares this to the value of benefit that would likely be available from either an income-rated medical scheme option or the applicable HCP benefit pay out (depending on the number of days spent in hospital) for a range of different cover levels. The costs are grouped per age level to make direct comparison with the different average contributions possible. It thus provides an indication of the value of these products, at a specific contribution level.

It is important to keep the following in mind when interpreting the results:

- The results are represented in the form of a benefit level percentage with 100% implying the cost of care has been met in full. A benefit level of 80% would imply that 20% of the cost of care was not covered by the benefit.
- The benefit level is based on the actual individual claims and thus represents an accurate assessment of the actual pay-outs. The results are then aggregated for all admissions to provide representative figures for benefit level percentages. This percentage level represents the **benefit richness** and is used as the main parameter in the comparison modelling of the different products and has been calculated for each age band. For example, a benefit value of 70% would imply that the member/insured would have to fund 30% out of his/her own pocket

in the form of a co-payment. It is also contrasted with the level of contributions to provide a **comparative value index** for the amount of benefit purchased relative to the amount of contribution spent.

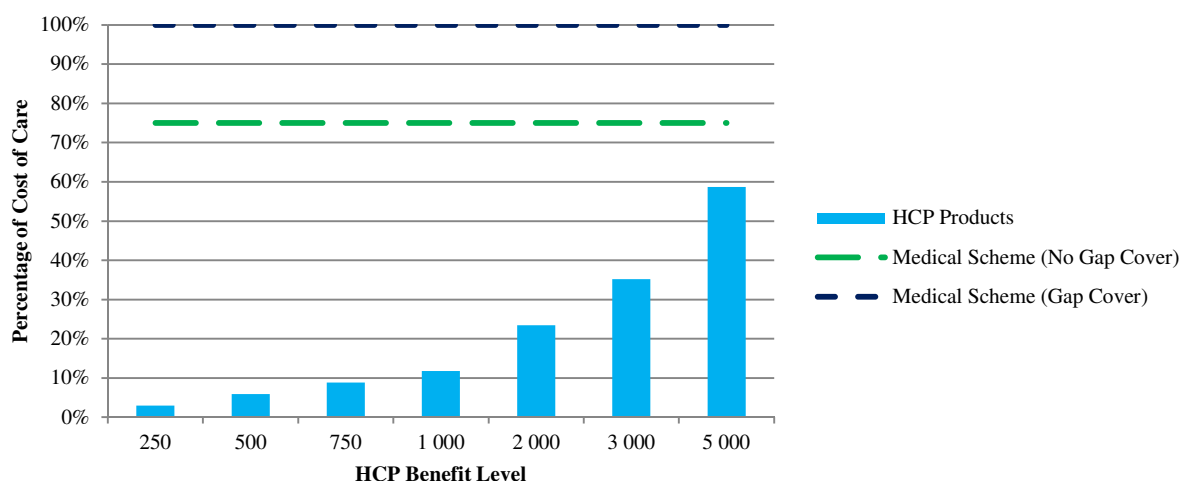
- The model is based on the average HCP offering in the industry and incorporates a required minimum 3-days hospitalisation period for a benefit pay-out to be triggered with benefits being backdated to the first day of hospitalisation. An allowance for an additional 50% daily cash benefit for each day in ICU has also been included.
- The benefit values for HCP products illustrated below would represent the upper most estimate of the benefit richness values as waiting periods were not incorporated in the model and only the most general exclusions were taken into account.
- The benefit richness values for medical scheme products takes account of the average hospitalisation benefits of income-rated options at 100% of the scheme rate and assumes that PMB claims will be paid at cost.

The table and figure below illustrate the relative benefit richness for each benefit category per age band for an average HCP. A comparison is also drawn to the average benefit richness of an income rated medical scheme, with and without Gap cover.

Table 12: Benefit Richness

		Cover Level						
		R 250	R 500	R 750	R1 000	R2 000	R3 000	R5 000
Age	18 - 24	3%	5%	8%	11%	21%	32%	53%
	25 - 34	3%	6%	9%	12%	24%	36%	59%
	35 - 44	3%	6%	9%	12%	24%	36%	60%
	45 - 54	3%	6%	9%	12%	25%	37%	62%
	55 - 65	3%	5%	8%	11%	21%	32%	53%
Average		3%	6%	9%	12%	23%	35%	59%
Medical Scheme (No Gap Cover)		75%						
Medical Scheme (With Gap Cover)		100%						

Source: LAC Signal benefit comparison model using Metropolitan Health data.

Figure 9: Benefit Value Comparison

Source: LAC Signal benefit comparison model and Metropolitan Health data.

HCPs have significantly lower benefit richness compared to income-rated Medical Schemes. The results in Figure 9 illustrate the shortfall between medical schemes and HCP products. Even at very high cover levels HCPs would not provide a sufficient level of protection against the cost of a major medical event in a private facility. It is interesting to note that HCP products seem to be marginally more effective in servicing the needs of policyholders between the ages of 35 to 55. We explore the reasons for this below.

The table below illustrates the different costs and length of stay (LOS) averages per age band both for the hospital admission only and the related costs.

Table 13: Hospitalisation Breakdown

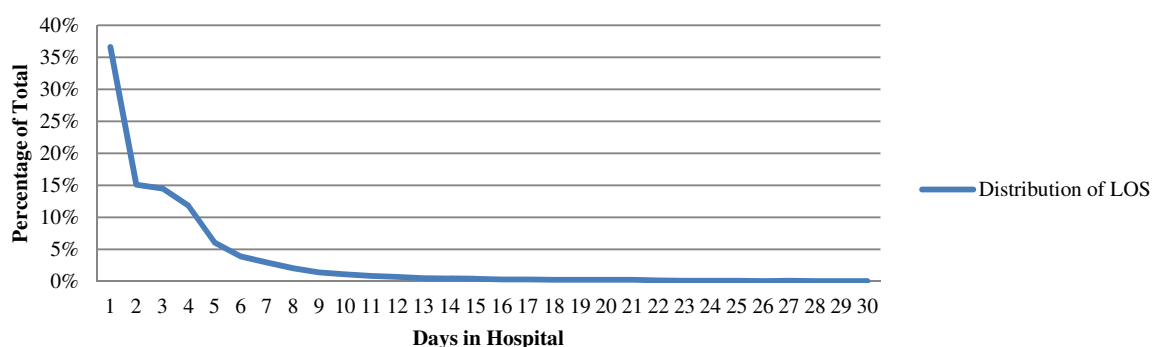
		LOS	Average Cost per Day Hospitalisation Only	Average Cost per Day Related Costs Included
Age	18 - 24	2.9	R 4 412	R 6 461
	25 - 34	3.3	R 4 492	R 6 564
	35 - 44	3.6	R 4 620	R 6 925
	45 - 54	3.9	R 5 075	R 7 630
	55 - 65	3.9	R 6 267	R 9 312

Source: Metropolitan Health hospital data extracts

From the table above it is evident that younger policyholders below the age of 35 are more likely to be admitted to hospital for a shorter LOS and thus would have a larger probability of not receiving a benefit payment, since HCP benefits are usually only applicable for LOS of 3 days or more. Middle-aged policyholders would be admitted for long enough periods to qualify for HCP benefits, but would incur lower direct costs than older policyholders and, due to the fact that HCP products provide fixed benefits unrelated to the cost of care, they would have a higher relative benefit from a HCP product than older policyholders who will incur larger co-payments.

The graph below illustrates the average LOS used for the analysis.

Figure 10: Average LOS per Admission



Source: Metropolitan Health hospital data extracts

Only 50% of claims will likely trigger a HCP pay – out. The low benefit richness for all HCP products, even those that offer benefits comparable to the average cost per day (R 5,000 per day) is due to the 3 day minimum hospitalisation requirement. From the graph above it is clear that 52% of admissions are for less than 3 days in hospital and thus would not qualify for a benefit pay-out from a HCP product.

The results also provide an intuitive check on the benefit richness calculations. Benefit pay-outs of R 5,000 a day would be closely matched to the average daily cost of hospitalisation. Benefit pay-outs will only be applicable to approximately 50% of claims thus a HCP that provides cover of R 5,000 per day should provide benefit richness roughly equal to 50%. Taking account of the additional 50% benefit for ICU claims, the slightly higher richness values than 50% in Table 12 seem reasonable.

The aim of the above analysis is to point out that HCPs do not offer benefits that would be able to fund the cost of care in a private facility and thus do **not** compete with income-rated medical schemes on a benefit level. It should be noted that private facilities often require a substantial lump sum payment before a stable non-medical scheme patient can be admitted and thus even if HCPs were able to provide private sector level benefits, low income earning policyholders would still not be able to access this level of care due to the initial cash barrier.

Further analysis regarding the benefit value modelling and benefit and contribution trade-offs at different cover levels has been provided in Appendix 2 of this report.

6.3 Benefit Quantification (State Facility)

In Section 6.2 the benefit of HCP products in funding the direct costs of private sector care was quantified. This section analyses the benefit of HCP products for persons that make use of state facilities. Metropolitan Health data for state hospitalisation has been used to recalibrate the Signal model to illustrate the benefit richness to policyholders that would make use of a state facility. The analysis is based on approximately 20,000 state hospital admissions over a 2 year period and would represent a large sample size of data.

Public Hospitals are available at a discount to low income persons. Low income persons are eligible for a subsidy for the cost of care in hospital through the application of the state means test and the applicable UPFS tariffs as outlined in Table 14. The correct implementation and functioning of the state means test has been a problem in the past. The main difficulties relate to confirming patients' income, understanding and implementation by hospital staff, paper-based or lack of record keeping in the public sector and unethical or fraudulent patient behaviour. This will likely be a target area for improvement for the South African government in future.

The table below sets out the 2012 UPFS categorisation and applicable fee structures for the state means test. The percentages relate to the percentage of the full UPFS tariff that will be applied to the patient bill in a state facility.

Table 14: Means Test and UPFS Rates

Level	Means Test	Amount paid by patient	
		Consults	Other
H0	Unemployed, Social Pension, Government Subsidies	0%	0%
H1	Individual less than R 3 000 , Household less than R 4 167	20%	20% for consultations, 1% of UPFS general ward day tariff, maximum 7 days for each 30 days in hospital.
H2	Individual R 3 001 - R 6 000, Household R 4 168 - R 8 333	70%	70% for consultations, 7% of UPFS per day for in-patient stays, differentiation by bed type.
H3	Individual more than R 6 001, Household more than R 8 334	100%	100% (full UPFS rate)

Source: UPFS, 2012

The UPFS structure aims to incentivise medical scheme membership for those that can afford it. The means test income rates are set with reference to the different percentiles of income for South Africa as compiled by Statistics South Africa. The cut-off for H1 is set at the 80th percentile of income and H2 is set at the 90th percentile of income. Thus a significant proportion of South Africa's population would be able to qualify for some level of subsidy. The UPFS tariff structure was designed to encourage persons who can afford medical scheme cover to take out this cover and thus reduce the burden on the state.

