



Global Credit Rating Co.

Medical Schemes Industry Presentation

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Agenda

1. Brief background to GCR
2. Membership trends
3. Financial and operating performance
4. Medical scheme credit ratings
5. Operating & regulatory environment – Key topical issues/views
6. GCR's outlook



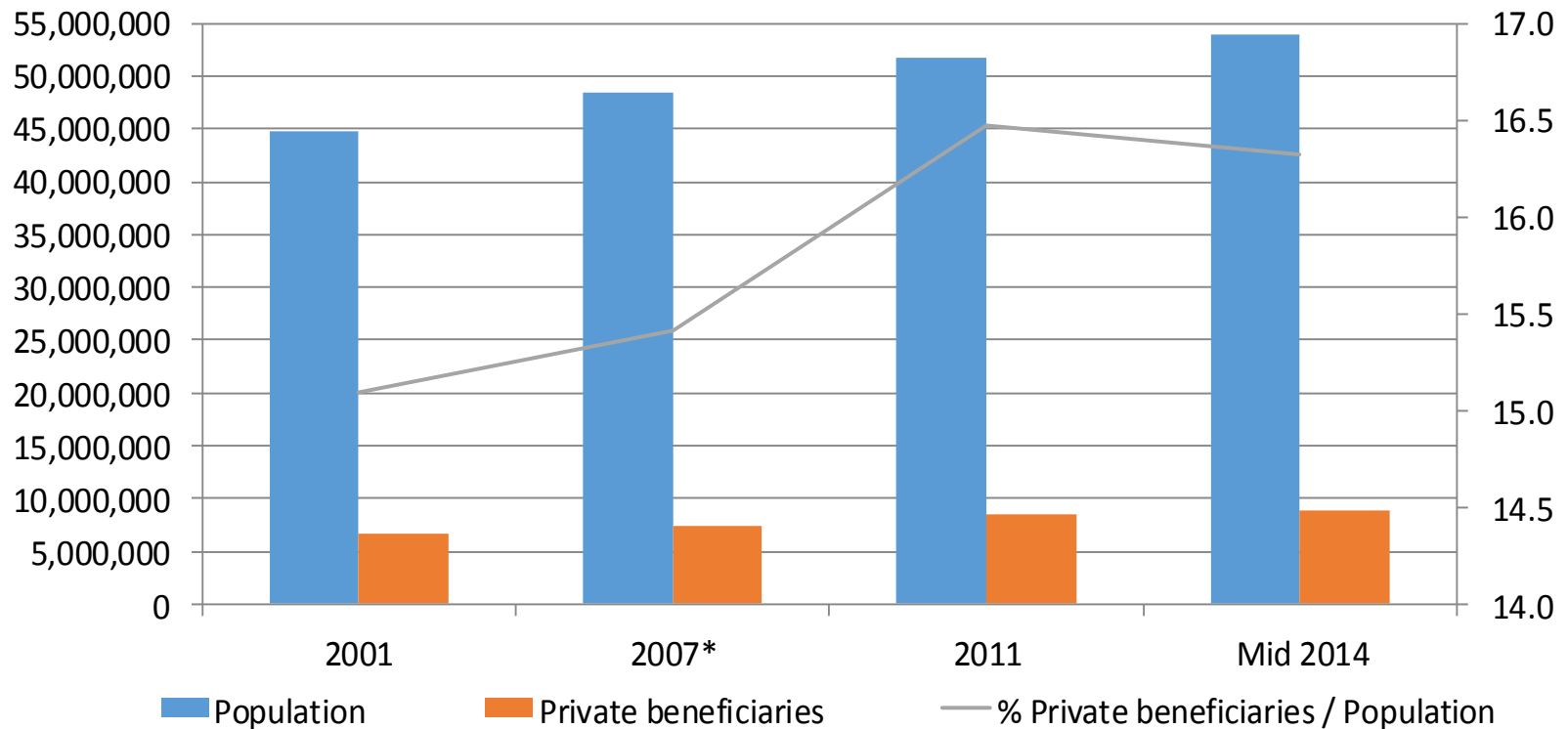
Background to GCR

- Established in 1996 as Duff & Phelps Africa
- Renamed Global Credit Ratings in 2001, to expand and specialise in Emerging Markets
- Full service rating agency
- Regional offices in 3 African countries
- Market leadership established in Africa
- International institutional shareholders - DEG/KFW group, French government owned PROPARCO



Private sector penetration

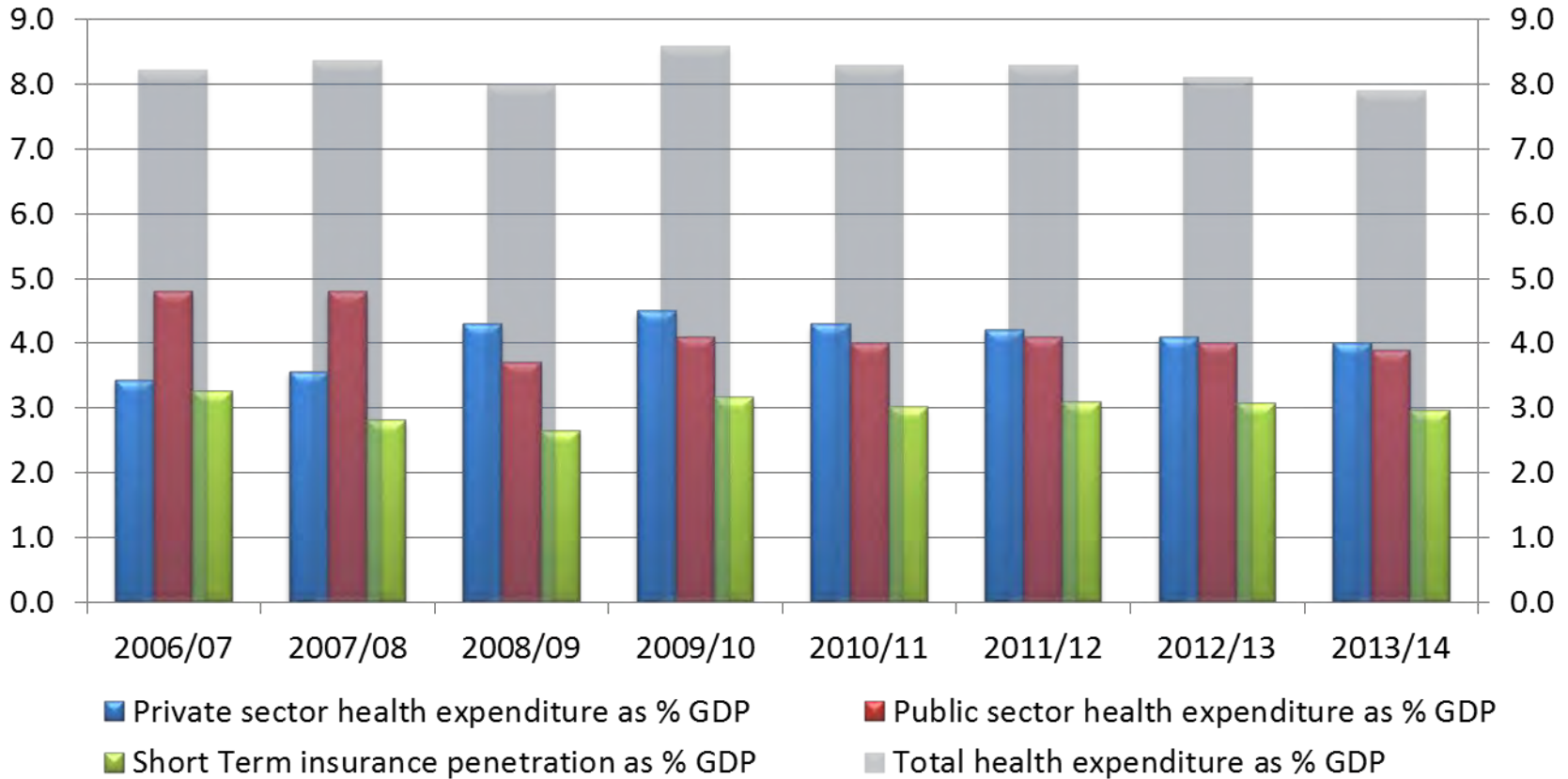
SA population versus private beneficiaries