Persons who typically make use of public facilities at reduced or subsidised rates are classified as falling into categories H0, H1 and H2. It is expected that these individuals would not belong to a medical scheme but that they can access private health insurance through an HCP as outlined in Section 6.1. The benefits of these products could be used to either fund some of the direct cost of care

or to fund the related expenses incurred with a major medical event (Ministerial Task Team, 2005). As illustrated in Section 6.1, persons in these income categories would likely be unable to access cover above R 2,000 or R 3,000 per day due to both affordability reasons as well as income underwriting at higher levels of cover. Given that older persons will also pay higher contributions levels our benefit analysis for state hospitals is thus based on daily HCP cover levels of a maximum level of R 1,000 or less for H1 and R 2,000 or less for H2, and takes into account not only direct costs of hospitalisation but also related or indirect costs associated with a family member being hospitalised such as transport to hospital (patient and family), child care during hospitalisation and loss of income for persons in H1 and H2. These expenses would vary per individual circumstances and the average figures used to approximate the totals for the analysis are outlined in the table below.

Table 15: Related Costs of a Major Medical Event

	Related Expenses		
	Income per Month	Child Care per Month	Average Transport Costs
H1	R 3,000	R 150	R 100
H2	R 6,000		

Child care was used as a monthly rate and pro-rated for days in hospital. The average transport costs represent the average costs per trip for a family to travel to and from hospital to visit an injured or sick family member.

H0 Patients

Patients that fall into this category would be classified as unemployed and would receive all care free of charge. They would not be able to afford a protection product and as such have not been included in the analysis.

H1 Patients

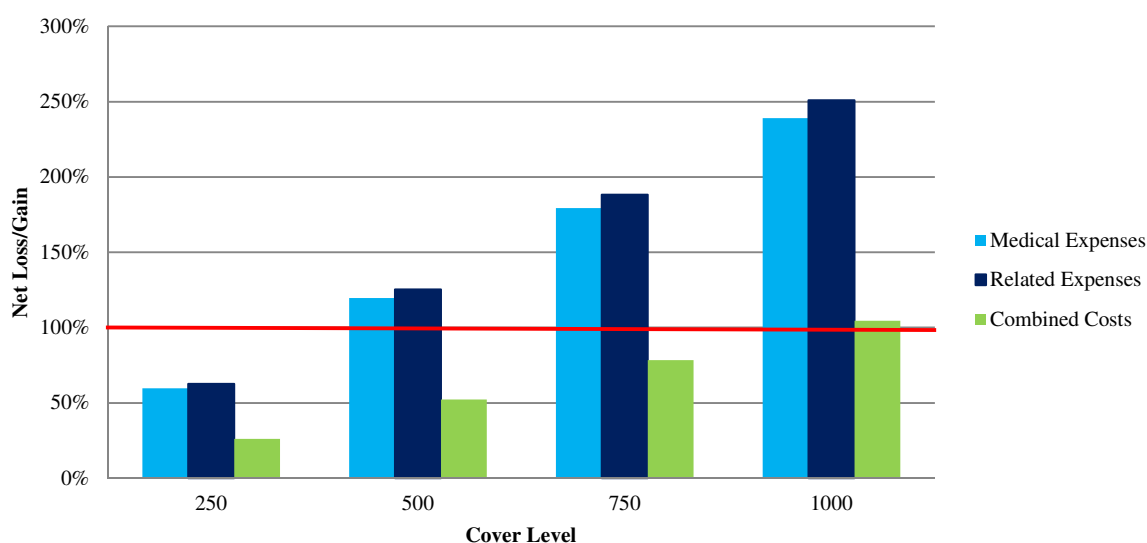
Given the relatively high subsidies for this group patients in this category would only incur a small percentage of the direct medical expenses and any benefits in the form of HCP benefits would likely be used to fund the related costs or to provide a windfall claim to the policyholder after the direct and related costs have been met.

HCP products would likely be affordable for H1 persons. The income for an individual in this category would be no more than R 3,000 per month and as illustrated in Figure 8 Section 6.1, HCP contributions would amount to between 3% and 9% of monthly salary¹⁸ depending on the individual's age and cover level.

¹⁸ 3% for R250 per day cover, 9% for R2,000 a day cover

The graph below illustrates the benefit richness of each cover level for a policyholder in this income category.

Figure 11: HCP Benefit Richness – State Facility (H1 income level)



Source: LAC Signal benefit comparison model.

Benefit values of R250 per day would on average not be able to meet either the direct or related costs of hospitalisation and would leave a policyholder with a shortfall to be funded by an out-of-pocket payment. Benefit levels of R 500 or R750 a day could on average cover either the related or direct cost of hospitalisation. And R 1,000 per day benefit would likely cover both the direct and related costs of a major medical event. The policyholder would incur no co-payments and could even receive a windfall claim.

Significant windfall payments are possible. Often the impact of a major medical event can be long lasting requiring a long and expensive recovery period once the patient leaves the hospital. It is also likely that the person will be unable to work during this period and in severe cases the person might be left with a permanent disability or inability to perform his/her previous occupation. Most formally employed South Africans will be able to make use of a permanent disability product to provide income in this event. However, persons classified as H1 would likely not have access to such a product and would have to rely on family members to take care of them or could even possibly be left destitute. HCP products can provide significant windfall claims to policyholders in some cases. These windfall claims could be used to fund some of the longer lasting effects of a major medical event.

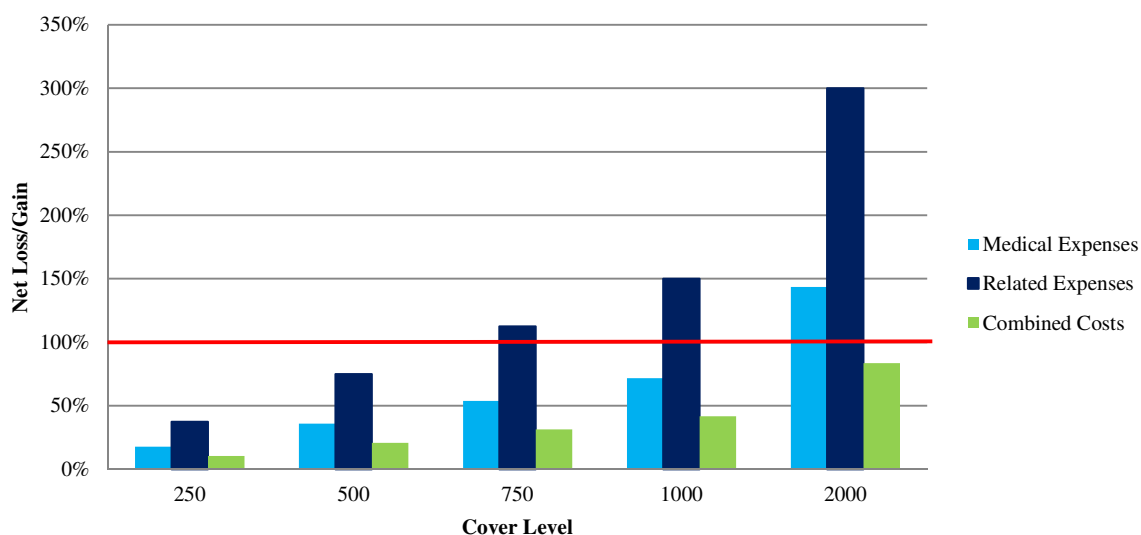
H2 Patients

Given the lower subsidies at this level patients in this category would incur a significant percentage of the direct medical expenses and any benefits in the form of HCP pay-outs would likely be used to fund the direct costs of care.

HCP products very affordable to H2 persons. The individual income for somebody in this category would be between R 3,001 and R 6,000 per month and as illustrated in **Error! Reference source not**

found. Figure 8, HCP products would be affordable for benefits of at least R 2,000 a day. HCP contributions would amount to between 2% to 6% of monthly salary at this level. The graph below illustrates the benefit richness of each cover level for a policyholder in this income category.

Figure 12: HCP Benefit Richness – State Facility (H2 income level)



Source: LAC Signal benefit comparison model.

Benefit levels as low as R 750 a day could on average cover the related cost of hospitalisation. Benefit values of R 250 or R 500 per day would likely not be able to meet either the direct or related costs of hospitalisation and would leave a policyholder with a shortfall to be funded by an out of pocket payment. . Benefit levels of R 2,000 would enable the policyholder to meet either the direct or related costs of hospitalisation.

Thus, H2 patients would require a higher level of cover to provide the same benefit as possible for H1 patients. This is because of the higher proportion of medical costs such patients would be required to fund under the state means test and UPFS categorisation as well as proportionally higher additional costs. But HCPs are still able to provide a significant level of cover for these persons.

HCP products provide benefit in the event of a hospital stay of 3 days or more. A major medical event would usually require a period of hospitalisation of more than 3 days and as such these products would provide even higher value if only major medical events (LOS > 2 days) are considered as opposed to the average of all admissions as set out above. An analysis into the benefit richness if only cases with LOS of 3 days or more together with details of the distribution of losses and gains (windfall claims) has been provided in the Appendix 3 of this report.

H3 Patients

Patients that fall into this income category earn more than R 6,001 a month and would incur the full UPFS tariff if they made use of a state facility. Persons in this income bracket would likely be able to access membership of a medical scheme and would thus prefer to use a private facility for

hospitalisation. The results of the effectiveness of HCP products when private facilities are used are illustrated in Section 6.2.

6.4 Chapter Summary and Conclusion

The results of Section 6 illustrate the relative affordability of HCPs when compared to medical schemes and the potential of HCP products to provide some form of cover to persons that cannot afford a medical scheme. Though insurance products do not offer indemnity benefits, the pay-outs can be used to cover the related costs as well as contribute to the direct costs in some cases.

Section 6 highlights the plight of the large uncovered population in South Africa that earn enough not to be able to access free care at public health facilities but are also not wealthy enough to gain access to a medical scheme. These people are underinsured and would be faced with significant risks in the event of a major medical event. HCP products can soften the blow of a major medical event to this group, and would be able to cover both the direct and indirect costs in some cases, but unfortunately do not provide full protection due to minimum hospital stay requirements, exclusions and rating factors.

Section 6 also highlighted the fact that income-rated medical schemes options have a regressive structure, charging a higher relative amount (as expressed as percentage of salary) for members that fall into lower income bands. The income cross-subsidy is insufficient to significantly increase access to these options. Admittedly it is a delicate balance to ensure the option as a whole is sustainable with sufficient revenue from higher income bands.

The table below summarises the key points of each sub-section and the outcomes of the modelling and analysis:

Table 16: Summary of Analysis and Comparison Modelling

Section	Key Results	
	H1	H2
Affordability Comparison	Cover up to R 2,000 per day affordable	Cover up to R 3,000 per day affordable
	Medical schemes not affordable	
Private Sector Benefit Modelling	Persons likely not able to access private facilities	
	Average HCP not able to offer competing benefits to medical schemes	
	Significantly lower benefit available	
Public Sector Benefit Modelling	State provides measure of protection from direct medical costs	Exposed to significant potential OPP
	Direct or related costs met at R 500 a day	Related costs met at R 750 a day
	Both the direct and related costs met at R 1,000 per day (all cases)	The direct or related costs met at R 2,000 per day (all cases)
	Benefit offering significantly higher at more serious cases (LOS > 2 days)*	

*Please see Appendix 3 for more details on this analysis

From the table above it is clear that HCP can possibly be an effective tool to mitigate the full costs of treatment at state hospitals for certain patients that qualify for the different levels of the state means test.

7. Impact of Revised Demarcation and NHI

7.1 Impact of Revised Demarcation

The proposal for the revised demarcation between medical schemes and health insurance proposes that, amongst other things:

- Income underwriting and benefit limits be applied:** All health insurance policies should be subject to income underwriting and a limit of 70% of net daily income (of the policyholder) should be applied to all HCP benefits. The aim of the benefit limit is to ensure that the benefits are more aligned to policyholders' income replacement needs and not to the potential direct costs of health care.
 Benefits unrelated to health care costs: The proposed revised demarcation also states that benefits cannot be aimed at meeting the cost of care. This implies that all Gap cover products in their current form will fall outside the revised demarcation and insurers would not be able to continue providing these products. Insurers that currently offer these products would either need to **register as medical schemes** or would need to convert their offering to within the required limits for health insurance products.

From Section 6.3 it should be evident that there are a large number of patients for whom a medical scheme would be unaffordable and while they would be able to access medical care at significantly reduced rates via state facilities, many would still incur costs in this regard. HCP products would be able to relieve some of the cost burden at an affordable price to these policyholders. However, this will no longer be the case if benefits are capped at 70% of net income.

The table below illustrates the differences in benefit levels available to policyholders under the original and revised demarcation.

Table 17: Available Benefits

Income	Current Demarcation	Revised Demarcation
H0	No regulatory restriction on cover, might not be able to afford cover	Unable to purchase cover as no income earned
H1	Up to R 1,000* cover per day (contribution less than 10% of income for all ages)	Maximum benefit of R105 per day
H2	Up to R 3,000* cover per day (contribution less than 10% of income for all ages)	Maximum benefit of R210 per day

Source: UPFS, 2012; product brochures; PRDA, 2012 and authors own calculations.

**It should be noted that older persons will pay more for HCPs and thus to ensure the results represent a conservative average estimate the benefit levels modelled have been set at R 1,000 for H1 and R 2,000 for H2.*

From the table above it is clear that the benefits available under the revised demarcation will be significantly lower than what is currently available in the market and would likely be of very little value in defraying either the direct or related costs associated with a major medical event. While

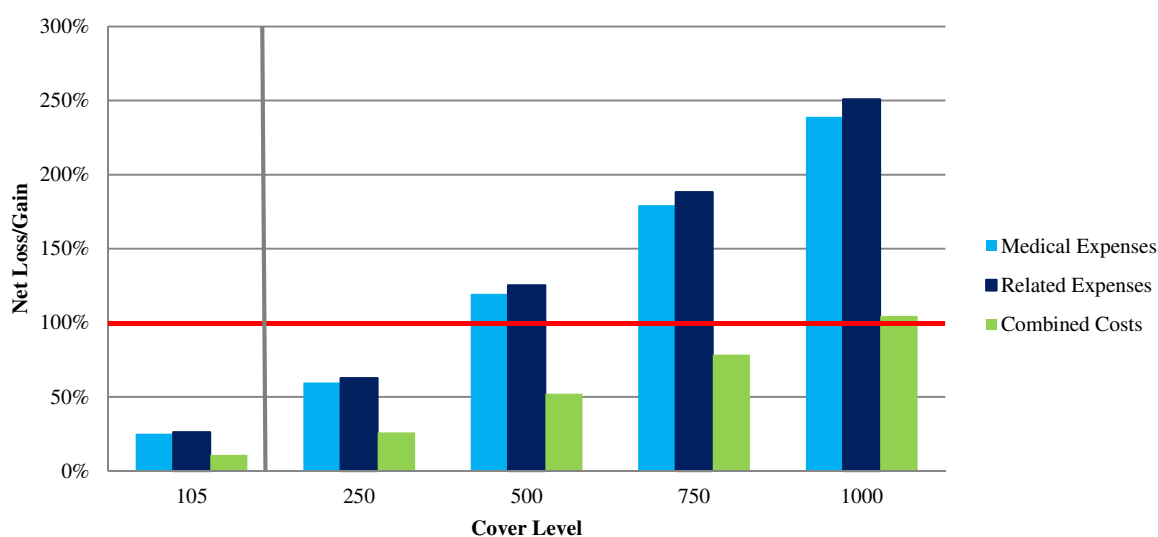
benefits under the revised structure provide for replacement of lost income of up to 70%, they do not consider compensation for other related expenses incurred due to major medical events.

The section below illustrates the revised scenario analysis showing the impact of the proposed income limit on benefit richness for the direct and related costs of each income band. All assumptions regarding the direct and related costs remain unchanged from the previous section.

Level H1 – Impact of Revised Demarcation

An individual person in H1 would earn less than R 3,001 per month and would be able to receive significant discounts if making use of a state facility. However, despite these discounts this person would still incur both direct and related costs and would be able to use a HCP to defray some of the direct and related costs under the current product formats.

Figure 13: Impact of Revised Demarcation on HCP Benefit Richness H1 (State Facilities)

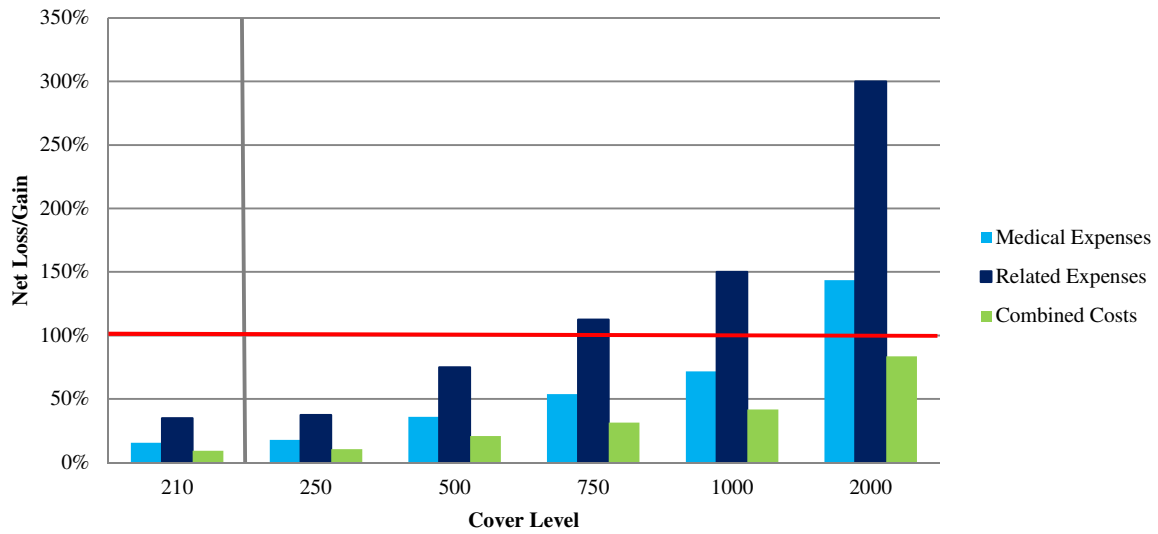


Source: LAC Signal benefit comparison model.

The proposed revised demarcation would have a significant negative impact on the effectiveness of a HCP for income level H1. Figure 13 sets out the proposed demarcation income limit line in grey. The product would offer very little if any benefit to the policyholder and could leave clients vulnerable to significant out of pocket payments. To clearly identify the risks for a member in this income category, the results of a scenario analysis have been included in Appendix 4 that illustrate the benefits of HCPs and the impact of the proposed revised demarcation.

Level H2 – Impact of Revised Demarcation

An individual person in H2 would earn between R 3,001 and R 6,000 per month and would be able to receive a partial discount if making use of a state facility. A person in this income band would likely still not be able to afford membership of a medical scheme but could make use of a HCP product to defray some of the costs incurred due to hospitalisation (both direct and related) as outlined in the previous section (Section 6.3).

Figure 14: Impact of Revised Demarcation on HCP Benefit Richness H2 (State Facilities)

Source: LAC Signal benefit comparison model.

The revised demarcation would significantly impact the ability of HCP to service the needs of H2 policyholders. Figure 14 sets out a similar analysis to Figure 13 on the basis of an income level of H2.

From the results it is clear that HCP products under the proposed revised demarcation would be ineffective in meeting the needs of policyholders. Benefits would be severely restricted and, given the higher costs of living and increased proportion of the tariffs charged to H2 patients, there would likely be very little benefit or incentive to a person in H2 to purchase a HCP product. At these low premium levels and with the introduction of increased underwriting requirements and consequent increased costs, there will also be very little incentive to insurers to develop and sell these products.

It is quite likely that the impact on the benefit offerings of these products is an unintended consequence of the legislation. While there would likely be value in more stringent regulation in this industry, like sharing of information and disclosure requirements, the current format of the proposed regulation would likely negate the benefit of these products to low-income members who need this type of cover most.

70% cap on benefit could result in HCP being unavailable to the majority of low income earners. The table below illustrates the required monthly salary (net of tax) per benefit level under the revised demarcation.

Table 18: Required Salary per Cover Level

Cover Level (per day)	Required Net Monthly Salary
R 250	R 7 100
R 500	R 14 300
R 750	R 21 500
R 1 000	R 28 500
R 2 000	R 57 100
R 3 000	R 85 700
R 5 000	R 142 850

Source: PRDA, 2012 and authors own calculations.

Beneficial cover levels would become unaffordable. From Table 18 it is clear that nearly all current cover levels would be unaffordable for low-income persons under the revised demarcation. Cover levels above R 2,000 would also likely be unaffordable to the majority of people that are currently members of a medical scheme given the immense salary requirement as outlined above.