Medical vs short term insurance penetration

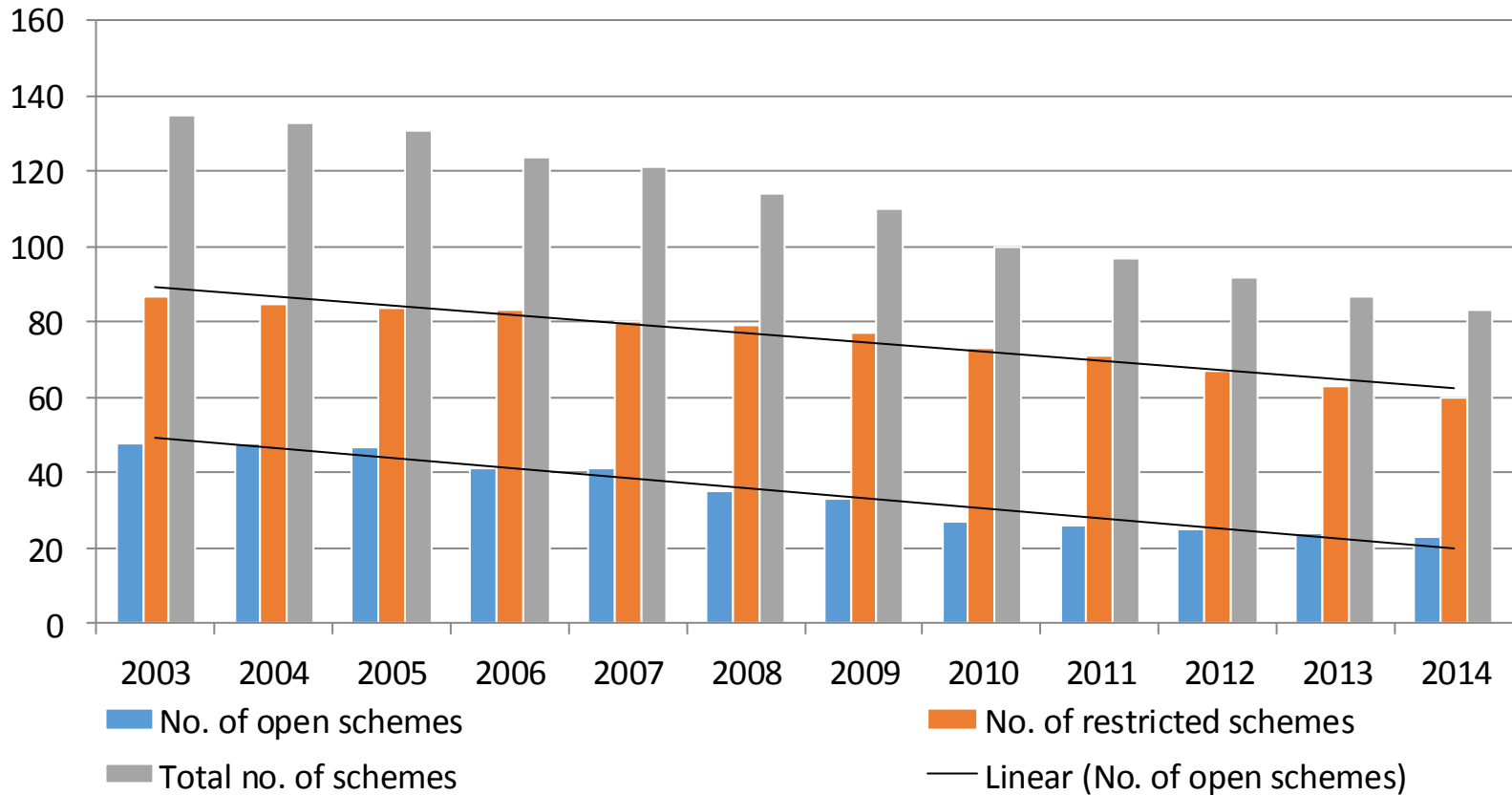
Healthcare vs insurance penetration





Open vs restricted schemes

Number of schemes





Consolidation

- January 2010, PUREhealth liquidated, Medcover merged with Liberty, and Telemed amalgamated with BESTmed.
- October 2010, Oxygen merged with Medshield, liquidation of Gen-health - Medshield absorbed most members.
- August 2012, Resolution concluded merger with NIMAS.
- January 2013, Bonitas merged with Pro Sano.
- March 2013, Discovery merged with Nampak (closed), followed by merger between Discovery and IBM in July.
- BESTmed merged with Sappi (closed) April 2013.
- Discovery & Altron November 2013



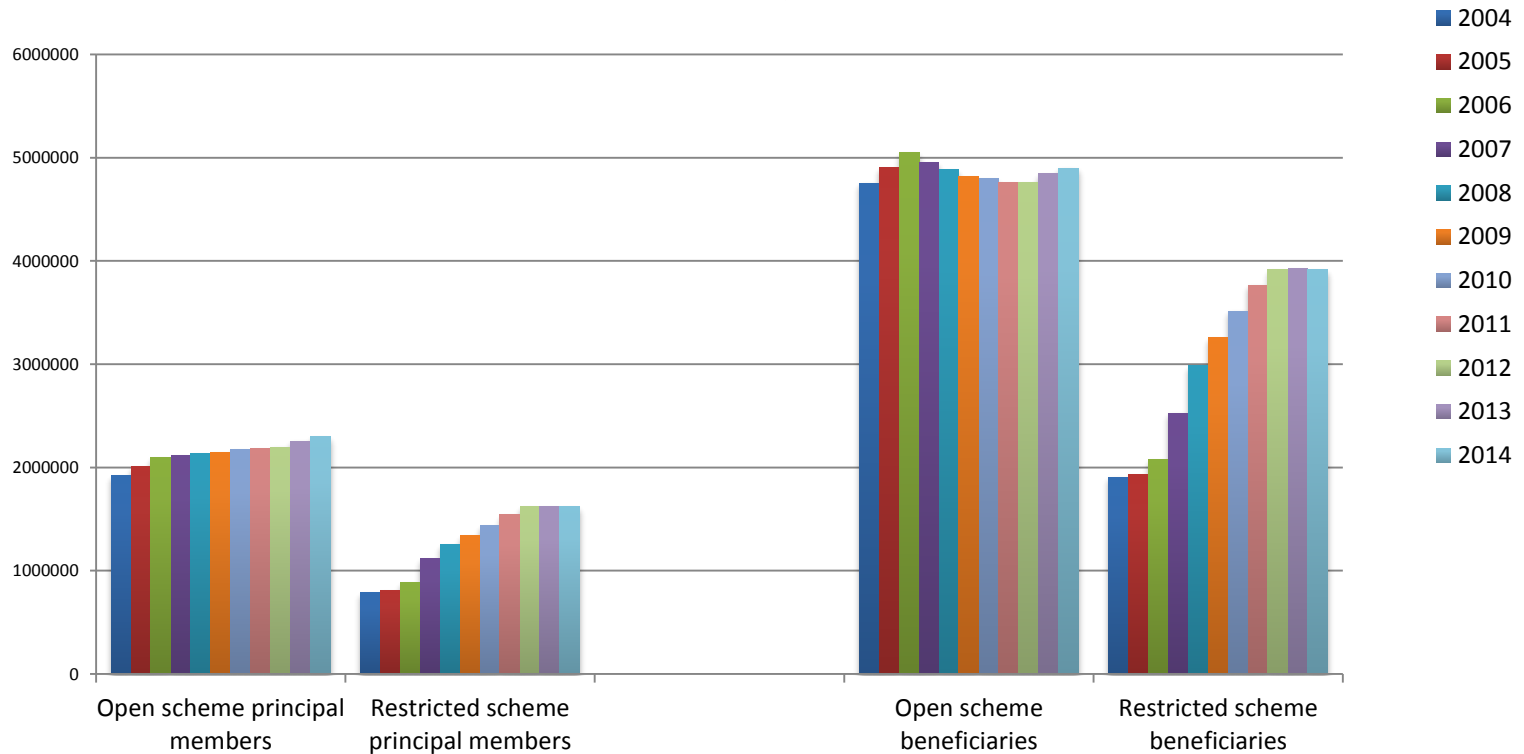
Consolidation

- Top 5 open schemes represent 79% of membership from 50% a decade ago
- GCR expects industry consolidation to continue amidst persistent healthcare cost pressures
- Benefits of scale; negotiating power
- Market could still exist for some small niche schemes
- Consolidation positively considered by GCR as schemes have generally become financially more stable



Membership

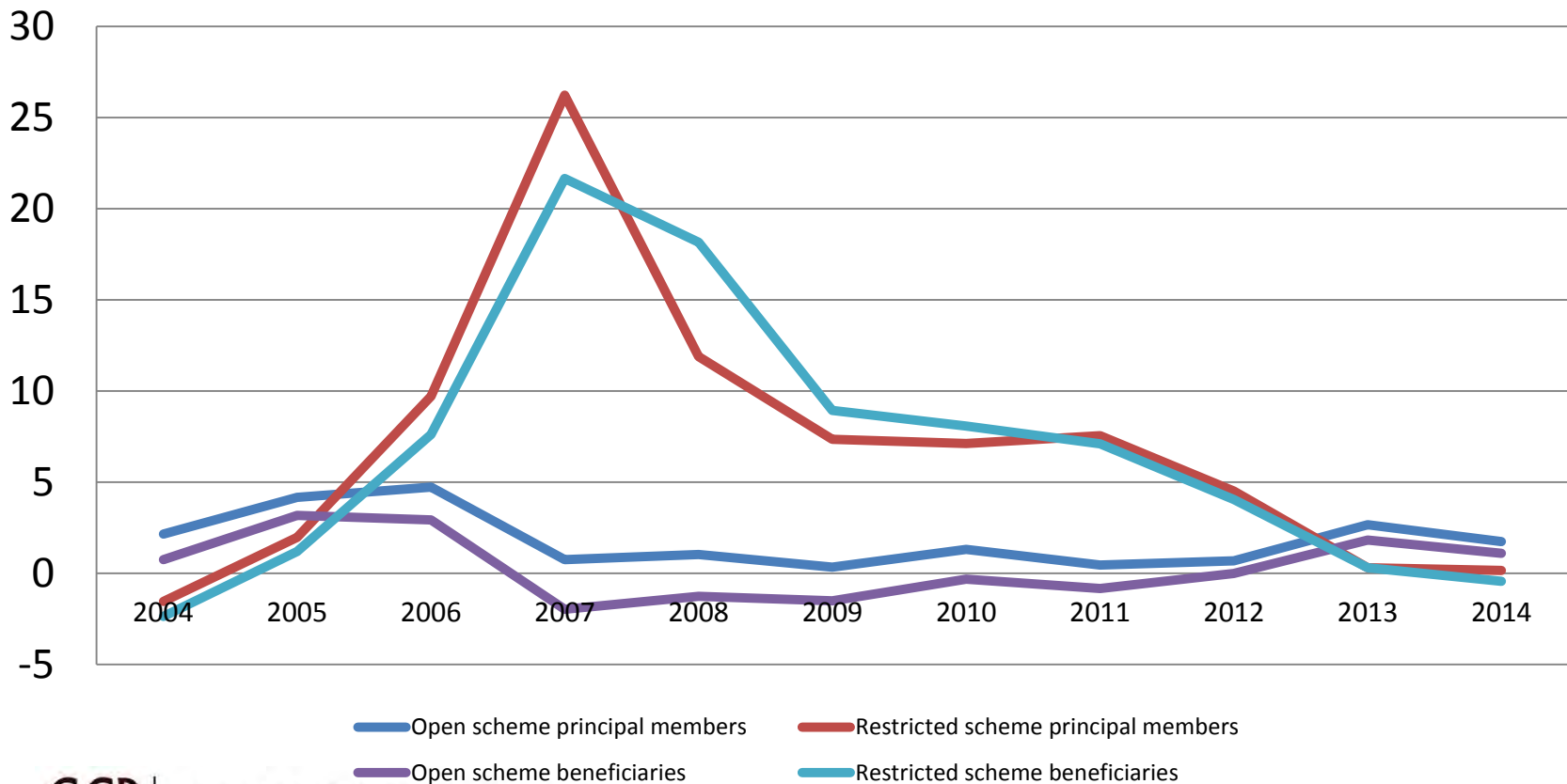
Membership trends





Membership

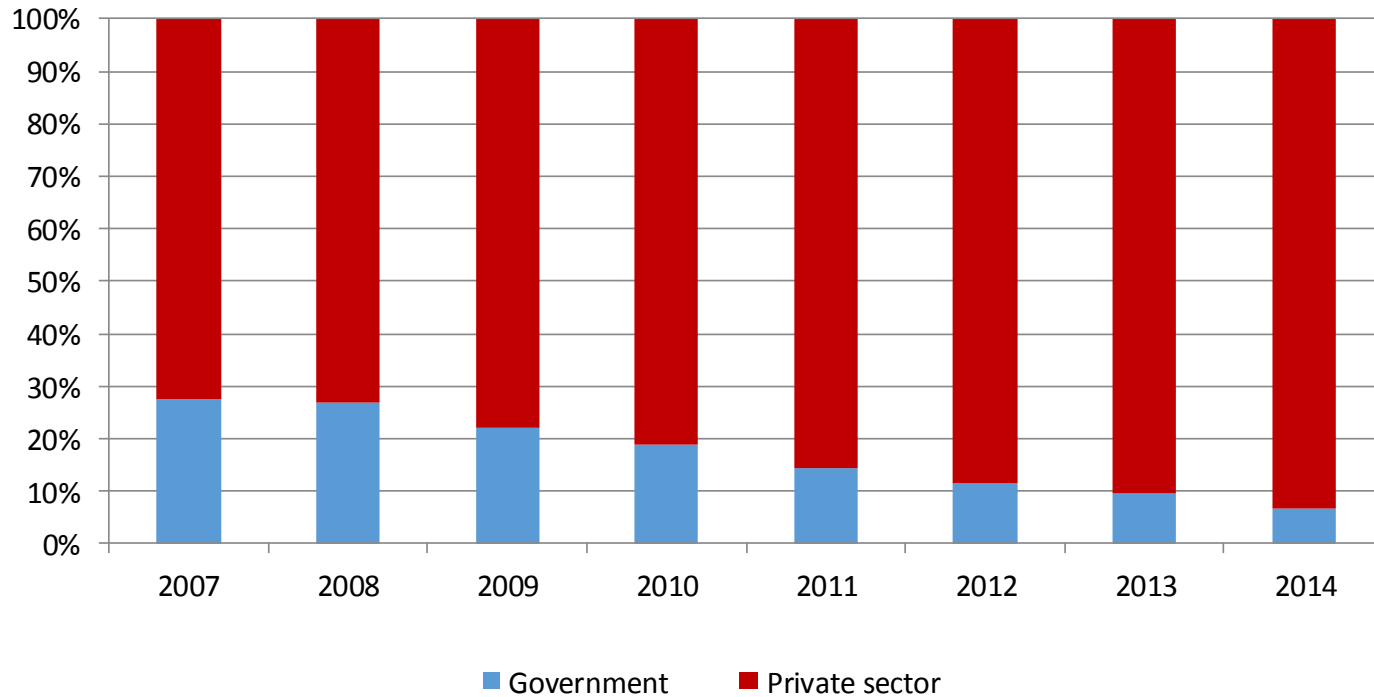
Membership trends





Membership – government

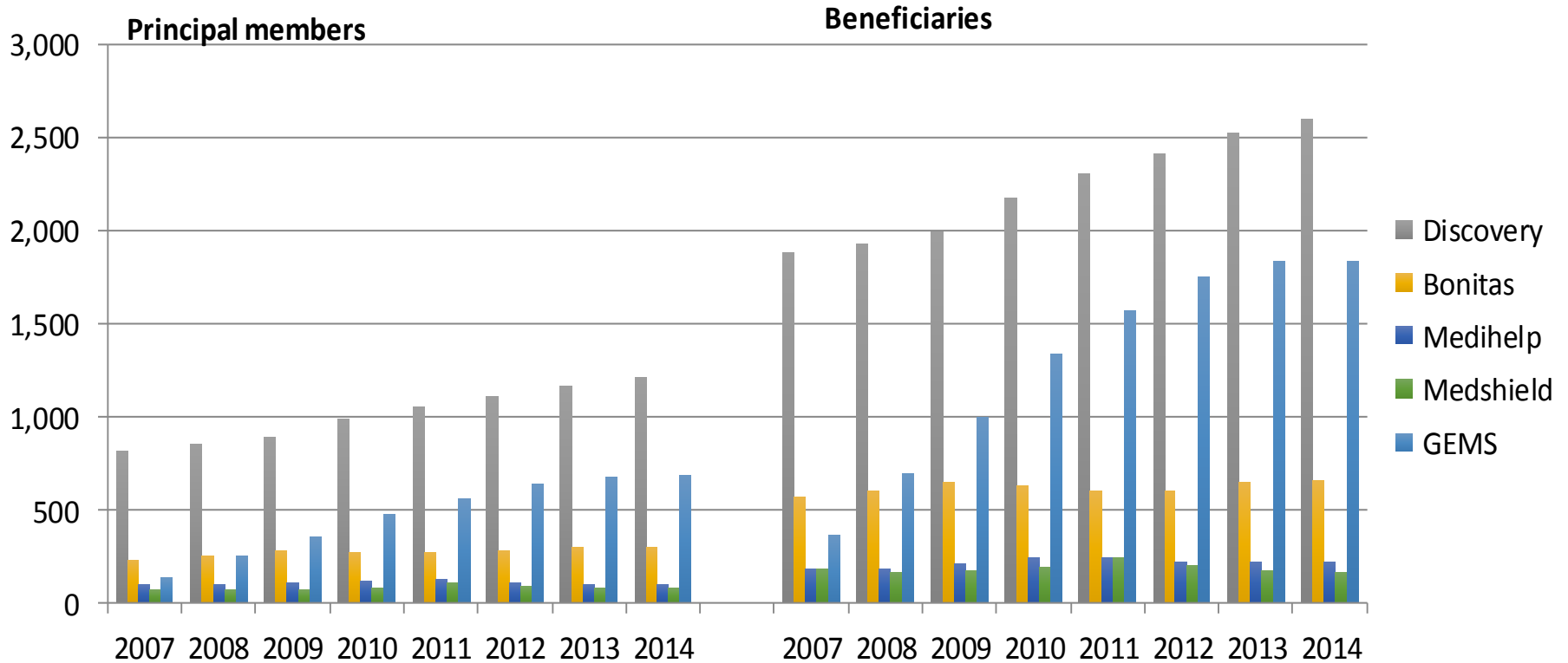
Segmental composition of principal membership