Given the affordability constraints on higher cover levels and the reduced incentives for lower cover levels, the future sustainability of the HCP market would be seriously threatened under the revised demarcation and would likely not be available to low income earners. Significant product innovation will be required for the market to continue to thrive as it has been doing. .

Part of the difficulty in regulating HCP products lies in the fact that they do not meet a specified need. Under the current regulatory structure policyholders can use the benefits received for whatever they wish including defraying direct and related expenses associated with a major medical event. The new demarcation guidelines however place HCPs firmly in the camp of income replacement products, with the typical associated restrictions on cover. Traditional income replacement products offer cover for extended periods and typically low frequency events. Major medical admissions however are typically more frequent and shorter in duration. It is therefore questionable whether income replacement is the correct category for these policies. It seems clear that cover for direct health care costs will be excluded; this, however, will be at the risk of decreasing benefits that could assist with the recovery of indirect expenses to too low a level to be worthwhile for the policyholder.

7.2 Considerations

Significant market disruption and policyholder exposure. One of the areas of concern in the revised proposed demarcation is the ability of the regulators to effectively cancel all policies (that fall foul of the new demarcation) that were issued up to the implementation date of the new demarcation. Given our estimates of market size this will affect a great number of policyholders and, for some, leave them without cover for legitimate needs. This proposal could be reconsidered to avoid such a significant disruption.

Reconsider 70% of income restriction. This change is one of the most significant restrictions of the new proposed demarcation. The aim of this restriction relates to achieving balanced income protection to avoid having policyholders being over-insured and thus have little or no incentive to return to work. The restriction does not however take into account that certain additional costs are typically incurred with major medical events. Even ignoring the direct costs of care, the costs of travel alone can be significant for people seeking care at a hospital. In many cases, patients have to incur other non-health care costs such as changes to their home, perhaps the renting of a wheel chair, accommodation and transport for family members, and the like. As an alternative, the income cap could be applied only to higher cover levels (R 3,000 and up) to ensure that beneficial levels of cover are still available.

Questionable value and high risk costs. A key concern and policy question is whether a profit making product with such low risk costs is the correct vehicle for financing of health services. While this is not the ideal method, the results above illustrate that it is an effective one for low income persons and in the absence of other offerings the only short term solution. More comprehensive and separate reporting requirements for insurers selling HCPs, that require them to quantify the value of products may ensure that those products that do not offer value are identified and ultimately removed.

7.3 Expected Impact of NHI

Private insurance is usually a feature of a NHI type system. There is a question as to the broader role of HCP products in the proposed health reform path South Africa is currently embarking on – a National Health Insurance (NHI) structure¹⁹. In most markets where there is an NHI existing in tandem with private health insurance, it is typical for private sector insurers to offer cover for services not provided by the NHI or to offer substitutive cover for similar services provided by the private

¹⁹Note that at the time of writing this report the details on NHI are not clear and a protracted rollout period is expected.

sector²⁰. Whichever structure is chosen these private health insurance products are typically indemnity-based products covering the actual cost of care incurred. The role of medical schemes in an NHI environment is the subject of much debate in South Africa whereas the role of HCPs and other products does not seem high on the agenda.

NHI could have a significant impact on the demand for HCP type products. One of the proposed NHI features is that patients will not be required to pay for services at the point of treatment. This is subject to debate as some policymakers argue for user fees and some argue against these. If there are no user fees under the NHI (which would be roughly equivalent to doing away with UPFS billing for any income level) this would significantly decrease the potential out of pocket burden faced by patients, and decrease the need for HCP type products to assist in recovering these direct expenses. Similarly, if no co-payments are required for health care services, then the need for Gap cover products is limited. Assuming Gap cover products survive the current demarcation debate the specific role they could play in an NHI context is not clear and depends to some extent on the form the NHI will take. It is possible that Gap cover products will be the basis of top up cover from the NHI similar to private health insurance in the UK market. Alternatively, medical schemes in some altered form may form the basis for this top up – there is at present no clear path.

Whatever vehicle is used for the funding of health care services, indirect expenses due to the medical event will be incurred by patients and so HCPs may still provide this undefined benefit of assisting patients recover related expenses. From a demarcation and general health policy direction then, HCP products seem destined to continue providing cover related to indirect expenses and income replacement benefits.

²⁰World Health Organisation data

8. Conclusion

Traditional indemnity based health care protection products in the form of medical schemes are unable to cater for the majority of South Africans due to the relatively high cost of contributions and the relatively low income level of the majority of the population. Gap cover, though providing nearly complete indemnity for the cost of private hospital care when combined with a medical scheme, is equally unaffordable for the low income population due to the requirement that this can only be used with a medical scheme product.

Hospital Cash Plan products represent a substantial market (estimated size approximately 27% of the medical scheme market) and are lower cost insurance products providing fixed benefits of R 250 to R 5,000 a day in the event of hospitalisation for monthly premiums of between approximately R100 and R850 respectively . While cover at these levels is insufficient for private hospital care, HCP benefits can offer affordable value to low income members of the population who use public hospital facilities but have to pay for services under the state means test. Policyholders are in some cases able to meet the direct costs or related costs from R 500 per day cover while daily benefit values as low as R 1,000 can at income levels below R3,000 meet both the direct and related costs.

The proposed revised demarcation regulations present a barrier to servicing the needs of low income South Africans that require protection for the expenses associated with a major medical event requiring hospitalisation. In particular, the income replacement limit of 70% on fixed benefit policies would severely hamper the ability of these products to meet the needs of policyholders seeking some form of protection for the direct and related costs of a major medical event. At income levels of up to R6,000 the maximum cover level would be R210 per day which would be insufficient to fund either the direct or related costs of hospitalisation at a state facility. Further, the higher cover levels would be unaffordable even to middle income earners. The resultant limited attraction of these products and the higher fixed cost relative to lower premiums means that there would be limited business rationale for insurers to provide these products under the revised demarcation.

In general the use of an insurance product to deliver health cover is not ideal. HCP products have some limitations as they are generally not available to people over the age of 65 and in most cases would only provide benefits if all exclusions and underwriting criteria are met, benefits are often only payable for stays in hospital of 3 days or more which is only about half of the cases, and benefits are not directly linked to any expense incurred by the policyholder and so the risk of a mismatch in cover and out of pocket payments is large. Even given these flaws, HCP products can be a very effective and affordable means of providing some form of cover to low income individuals who would have no alternative option available to them. This is especially true in the instances of serious medical events requiring prolonged periods of hospitalisation.

Appendix 1 Contribution Analysis

This section provides additional and more detailed information for Section 6.1 and illustrates the key affordability constraints and trade-offs.

Table 19: Contributions as a proportion of salary (Salary Level A)

		HCP Cover Level						Medical Scheme**	
		R 250	R 500	R 750	R1 000	R2 000	R3 000*		R5 000*
Age	18 - 24	3%	4%	4%	5%	8%	N/a	N/a	16% - 20%
	25 - 34	3%	4%	4%	5%	9%	N/a	N/a	16% - 20%
	35 - 44	3%	4%	5%	6%	9%	N/a	N/a	16% - 20%
	45 - 54	3%	4%	5%	6%	10%	N/a	N/a	16% - 20%
	55 - 65	3%	4%	5%	7%	11%	N/a	N/a	16% - 20%

Source: Product brochures and marketing material.

*Cover above R 3 000 would require a minimum level of salary above that of level A

Illustrates bounds with and without Gap cover for the average contributions as illustrated in **Error!

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The table below illustrates the HCP contributions as a percentage multiple of income rated medical scheme contributions for a person in Salary Level A.

Table 20: Contribution Comparison Scenario (Salary Level A)

		Cover Level						
		R 250	R 500	R 750	R1 000	R2 000	R3 000*	
Age	18 - 24	509%	463%	380%	314%	206%	n/a	n/a
	25 - 34	502%	449%	371%	302%	190%	n/a	n/a
	35 - 44	498%	424%	358%	289%	182%	n/a	n/a
	45 - 54	494%	406%	357%	269%	162%	n/a	n/a
	55 - 65	492%	367%	320%	239%	144%	n/a	n/a
Average		499%	423%	357%	283%	177%	n/a	n/a

Source: Product brochures and marketing material.

Table 21: Contributions as a proportion of salary (Salary Level B)

		HCP Cover Level						Medical Scheme**	
		R 250	R 500	R 750	R1 000	R2 000	R3 000		R5 000*
Age	18 - 24	2%	2%	3%	3%	5%	5%	n/a	12% - 14%
	25 - 34	2%	2%	3%	3%	5%	5%	n/a	12% - 14%
	35 - 44	2%	2%	3%	3%	5%	7%	n/a	12% - 14%
	45 - 54	2%	2%	3%	4%	6%	8%	n/a	12% - 14%
	55 - 65	2%	3%	3%	4%	7%	9%	n/a	12% - 14%

Source: Product brochures and marketing material.

*Cover of R 5 000 would require a minimum level of salary above level B

**Illustrates bounds with and without Gap cover.

The table below illustrates the HCP contributions as a percentage multiple of income rated medical scheme contributions for a person in Salary Level B.

Table 22: Contribution Comparison Scenario (Salary Level B)

		Cover Level						
		R 250	R 500	R 750	R1 000	R2 000	R3 000	R5 000*
Age	18 - 24	626%	570%	468%	387%	253%	231%	n/a
	25 - 34	617%	552%	457%	372%	234%	221%	n/a
	35 - 44	613%	522%	440%	355%	224%	181%	n/a
	45 - 54	608%	499%	439%	331%	199%	160%	n/a
	55 - 65	605%	451%	394%	294%	177%	136%	n/a
Average		614%	419%	440%	348%	218%	186%	n/a

Source: Product brochures and marketing material.

The table below illustrates the average HCP contributions as a percentage of salary and for 4 different income levels and how this compares to income rated medical scheme contributions. The last two columns also clearly illustrate the regressive nature of medical scheme contributions.