Membership

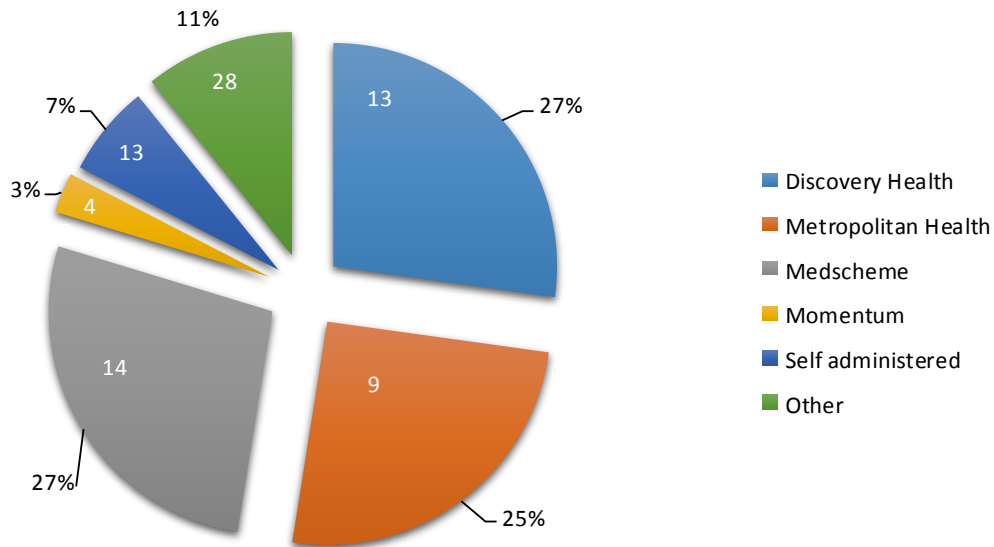
Membership - GEMS vs top 4 open schemes





Membership

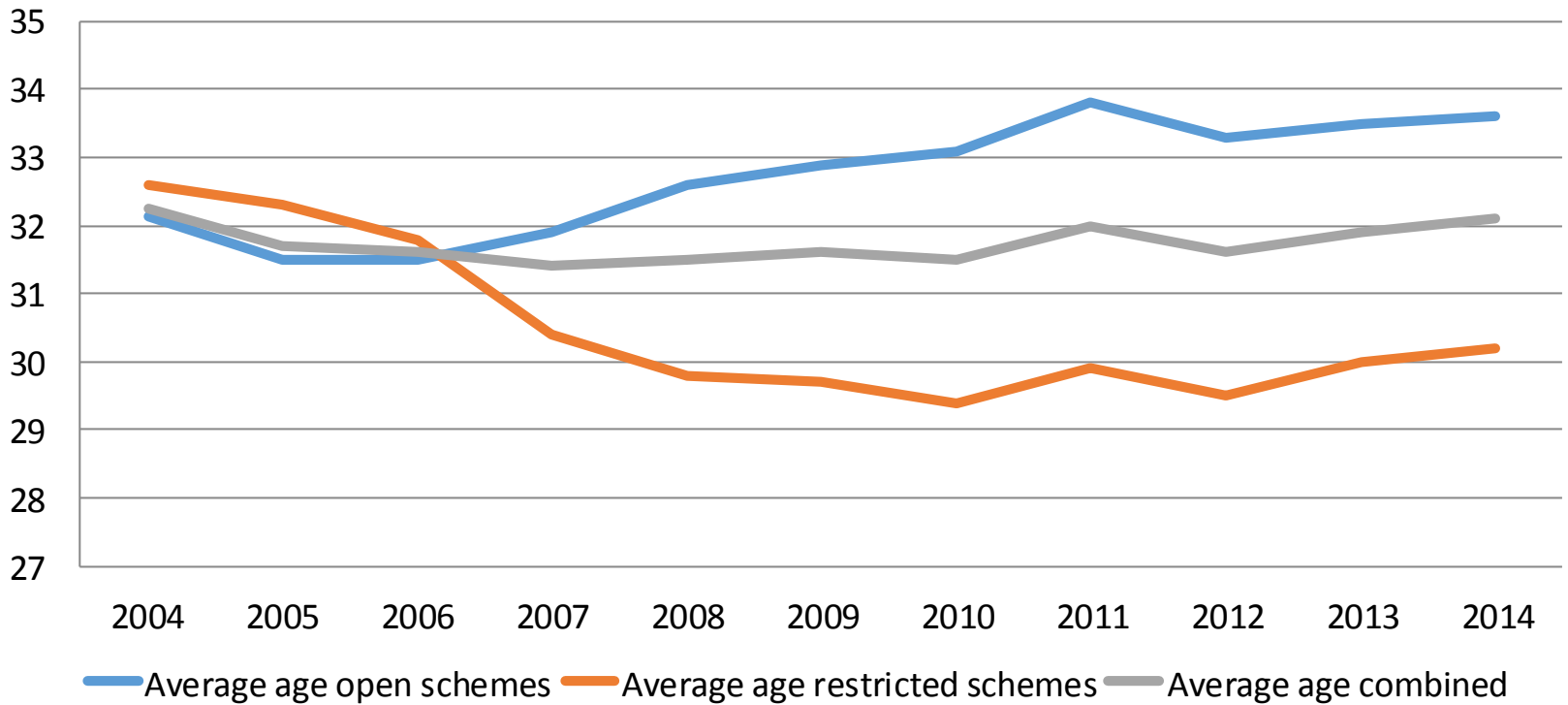
Average beneficiaries by administrator (no. schemes administered)





Membership

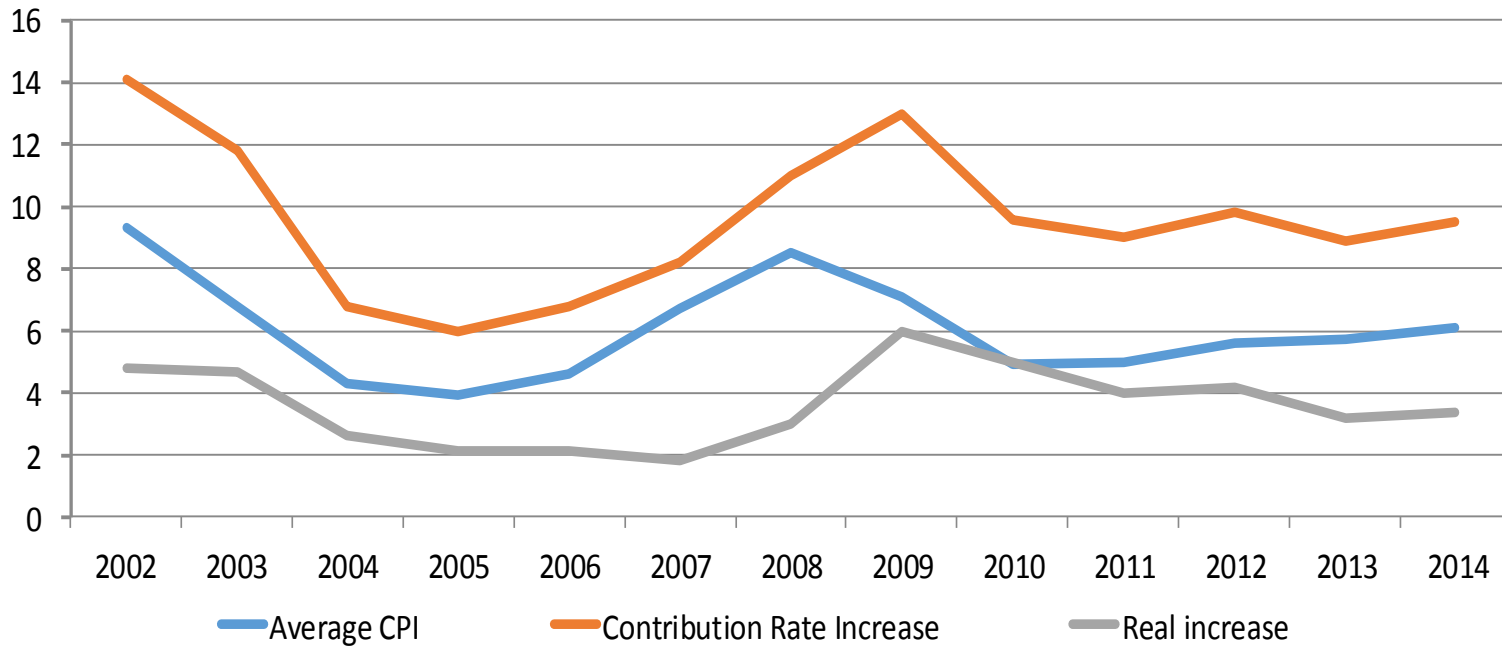
Average beneficiary age





Contribution trends

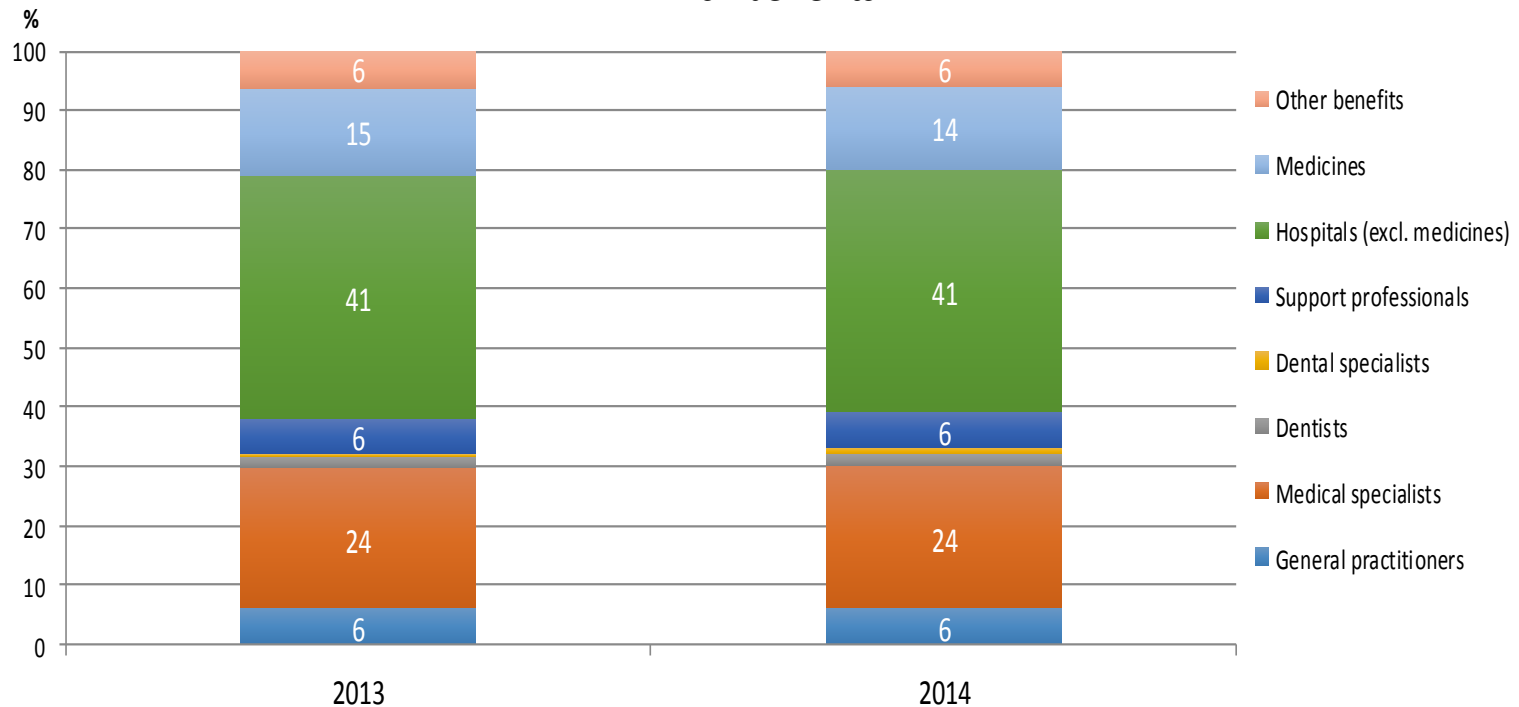
CPI vs medical contribution increases





Claims expenditure

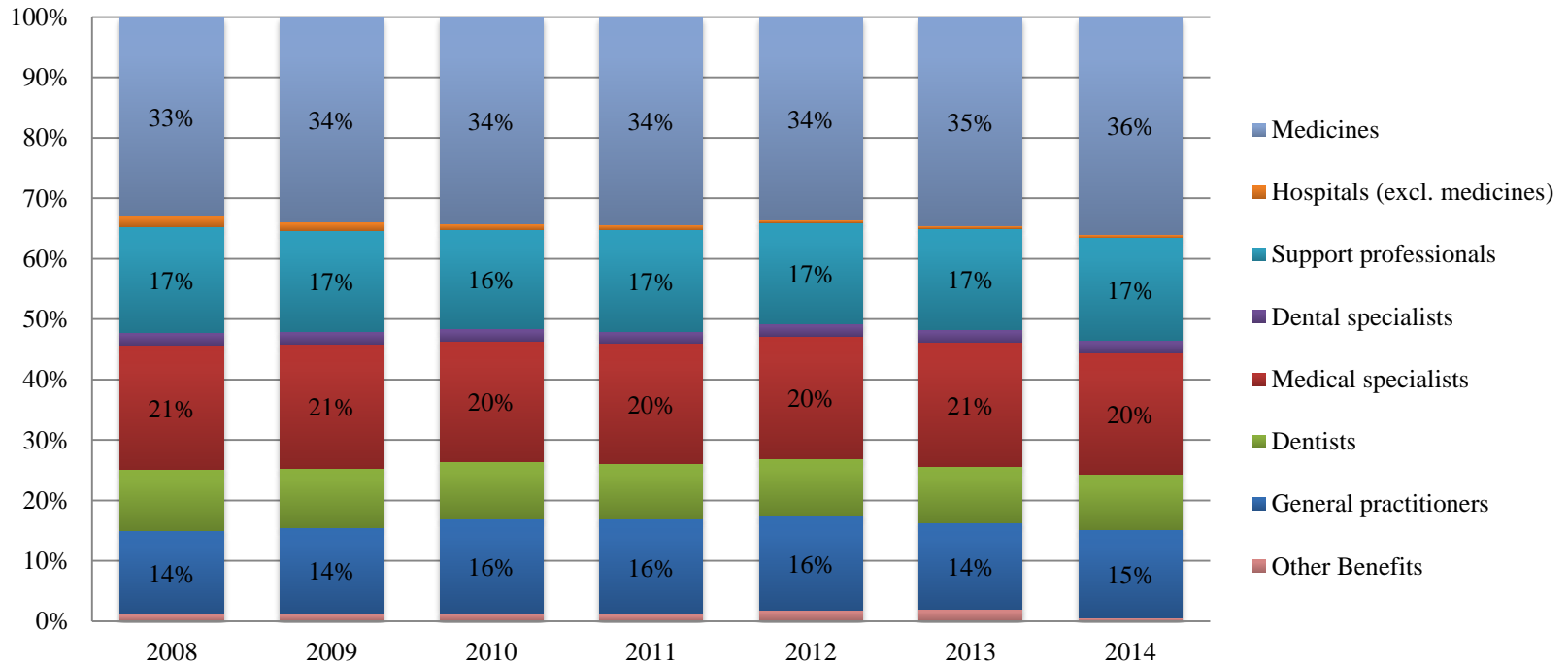
Risk benefits





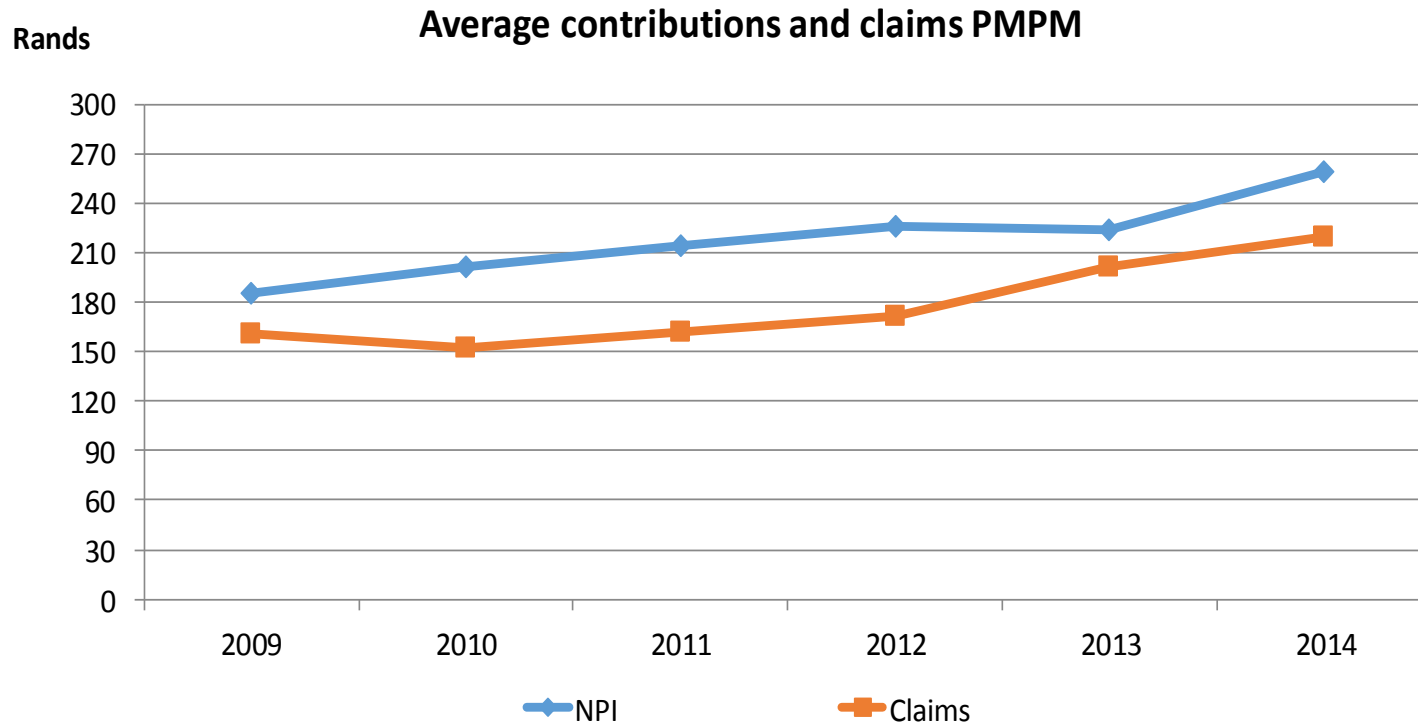
Claims expenditure

Medical savings benefits paid





Claims expenditure (open)





Claims expenditure

Key drivers

- PMBs
- New medication and technological advancements
- Increased disease burden
- Benefit abuse / fraud

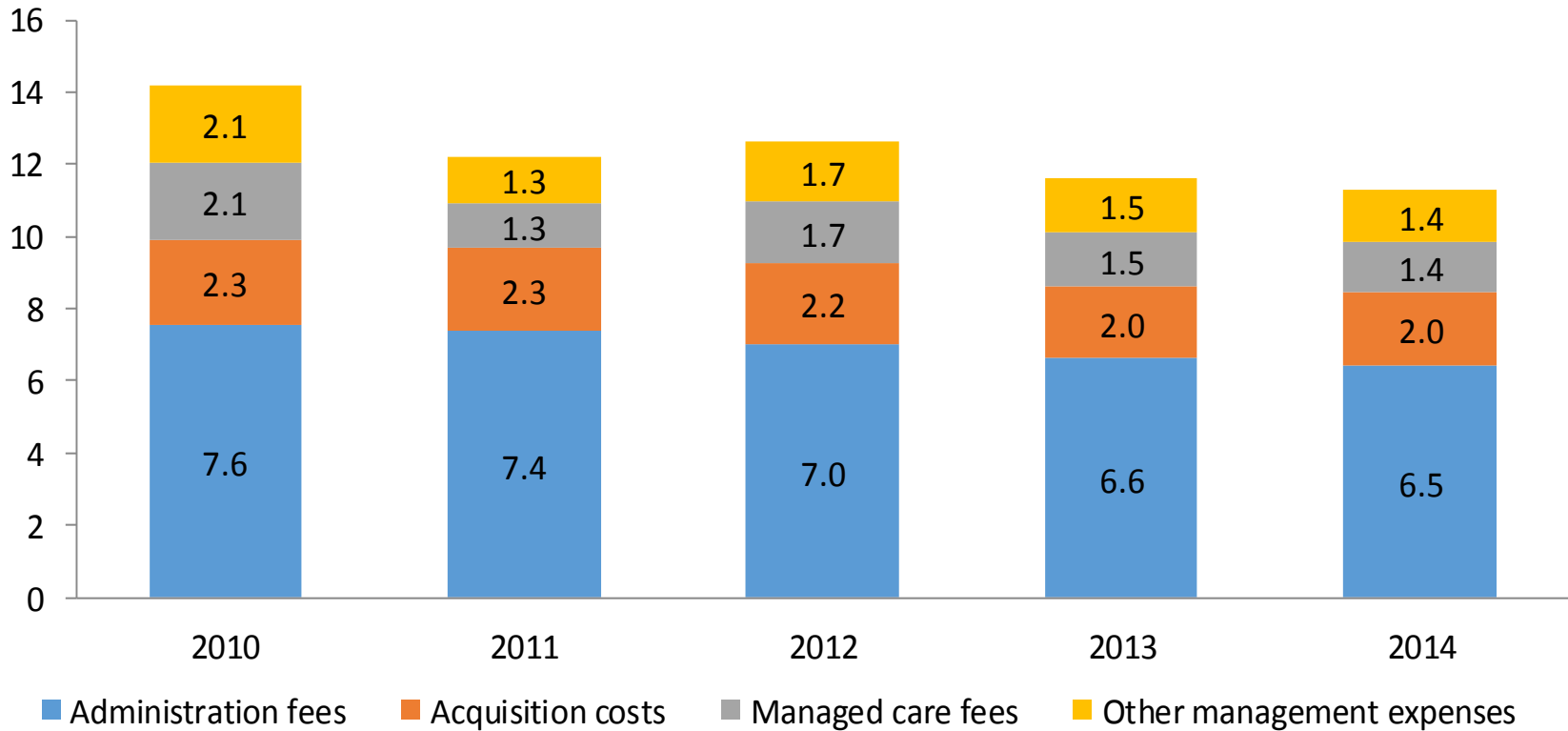
Corrective measures

- Enhanced risk management procedures and ongoing benefit design (ongoing process)
- Schemes have established their own DSP networks (hospital, GP, specialists), in particular for PMB diagnosis & treatment
- Switch from patent to generic drugs for chronic