Table 23: Proportional Income Summary

Income	HCP Cover Level							Medical Scheme	
	R 250	R 500	R 750	R1 000	R2 000	R3 000	R5 000	No Gap	Gap
R 2 000	5%	6%	7%	9%	14%	N/a	N/a	25%	31%
R 5 000	2%	3%	3%	3%	6%	7%	N/a	12%	14%
R 7 000	1%	2%	2%	2%	4%	5%	9%	10%	11%
R 8 000	1%	2%	2%	2%	4%	4%	8%	max 13%	Max 14%

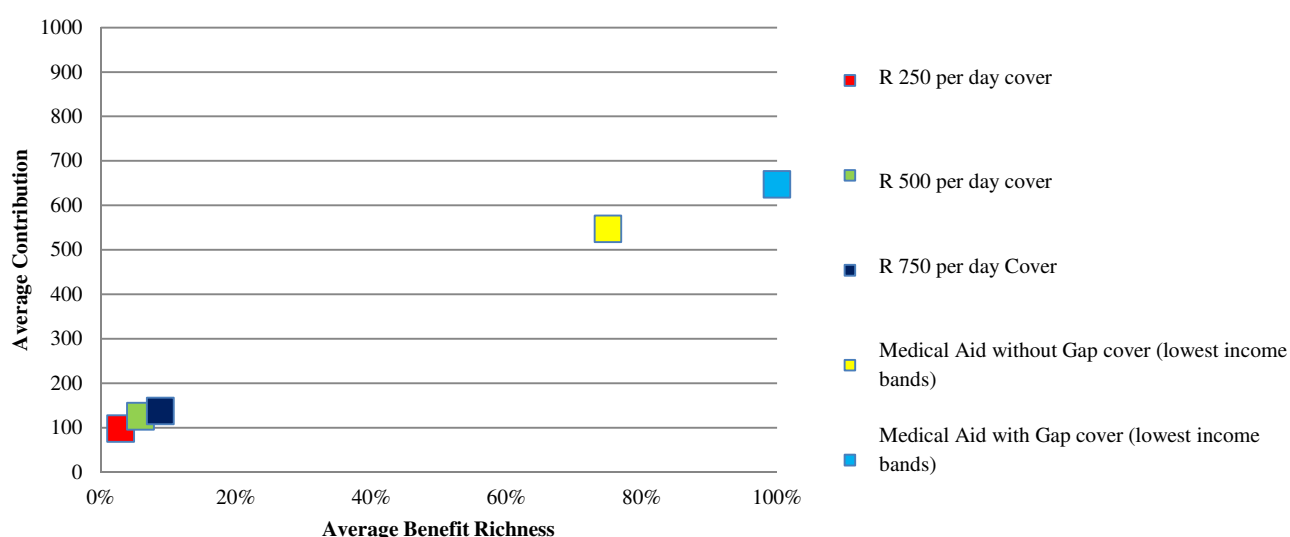
Source: The figures above are based on contributions as per product brochures (see references)

Appendix 2: Private Sector Benefit Value Offering Mapping (Additional Results)

The results expand on the analysis of Section 6.2 and illustrate the contribution and benefit trade-offs at low, medium and high HCP cover levels compared to an income rated medical scheme offering (HCP products were allocated by daily benefit amount and medical schemes were allocated by income band). Benefit richness values are contrasted with the required contributions to illustrate the value offering of each set of products. Options that are in the lower right-hand portion of the graphs would represent the best value for money offerings as these options would provide relatively rich benefits at comparable low contributions.

Low Cover Options

Figure 15: Benefit Richness Mapping (Low Cover Levels)



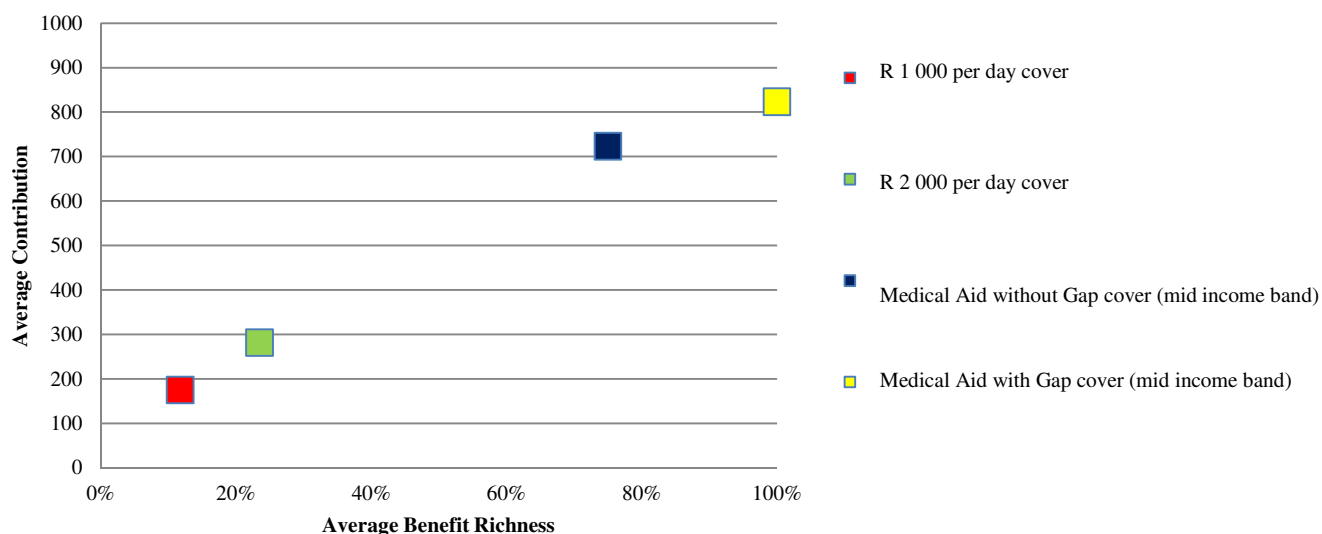
Source: LAC Signal benefit comparison model and Metropolitan Health data.

Low income members face significant risks (private facilities). The results above graphically represent both the financial trade-off that a low income person (salary level A) will face, as well as the risk to these persons of under-insurance. Though a HCP product is significantly cheaper than the cheapest income-rated medical scheme option, it provides only a fraction of the overall protection in terms of meeting a policyholder's *direct cost needs* for hospitalisation in a *private facility*. As illustrated above these products fall far short of providing indemnity cover for the direct costs.

The scenario analysis in Appendix 3 will illustrate that products with benefits between R250 and R750 a day would be able to provide cover in some instances for the *direct costs* in a *public health facility*.

Medium Cover Options

Figure 16: Benefit Richness Mapping (Medium Cover Levels)



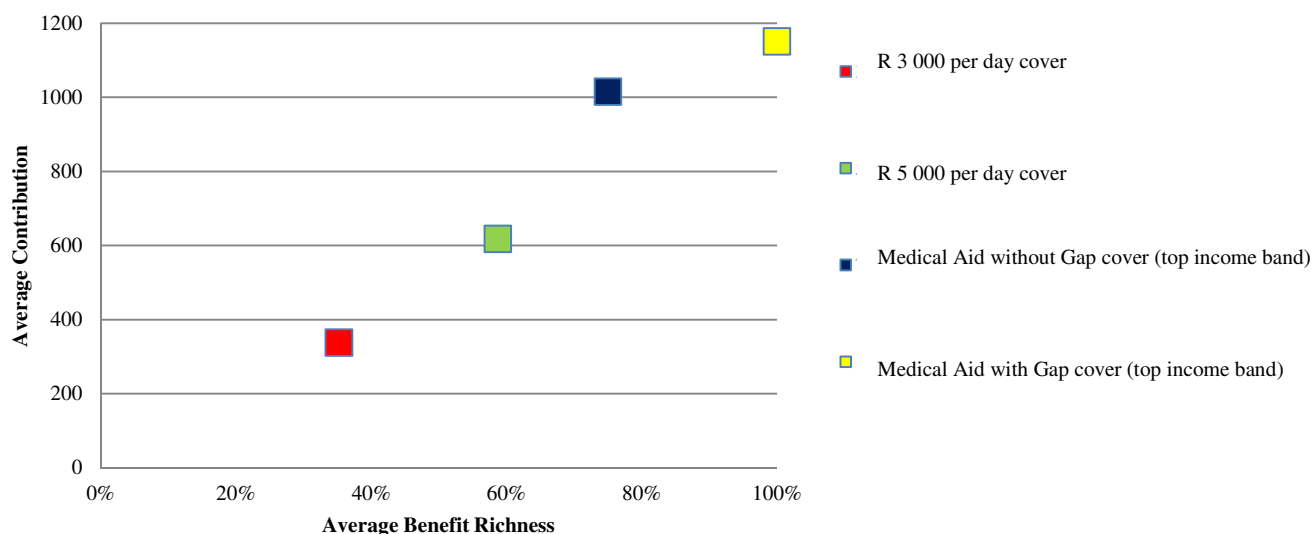
Source: LAC Signal benefit comparison model and Metropolitan Health data.

Mid-range HCP products still fall far short of meeting private facility costs. The results above graphically represent both the financial trade-off that a low-income person will face as well as the risk to this person of under-insurance given the benefits of a medium cover HCP product.

Products that provide cover of up to R 2,000 per day will significantly increase the benefit richness and will enable a patient to meet more of the direct costs of private hospitalisation. But the benefits still fall far short of indemnity cover for *private hospital procedures*.

High Cover Options

Figure 17: Benefit Richness Mapping (High Cover Levels)



Source: LAC Signal benefit comparison model.

High cover levels might provide some windfall claims, but still leave the policyholder significantly exposed in a private facility. The results above illustrate the trade-offs faced by a person that is able to afford a medical scheme. Policyholders that take out cover levels in excess of R 3,000 per day are likely doing so in tandem with a medical scheme and using the pay-out to fund the gap or to provide an additional windfall claim to cover indirect expenses associated with hospitalisation such as the replacement of income, commission earnings or even convalescent care. It should be noted that during interviews with insurers it was suggested that this market is quite small and the majority of HCP policyholders take out products with cover ranges of R 750 per day or less.

HCP products do not offer comparable benefits. It is clear that, as expected, medical schemes on average would offer significantly richer benefits and the results illustrate the vast cost differences between the different sets of products.

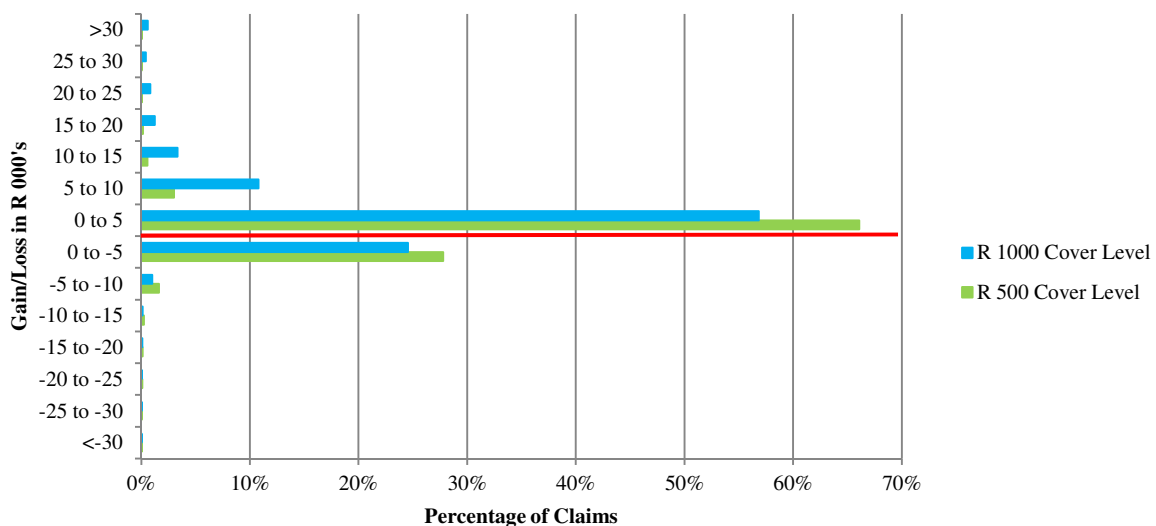
Appendix 3: State Sector Benefit Quantification and Scenario Analysis

This Appendix expands on the analysis of Section 6.3 and illustrates the value of HCP products in the instance of a serious medical event (LOS > 2) (50% of cases) as well as the distribution of losses or gains (windfall claims) under various cover levels.

H1 Analysis

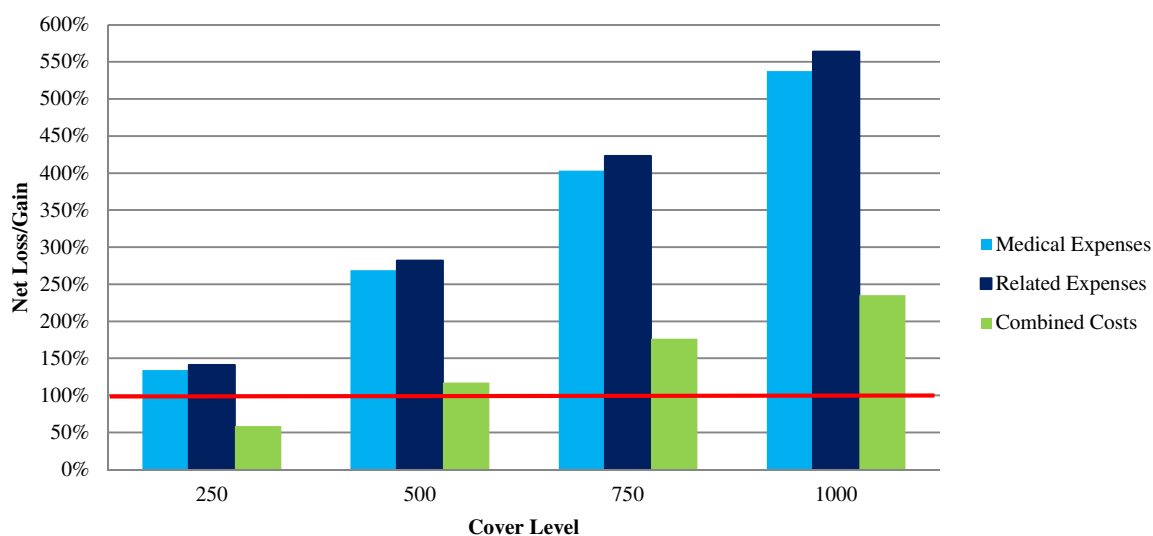
Figure 18 illustrates the distribution of gains/losses for the direct expenses for an H1 policyholder and provides an indication of the potential windfall under the cover levels of R 500 and R 1000.

Figure 18: Distribution of Gains/Losses (H1)



Source: LAC Signal benefit comparison model.

Majority of policyholders would receive windfall claims. More than 65% of all claims would lead to windfall claims for an H1 policyholder under a benefit level of R 500 a day. The majority of these windfall gains would be less than R 10,000, but at an income level of R 3,000 per month this would constitute a significant amount corresponding to more than **3 months'** worth of income. Under benefit levels of R1,000 per day approximately 75% of all claims would lead to windfall pay-outs with a number of policyholders receiving windfall pay-outs of up to R 20,000 (after the direct costs of hospitalisation have been met). This again illustrates the potential benefit of HCP products to persons in this income band but also indicates the incentive for fraud in this market.

Figure 19: HCP benefit richness – State facility (H1 income level with LOS > 2 days)

Source: LAC Signal benefit comparison model.

HCP can be of significant value to H1 patients that incur LOS of 3 days or more.

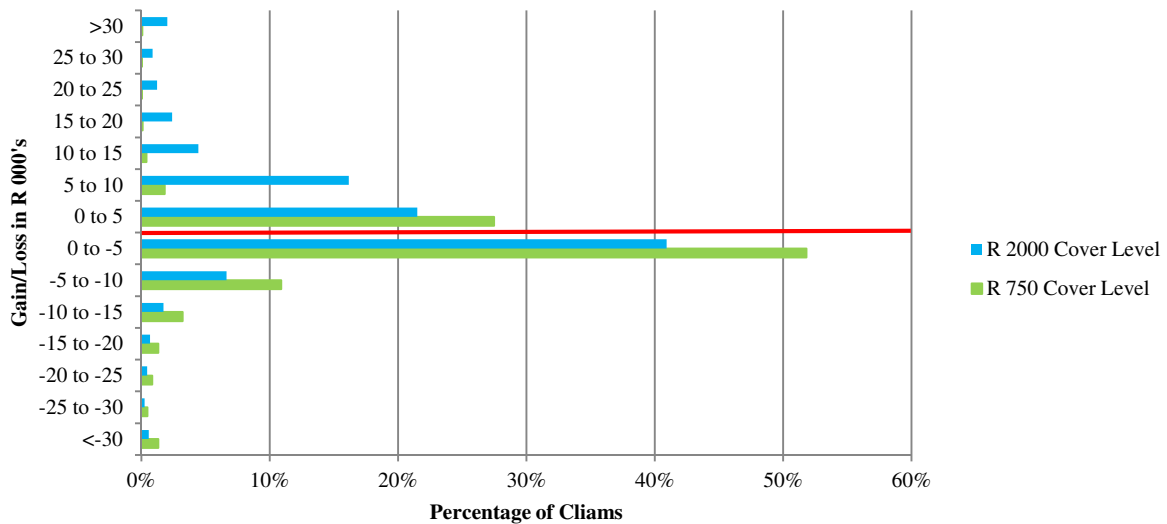
Figure 19 illustrates that for instances where the length of stay is more than 3 days and a HCP claim is paid, benefit values as **low as R 250** a day would be sufficient to cover either the direct or related costs of a major medical event for a policyholder classified as H1 that makes use of a state facility. Benefit values of R 500 per day or more would likely be sufficient to cover both the direct and related costs.

The results indicate the potential value of HCP products to a person classified as H1. These products would be relatively affordable (compared to a medical scheme) for a person in this classification and would be able to provide protection from both the related and direct costs of a major medical event at relatively low benefit levels. Though HCP products are not designed to meet a defined need (such as the cost of care), they could be very effective in providing a comprehensive form of cover for a major medical event under the circumstances outlined above.

H2 Analysis

The graph below illustrates the distribution of gains/losses for the direct expenses for an H2 person and provides an indication of the potential windfall to policyholders under the various cover levels (R 750 per day and R 2,000 per day) after the direct expenses of hospitalisation have been met.

Figure 20: Distribution of Gains/Losses (H2)

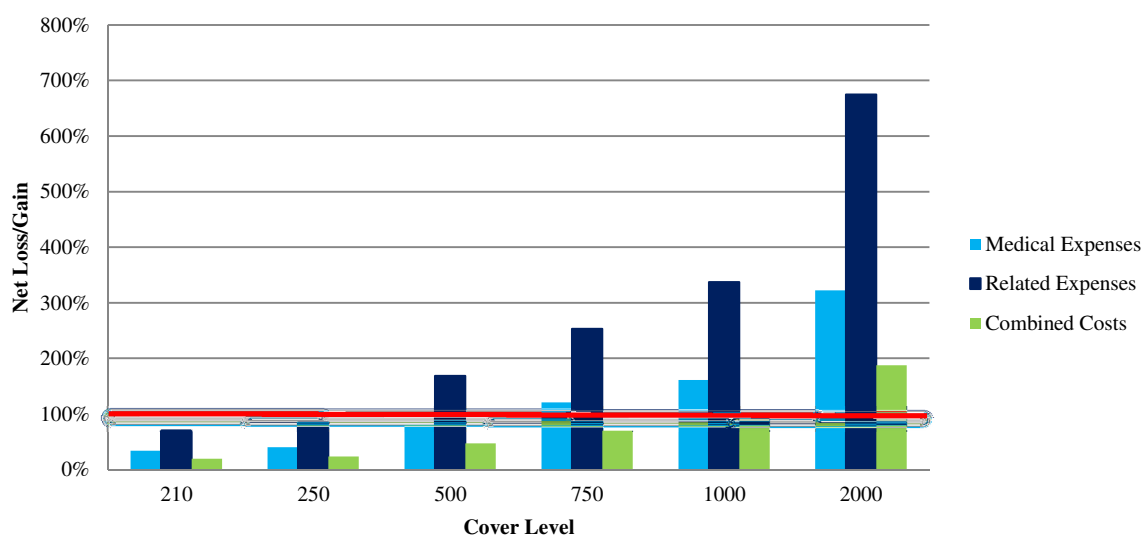


Source: LAC Signal benefit comparison model.

HCP products are less effective in meeting the direct cost of hospitalisation of an H2 person, but would still be able to provide significant coverage. The distribution of claims is shifted to the lower section of the graph indicating that a significantly larger proportion of policyholders would incur out of pocket payments related to the direct costs of hospitalisation than for H1 patients. This is the effect of the means tests and the higher proportion of costs billed for the higher income level persons classified as H2. The results illustrate the incentive for patients to lie about their income to avoid the additional charges.

Though a number of patients would possibly incur out of pocket payments for the direct cost of care, there are still a number of persons for whom significant windfall claims are possible. For example in one instance a person was hospitalised for burn injuries. The length of stay in hospital was noted as 99 days with no days being spent in ICU. The benefit pay-out of a HCP product would likely result in a significant windfall claim to this patient, even at low cover levels. Generally a windfall claim would be larger if the event required a prolonged stay in hospital but did not entail surgery.

The modelling above is based on the assumption that a minimum hospitalisation of 3 days would be required to incur a pay-out from a HCP and that benefits would be backdated to the first day. The results below illustrate the effect for all cases where a benefit pay-out was incurred, i.e. the LOS was for a period of 3 days or more.

Figure 21: HCP benefit richness – State facility (H2 income level with LOS > 2 days)

Source: LAC Signal benefit comparison model.