Delivery costs (open)

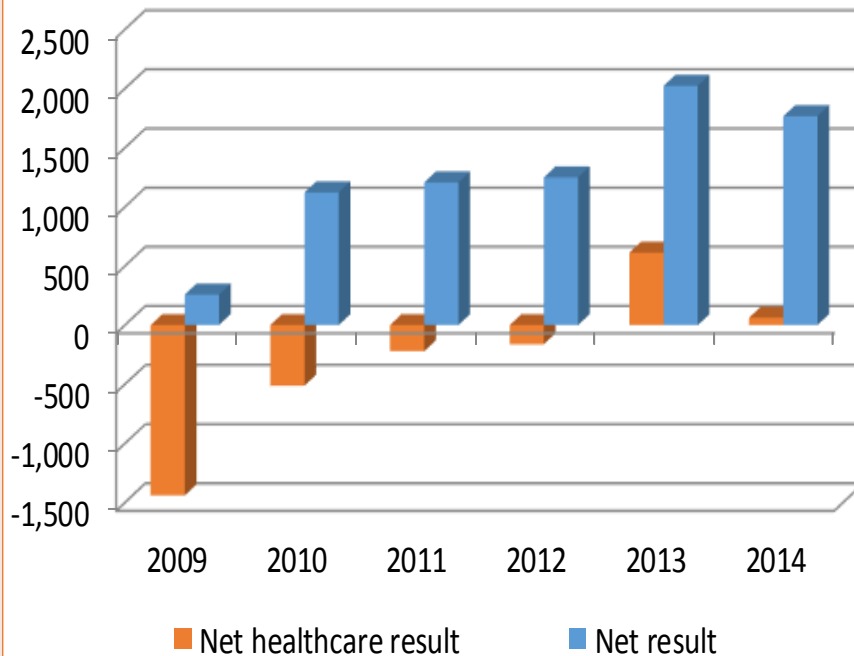
Delivery cost composition / GPI (%)



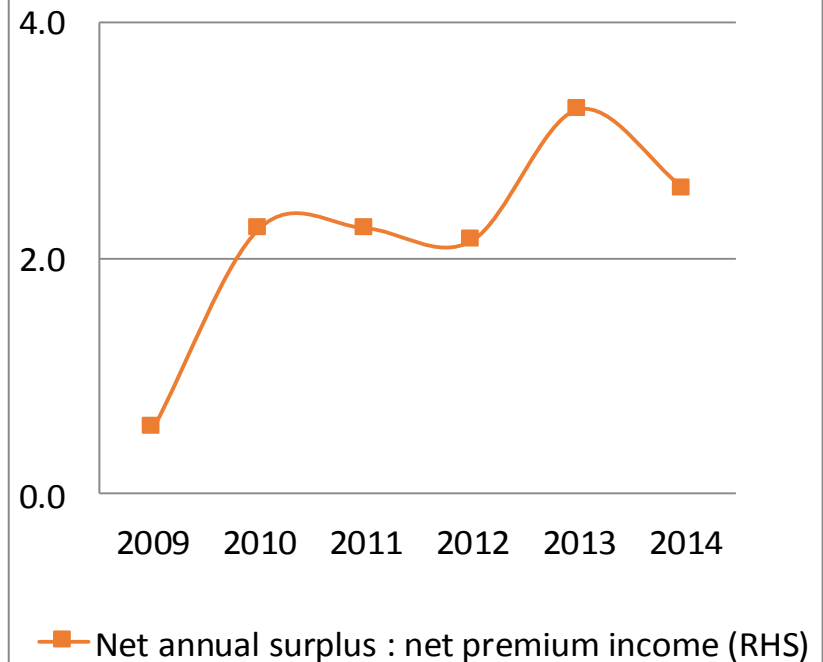


Financial performance (open)

Net healthcare and net result (Rbn)



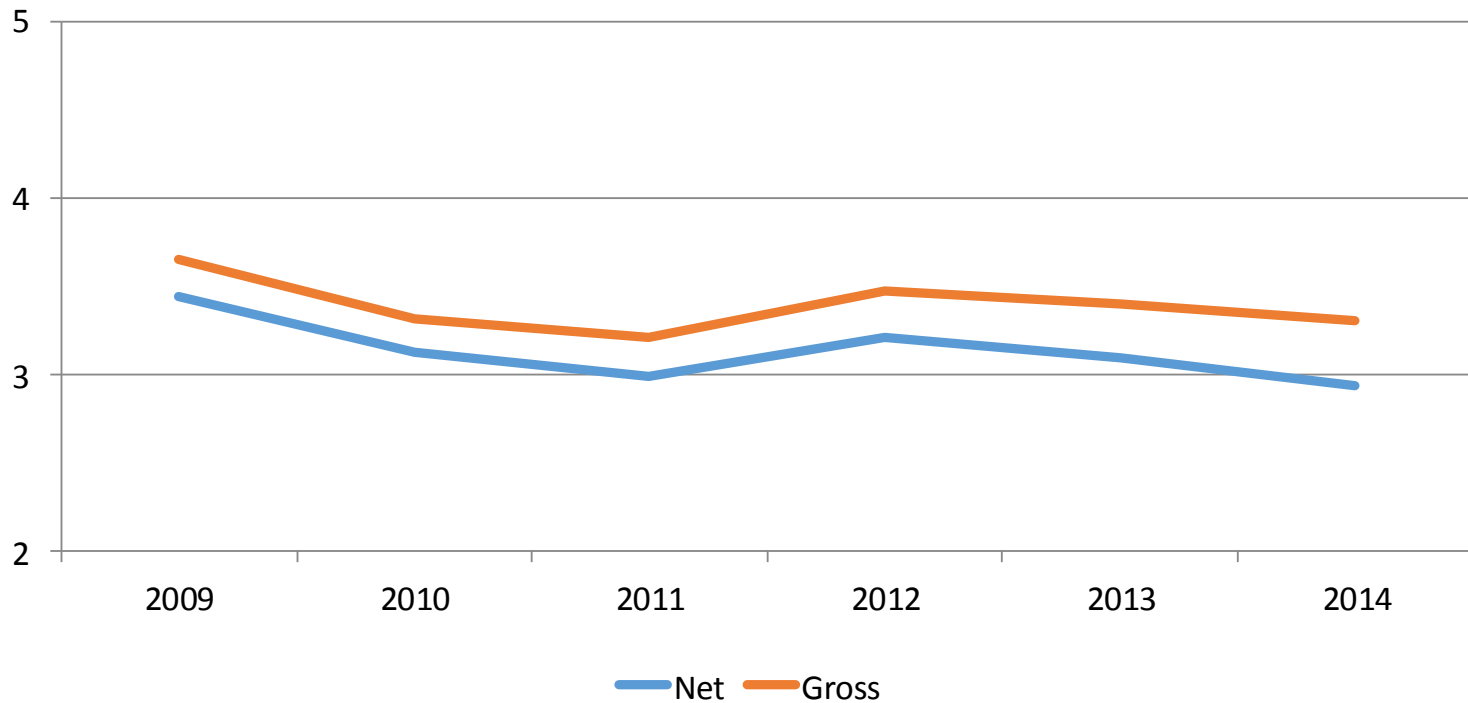
Financial performance (%)





Liquidity (open)

Cash coverage ratios (months)