HCP products effective in meeting the needs of H2 persons. The figure above illustrates that for instances where a HCP benefit is paid, benefit values as low as R 500 a day would be sufficient to cover the related costs of a major medical event. Benefit values of R 750 per day would be sufficient to cover either the direct or related costs and benefit values of R1,000 or more would cover both the direct and related costs of hospitalisation. The results indicate that though HCP products are less effective for H2 persons than H1 persons, there is still significant value to policyholders in this category.

H2 persons would still be unable to afford a medical scheme and the state means test would imply that these persons would be even more exposed to significant financial losses in the absence of a HCP, if faced with a major medical event.

Appendix 4: Scenario Analysis

The results of the modelling represent the average benefit. To clearly illustrate the impact that HCPs can have and how the proposed revised demarcation would impact the results, this Appendix represents a scenario analysis based on two actual public sector claim instances as provided by Metropolitan Health. The results complement the analysis of Section 6.3 and Section 7.1.

- **Scenario 1** relates to hospitalisation for pneumonia. The total stay in hospital was 11 days, none of which were spent in ICU and the total hospital bill was R 19,767.
- **Scenario 2** relates to hospitalisation for an intracranial injury, likely from a motor vehicle accident. The total stay in hospital was 30 days of which 14 days were spent in ICU and the total hospital bill was R 104,776.

The related expenses and hospitalisation costs are set out in the table below under the different UPFS income classifications.

Table 24: Expenses

	Patient Level	Full Medical Costs	Billed Amount	Related Expenses	Total Expenses
Scenario 1	H1	R 19 767	R 2 965	R 2 100	R 5 065
	H2	R 19 767	R 9 884	R 3 700	R 13 584
Scenario 2	H1	R 104 777	R 15 716	R 4 000	R 19 716
	H2	R 104 777	R 52 388	R 7 200	R 59 588

Source: *Metropolitan Health hospital data extracts*

The analysis below is based on cover levels that are likely affordable to the particular policyholders. The table below illustrates the different costs to the policyholders and the impact of different cover levels of HCP benefits for both the direct and related expenses for each scenario.

Table 25: Public Sector Scenario 1 Analysis

Net Gain or Loss per Patient Category (Direct Medical Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 2 965)	(R 215)	R 2 535	R 5 285	R 8 035	N/A
H2	(R 9 884)	(R 7 134)	(R 4 384)	(R 1 634)	R 1 117	R 12 117

Net Gain or Loss per Patient Category (Related Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 2 100)	R 650	R 3 400	R 6 150	R 8 900	n/a
H2	(R 3 700)	(R 950)	R 1 800	R 4 550	R 7 300	R 18 300

Net Gain or Loss per Patient Category (Direct and Related Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 5 065)	(R 2 315)	R 435	R 3 185	R 5 935	n/a
H2	(R 13 584)	(R 10 834)	(R 8 084)	(R 5 334)	(R 2 584)	R 8 417

Source: Metropolitan Health hospital data extracts.

Table 26: Public Sector Scenario 2 Analysis

Net Gain or Loss per Patient Category (Direct Medical Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 15 716)	(R 6 466)	R 2 784	R 12 034	R 21 284	n/a
H2	(R 52 388)	(R 43 138)	(R 33 888)	(R 24 638)	(R 15 388)	R 21 612

Net Gain or Loss per Patient Category (Related Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 4 000)	R 5 250	R 14 500	R 23 750	R 33 000	n/a
H2	(R 7 200)	R 2 050	R 11 300	R 20 550	R 29 800	R 66 800

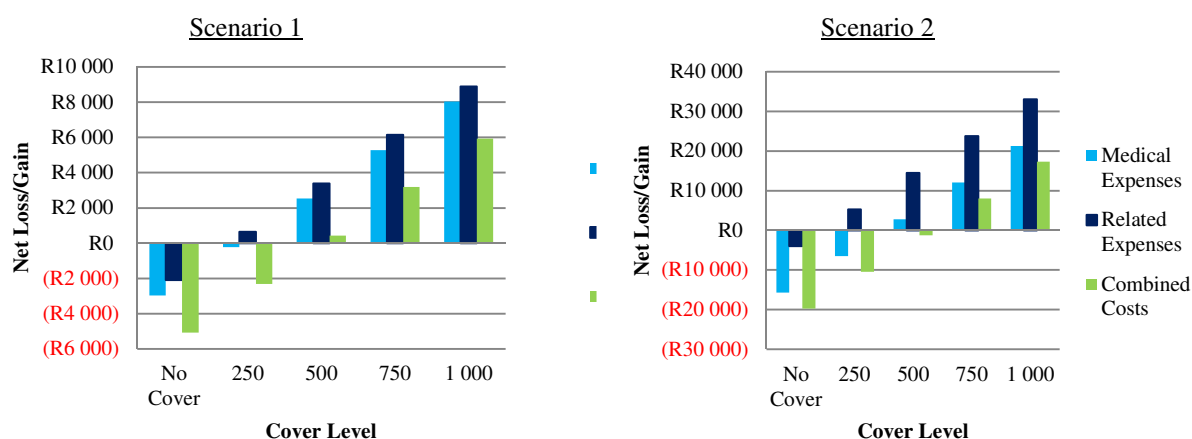
Net Gain or Loss per Patient Category (Direct and Related Expenses)						
Cover Level	No Cover	250	500	750	1 000	2 000
H1	(R 19 716)	(R 10 466)	(R 1 216)	R 8 034	R 17 284	n/a
H2	(R 59 588)	(R 50 338)	(R 41 088)	(R 31 838)	(R 22 588)	R 14 412

Source: Metropolitan Health hospital data extracts.

The results for each individual patient group are illustrated in more detail below.

H1 Patients

The figure below illustrates the net gain/loss to policyholders in H1 under different levels of HCP benefits given the 2 claim scenarios as outlined above.

Figure 22: Net Gain/Loss for H1 patients

Source: Authors own calculations.

Low cover HCP products provide significant benefits to H1 persons. HCP benefits of R250 a day would likely be insufficient to cover direct costs of a major medical event but would be able to provide sufficient cover for the related costs under both scenarios. Benefits of R500 per day or more would be able to cover both the direct and related costs in scenario 1 while cover of R 750 per day would provide cover for both the direct and related costs in scenario 2. Benefit levels above R500 a day would yield significant windfall claims to policyholders under scenario 1, while benefits levels of more than R 750 a day would provide significant windfall claims under scenario 2. Benefits up to R 1,000 a day would likely be affordable as even at higher ages contributions for these benefit levels would be a maximum of 7% of monthly salary.

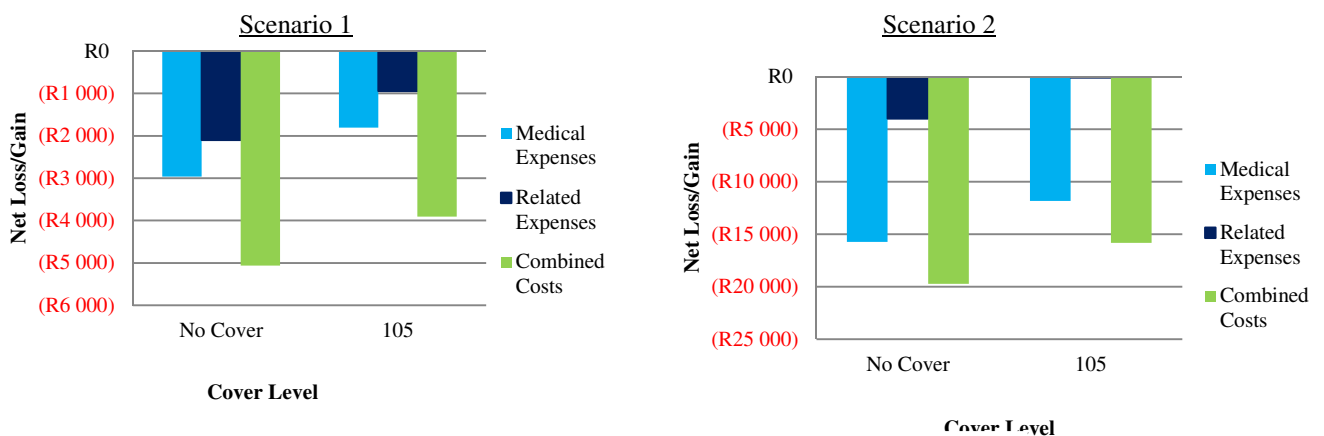
This illustrates the potential gain to customers from HCP products and their ability to service the needs of both the direct and indirect expenses for policyholders that would qualify for this category. But this also illustrates the incentive for fraud in this market with policyholders being able to receive significant pay-outs that far exceed their normal monthly earnings.

The results in the table below illustrate the impact of the proposed revised demarcation relating to capped benefit values versus the effects when persons have no cover.

Table 27: Capped benefits (H1)

Scenario	Expenses	Loss Without Cover	Loss With R105 per day Cover	% Costs Covered
Scenario 1	Direct Expenses	(R 2 965)	(R 1 810)	39%
	Related Expenses	(R 2 100)	(R 945)	55%
	Combined Expenses	(R 5 065)	(R 3 910)	23%
Scenario 2	Direct Expenses	(R 15 716)	(R 11 831)	25%
	Related Expenses	(R 4 000)	(R 115)	97%
	Combined Expenses	(R 19 716)	(R 15 831)	20%

Source: Authors own calculations and Metropolitan Health data

Figure 23: Net Gain/Loss to H1 Patients (Capped benefits)

Source: Authors own calculations and Metropolitan Health data

The proposed 70% Benefit cap would significantly reduce the efficacy of HCP product offerings for H1 persons. A benefit value capped at 70% of daily income would significantly decrease the impact that HCP products could have on covering either the direct or indirect expenses under scenario 1. The results for scenario 2 illustrate the impact of a prolonged stay in hospital. While the policyholder might be able to more closely match the related expenses under this scenario, the nominal impact of direct expenses would be significant for a member in this category and could lead to financial ruin.