Statutory solvency

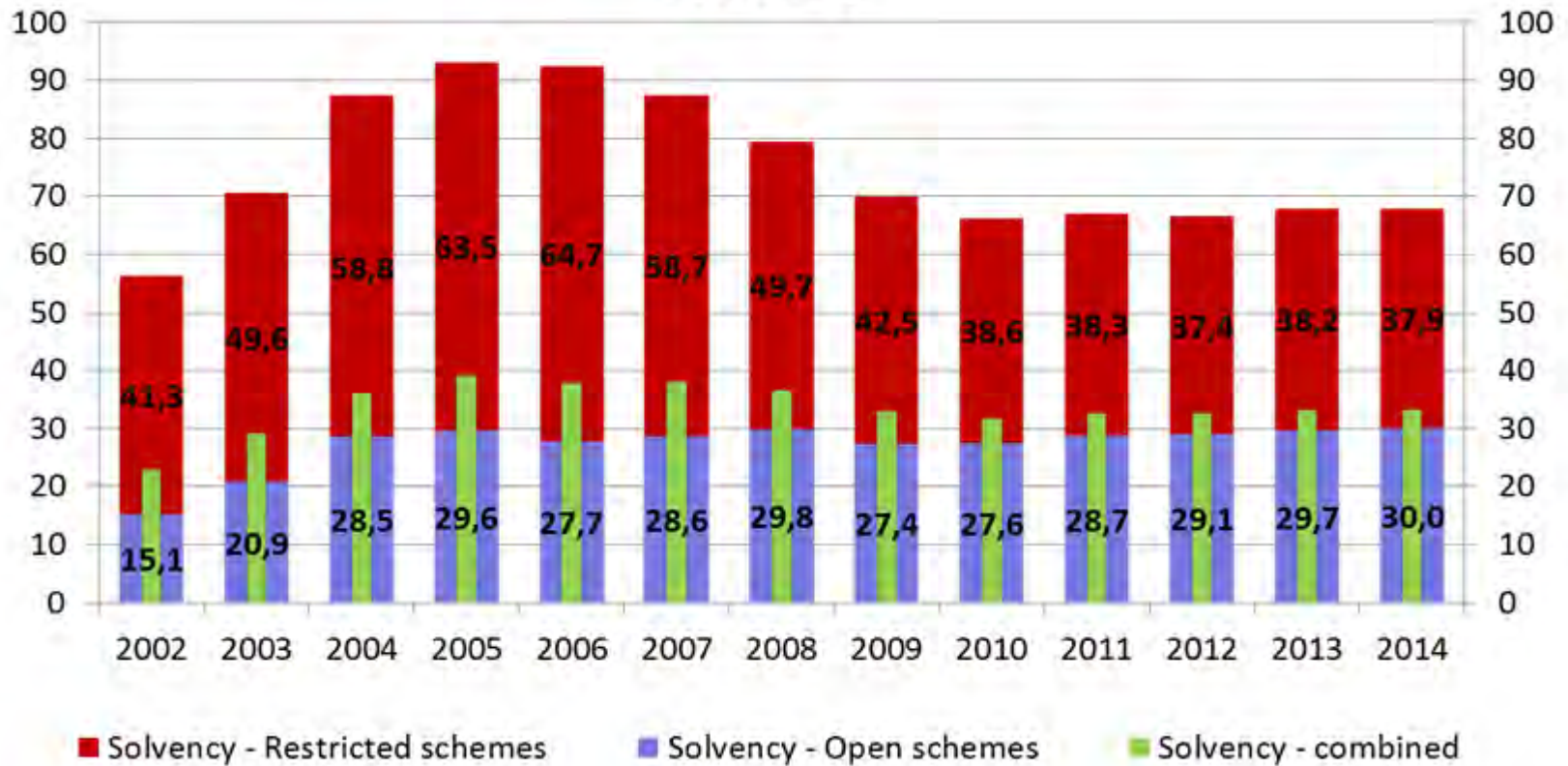
Statutory solvency requirement

- Accumulated funds expressed as a % of GPI (minimum of 25%)
- In GCRs view, this measure has various shortcomings; doesn't accurately convey overall scheme financial position, risks etc
- Should be risk based, incorporating balance sheet strength and asset/liability composition, underlying member risk profile etc
- "ICU schemes" on close monitoring by CMS
- Close monitoring justified for rapidly falling solvency
- CMS approach – submit business plan and monthly/quarterly management accounts to CMS, trustees attend regular monitoring meetings



Statutory solvency

Solvency

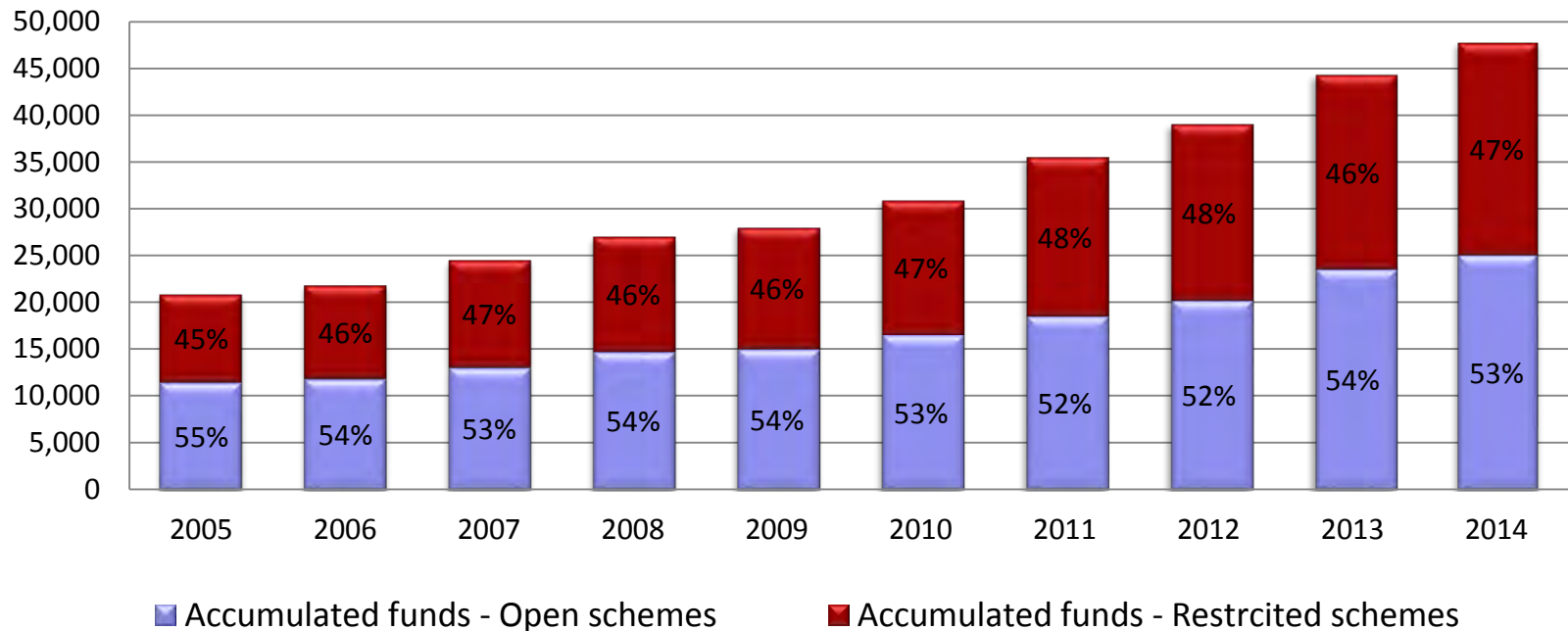




Accumulated funds

Rand (billion)

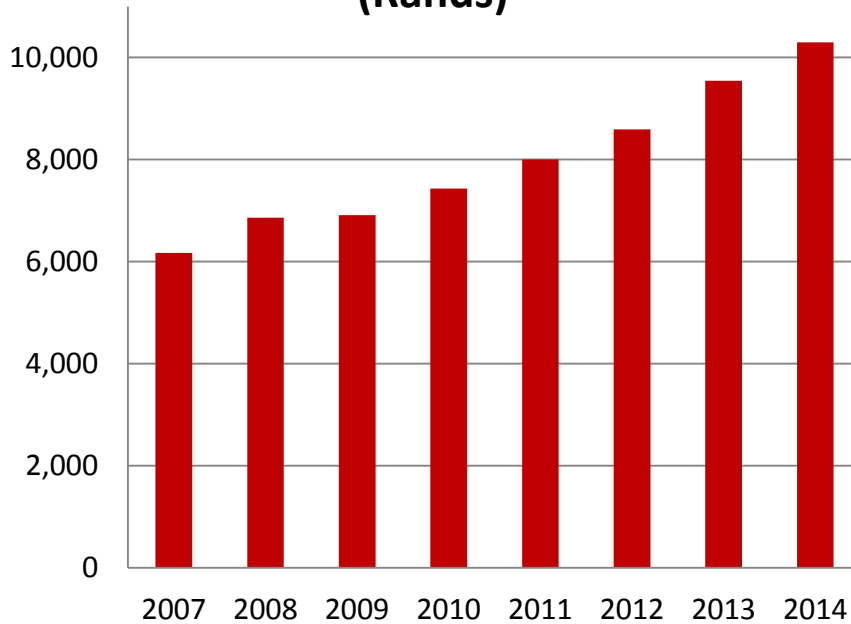
Accumulated Funds





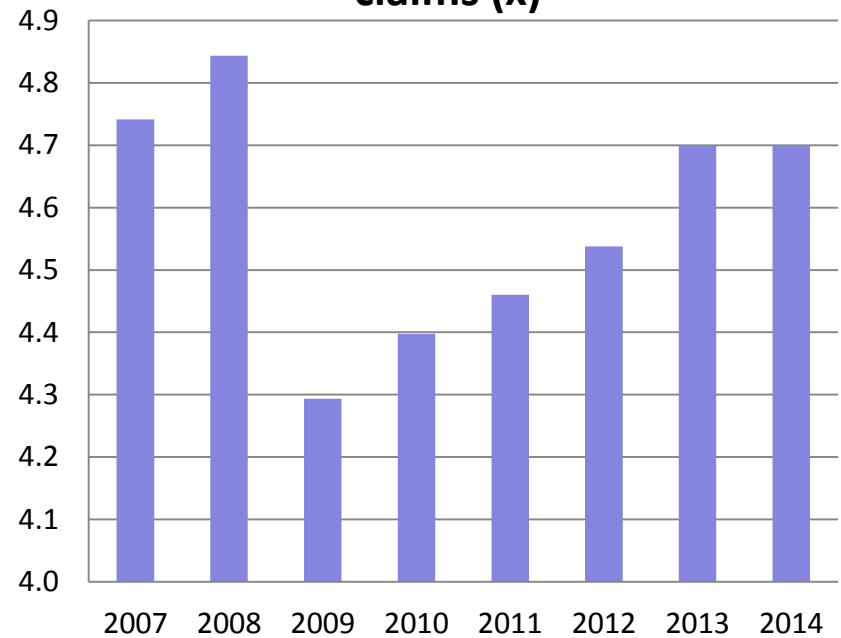
Accumulated funds (open)

Reserves per principal member (Rands)



■ Reserves per member (Accumulated funds per principal member)

Accumulated funds : Ave monthly claims (x)



■ Accumulated funds: Ave monthly claims



Ratings

3 Key areas to consider when selecting a medical scheme:

1. Price vs benefit / product offering
2. Service
3. Financial strength

Rating agency focuses on financial strength:

- Ratings reflect an independent opinion of a company's financial position, as well as how the financial position may change in the future (under reasonable & stressful scenarios)



Process of assigning ratings

Procedure

- Gathering of information, including historical operational & financial records, industry specific & economic data
- “Desk top analysis” – Relevant risks, financials & forecasts
- Meetings with management, in-depth information discussed
- Draft rating report compiled & forwarded to management
- Feedback from management obtained, a rating panel is convened & relevant issues discussed, ratings accorded
- Ratings communicated directly to management
- Ongoing monitoring & contact with management is crucial in maintaining the integrity of the ratings accorded



Credit ratings

Benefits of medical scheme ratings

- ❖ **Increased pool of members**
- ❖ **Increased distribution network** - Note: a number of leading intermediaries in SA wont place business with medical schemes that don't carry a minimum GCR rating.
- ❖ **Management benefit**
- ❖ **Useful in business development**



Medical scheme rating definitions

Claims paying ability (“CPA”) rating scale:

AAA - Highest CPA

AA band - Very high CPA

A band - High CPA

BBB band - Adequate CPA

BB band - Moderate CPA

B band - Speculative to a high degree

CCC - Scheme has been, or is likely to be, placed under order of the court

Notes:

Categories further subdivided by a +/-

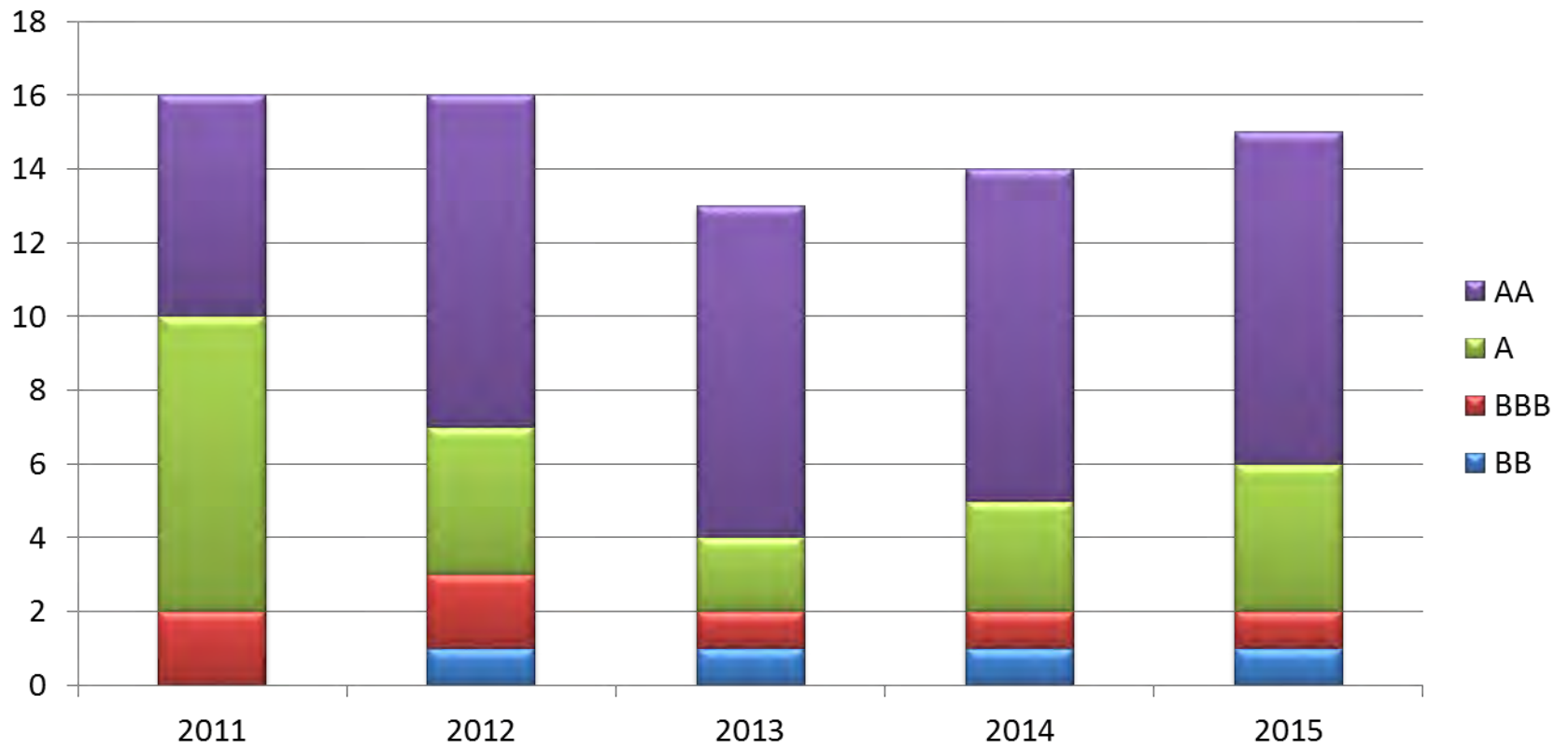
Industry risk ceilings

Rating watch, or positive or negative rating outlook



Credit ratings

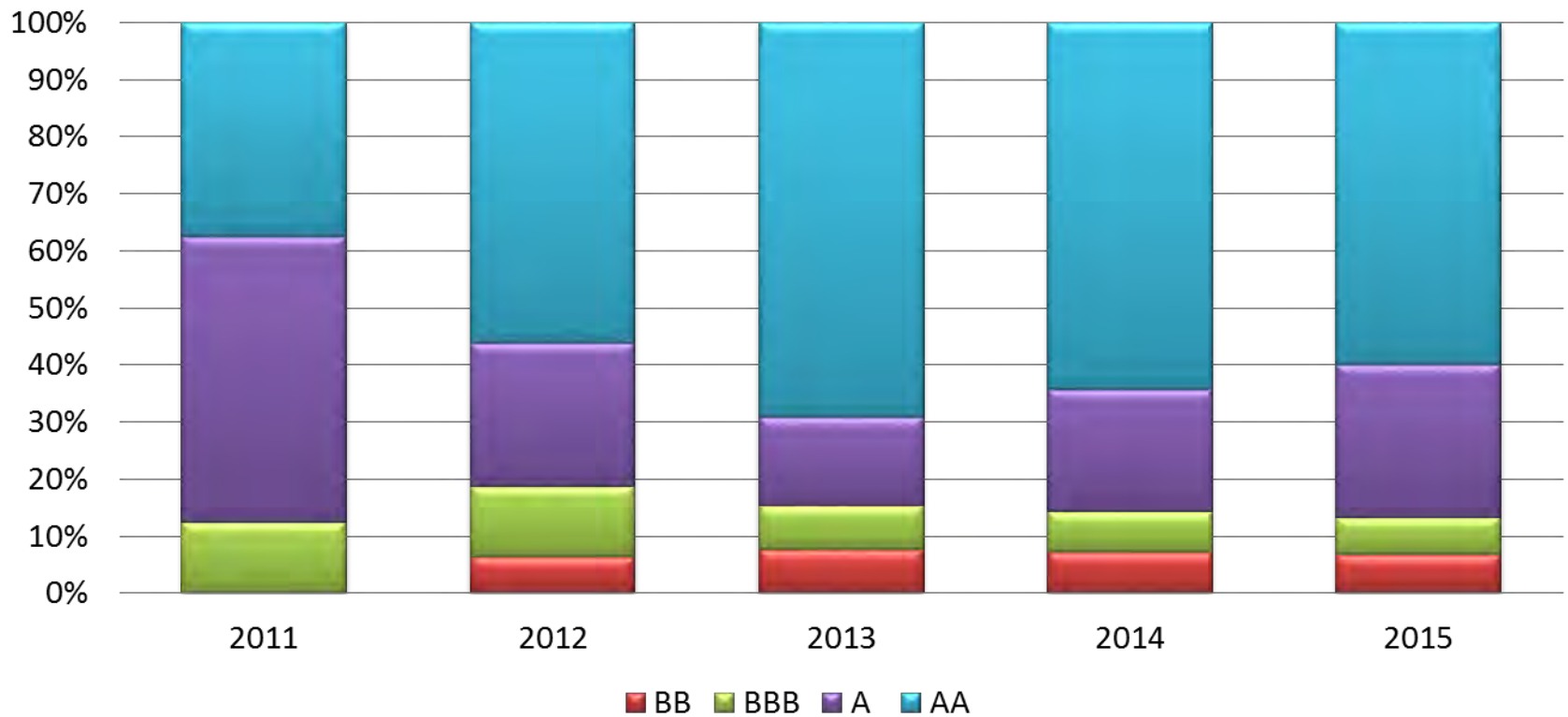
Ratings matrix (by scheme)





Credit ratings

Ratings matrix (by beneficiary)





Operating & regulatory environment

National Health Insurance

- Government has a long term horizon (NHI phased in over 14 years)
- Clarity so far only on “initial stage” (building and preparation) – increasing health budgets to rehabilitate public healthcare infrastructure (hospitals, nursing homes etc), bolstering human resource capacity
- Initial stage: general taxes will remain primary funding mechanism; thereafter funding uncertain (VAT and/or income/company tax)
- Risks: Role of schemes? Loss of younger, healthy members? Top up cover only?
- Short term: don't expect impact on private sector schemes/administrators
- Medium term: Opportunities for schemes/administrators? Service provider arrangements could be extended to upgraded public health institutions; Opportunity for schemes to build relationship with public sector; look at success of GEMS
- Long term: opportunities for schemes/administrators to be involved in NHI? Administrative aspect; existing platform; sharing of skills, data, expertise?
- Ultimately cost vs benefits/quality healthcare



Operating & regulatory environment

Prescribed Minimum Benefits

- 2011: unsuccessful court challenges by BHF i.e. scheme tariff vs invoiced cost
- CMS opinion unchanged: schemes must pay for PMBs in full at invoice price
- However, CMS has approached DoH regarding possible amendments to Medical Schemes Act, which could see some compromise?
- In the interim, PMBs expected to continue to drive elevated medical inflation (in particular hospital, medicine and specialist costs)
- These higher claims factored into contribution increases (spiral effect)
- Competition Commission's inquiry into rising medical costs (and system abuse) and the negative impact on affordability/sustainability of the industry – expected to be finalised in 2016.
- Positive findings would likely be beneficial to schemes and their members



Operating & regulatory environment

Demarcation

- Goal: Establish clear distinction between medical schemes & health insurance
- Address the risk of possible harm caused by s/t insurers drawing younger, healthier members away from medical schemes (“gap cover” impacting cross subsidisation)
- Regulations on demarcation between health insurance policies and medical schemes expected late 2015.
- While gap cover and hospital cash plan insurance is expected to remain, this must rather complement medical schemes as opposed to a negative effect
- Current vs future impact on schemes is uncertain, but not deemed significant



Outlook

- Overall - GCR has a stable outlook for the sector, expect ratings to generally remain sound
- Expect key financial metrics (solvency & liquidity) to be upheld
- Ongoing risk management interventions and enhanced management oversight is expected to continue delivering sustainable benefits & stable claims trends for foreseeable future
- Industry consolidation expected to continue
- Regulatory outlook presents certain challenges albeit unresolved



Closing

Thank you