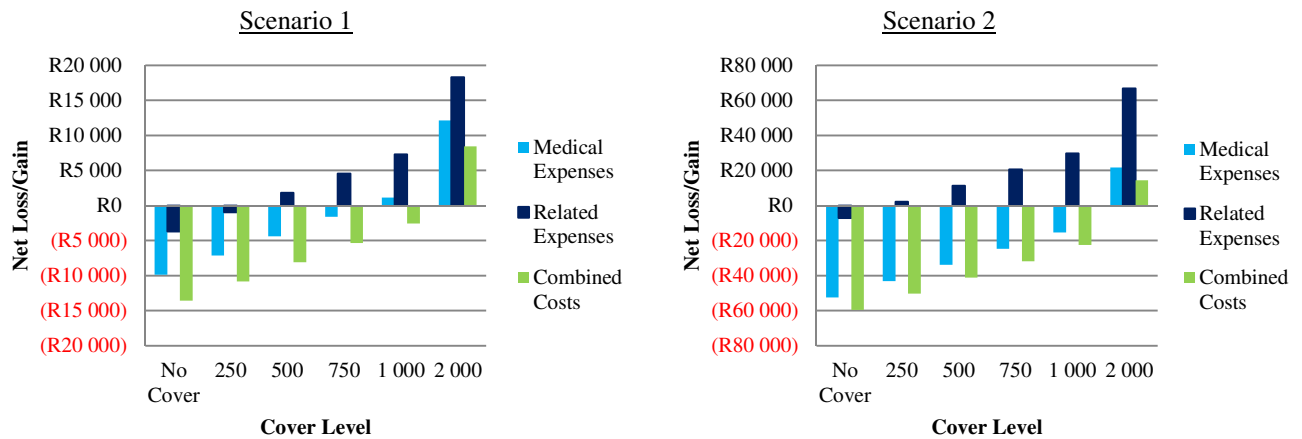
Coverage for the direct expenses will be reduced to 39% under scenario 1 and 25% under scenario 2. This implies that the policyholder would still incur a significant cost but have no ability to mitigate this risk. These costs would be significantly higher (in nominal terms) for more serious events (Scenario 2). By comparison a benefit amount of R750 per day would completely cover both the direct and indirect costs and produce a small windfall claim for this person. However, under the revised demarcation regulations such a benefit level would only be available to persons earning approximately R 21,500 per month or more.

The related costs are comparatively small and would be reduced by 55% under scenario 1 and 97% under scenario 2. Though the costs are almost met under scenario 2 the impact of the direct costs would completely nullify any benefit gained.

H2 Patients

The figure below illustrates the net gain/loss to policyholders in the H2 category under different levels of HCP benefits given the 2 claim scenarios as outlined above.

Figure 24: Net Gain/Loss for H2 patients



Source: Authors own calculations and Metropolitan Health data

HCP able to provide protection for H2 members in some cases. HCP benefits of R 250 to R500 a day or more would be required to cover the expected related costs of a major medical event in a public hospital for both scenarios, while the direct expenses could also be covered by a benefit of R 1,000 a day under scenario 1 and R 2,000 a day under scenario 2. Benefit levels of R 2,000 a day or more would be able to fund both the direct and indirect expenses under both scenarios.

The results for H2 patients with no cover illustrate the plight of the uncovered middle group regarding the funding of health care. They are too poor to afford a medical scheme but they are too wealthy to access a significant reduction in tariff via the state means test and thus are unavoidably underinsured. They would likely have to rely on savings or personal loans (this can be in the form of bank loans, loans from friends or family members etc.) to fund the cost of a major medical event. The losses at lower benefit levels and those if no cover was available would prove to be a serious risk to the individual and would provide a strong incentive to “cheat” the means test by not disclosing actual income levels. Fraud in this sense poses a threat to the sustainability of the state subsidy.

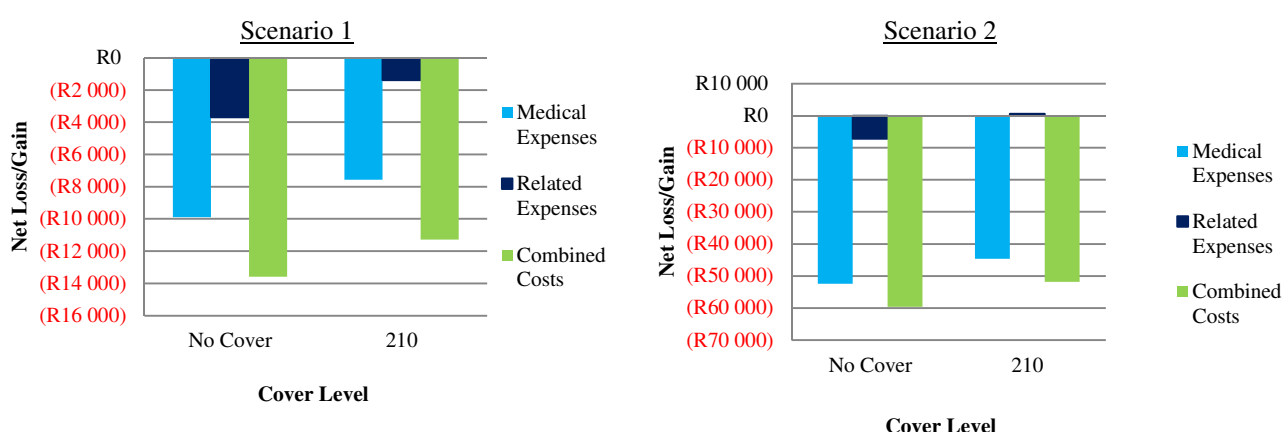
The results above indicate that though HCP products are not designed to meet the direct needs of a major medical event, they could be able to provide some form of cover and in some cases would be able to cover both the direct and indirect costs of hospitalisation.

The table and figure below illustrate the impact of the capped benefit in defraying the direct and indirect costs of a major medical event for H2 category persons under the 2 different claim scenarios compared to no HCP cover.

Table 28: Public Sector Scenario Analysis

Scenario	Expenses	Loss Without Cover	Loss With R210 per day Cover	% Costs Covered
Scenario 1	Direct Expenses	(R 9 883)	(R 7 573)	23%
	Related Expenses	(R 3 700)	(R 1 390)	62%
	Combined Expenses	(R 13 583)	(R 11 273)	17%
Scenario 2	Direct Expenses	(R 52 388)	(R 44 618)	15%
	Related Expenses	(R 7 200)	R 570	108%
	Combined Expenses	(R 59 588)	(R 51 818)	13%

Source: Authors own calculations and Metropolitan Health data

Figure 25: Net Gain/Loss to H2 Patients (Capped benefits)

Source: Authors own calculations and Metropolitan Health data.

70% Benefit cap will expose H2 HCP policyholders to significant risks. From the table and figure above it is clear that the cap on benefit amounts will have a significant impact for persons in the H2 category and there would likely be a reduced incentive for consumers to take out this cover for the direct costs associated with hospitalisation. A benefit of R210 is expected to cover only 23% of direct hospital costs under scenario 1 and 15% under scenario 2. Comparatively a benefit value of R 2,000 would have met the direct expenses under both scenarios but would require a salary of R 57,100 per month under the proposed revised demarcation.

The related expenses would be covered up to 62% under scenario 1 and 108% under scenario 2 and while this illustrates the ability of revised HCP products to possibly provide for the indirect expenses at low benefit levels, the member would be exposed to significant direct cost risks with the patient under scenario 2 being liable for nearly R 45,000.

The combined costs cover would be reduced by only 17% under scenario 1 and 13% under scenario 2 given the R 210 benefit level, leaving the rest to be funded by the patient. A benefit level of R 2,000 per day would have covered all of the costs under both scenarios but would require a monthly salary of slightly more than R 57,100 per month under the proposed regulations.

The results above tie in to Sections 6, 7 and 8 illustrate value of HCP products to this sector of the market and the potential damaging impact of the proposed revised demarcation.

Appendix 5

The tables below highlight the participants who took part in the survey.

Table 29: Industry Bodies and Other Participants

Organisation	Person/s Met	Date of Meeting
ASISA	Anna Rosenberg – Senior Policy Advisor	30 January 2012
Independent consultant (via telecon during ASISA meeting)	Rosanne de Silva – Independent Actuarial Consultant	
Liberty Medical Scheme – (via telecon during ASISA meeting)	Stephen Maasch – Chairman of the Liberty Medical Scheme	
Mediclinic Hospital Group	Roly Buys - Head: Funder Relations & Contracting	9 February 2012
	Guy D'Elboux – Manager: Funder Relations & Contracting	
	Chantel Heyns – Senior Manager: Funder Relations & Contracting	
MMI	Ali Hamdulay	1 March 2012
	Niyaaz Ebrahim	1 March 2012
Discovery Health Medical Scheme	Emile Stipp – General Manager: Group Health Actuary at Discovery Health	8 March 2012

Table 30: Insurers and Reinsurers

Organisation	Person Met	Date of Meeting
Sanlam	Michael Frylinck – Product Actuary	30 January 2012
Chartis	Erica Mackay – Product Development and Strategic Initiatives Manager	2 February 2012
Old Mutual	Nadine Dalling – Actuarial Consultant Old Mutual Health Solutions	8 February 2012
Prime Meridian	Brendan Benfield – Executive (Email response)	16 February 2012
Guardrisk	Richard Eales – Managing Executive: Corporate Risk Solutions and Admed	21 February 2012
Day 1 Health	Richard Blackman – Managing Director	24 February 2012
Reinsurance Group of America (RGA)	Michael Porter – Business Development Actuary	28 February 2012
	John Rutherford – Chief Actuary, International Health	
	Alex Brownlee – Actuary, Health	
Hollard	Jayesh Madhav – Product Development Manager – Life (Email response)	6 March 2012
Clientele (Ltd)	Heleen Peters – Head of Actuarial Member of Executive Management	8 March 2012
Gen Re	Paul Lewis	7 March 2012

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Providers and Products

This section provides a list of the product brochures and information as used for the analysis:

Admed Gap & Admed Pulse. 2012 Product information: <http://www.guardrisk.co.za/pages/203>

Ambledown Gap Cover. 2012 Product information:
http://www.ambledown.co.za/GAP_Cover/gap_cover.html

Bonitas Health Medical Fund. 2012 Product information: <http://www.bonitasmedicalfund.co.za/>

Chartis Hospital Cash Plan. 2012 Product information: http://www.hospitalcashplan.co.za/hospital-cash-plan_917_328763.html?phone=0860967529

Clientele Life Hospital Cash Plans. 2012 Product information:
http://www.clientele.co.za/?option=com_zoo&item_id=43&Itemid=186&view=item

Day 1 Health Plans. 2012 Product information: <http://www.day1health.co.za/>

Discovery Health Medical Scheme. 2012 Product information:
<http://www.discovery.co.za/portal/loggedout-individual/discovery-health>

Hollard Hospital Cash Back Plan. 2012 Product information: <http://www.hollard.co.za/dayaid>

Instant Life Gap Cover. 2012 Product information: <http://instantlife.net/life-cover/?gclid=CKYgq5C6v7ICFaXKtAodViYAYw>

Momentum Health Medical Scheme. 2012 Product information:
<http://momentum.cmpl.co.za/WebApp/files/health-brochure-2012-english.pdf>

Old Mutual Gap Cover. 2012 Product information: <http://www.oldmutual.co.za/personal/medical-cover/medical-gap-cover.aspx>

Old Mutual Hospital Cash Plan. 2012 Product information:
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