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RESEARCH REPORT ON THE DEVELOPMENT OF A CLOSED MEDICAL SCHEME FOR PUBLIC SERVICE EMPLOYEES

JUNE 2003
Ref: DPSA 09/2002

EXECUTIVE SUMMARY

1. Overview

The DPSA tender 09/2002 is based on the overall objective *"To develop and implement a closed medical scheme arrangement for the Public Service that meets the criteria of equity, efficiency and differentiation according to the adopted framework*."

Toth Resources cc was appointed as lead consultant on the project in February 2003 in association with the Mahlati Consortium.

The State as employer has embarked on achieving a system of providing healthcare coverage to Public Service Employees that meets the criteria of:

- Equal access to the most extensive set of basic benefits under equitable remuneration structures;
- Efficiency in respect of costs and delivery of benefits;
- Options for those who wish to purchase more extensive cover.

This report has been compiled on the basis of the preferred model being a single restricted membership medical scheme.

The approach to this project has been the application of multi-disciplinary team to develop a framework for implementation. The current impasse in the medical schemes market has been addressed by a structure whereby the administrators are not in control of the Scheme, purchasing power is harnessed to achieve purchasing discounts and public sector facilities are included as providers of choice (where accreditation standards are achieved).

2. Analysis of Data

We received data from the following entities:

1. PERSAL
2. Government Employees Pension Fund (GEPF)
3. Medical Schemes

The data received has enabled us to analyse membership by factors such as age, gender, region, department and income. The data from the schemes will facilitate analysis by benefit option and family size as well as the analysis of claims experience for costing purposes.

Summary Statistics from PERSAL data:

The data indicates that 44% of employees do not have medical scheme cover. 88% of covered employees (50% of total employees) belong to 13 medical schemes as follows:

Medical Scheme	Total	Percentage covered employees	Percentage of total employees
Scheme A	112,628	20%	11%
Scheme B	86,683	15%	9%
Scheme C	56,555	10%	6%
Scheme D	32,976	6%	3%
Scheme E	32,272	6%	3%
Scheme F	28,977	5%	3%
Scheme G	27,277	5%	3%
Scheme H	25,781	5%	3%
Scheme I	23,392	4%	2%
Scheme J	19,935	4%	2%
Scheme K	18,276	3%	2%
Scheme L	17,385	3%	2%
Scheme M	15,979	3%	2%

Analysis of covered versus uncovered employees:

We have compared the distribution of employees according to their coverage status (i.e. covered or uncovered).

The average age of covered employees is 41 years and the average age of employees without cover is 42. This difference is not significant.

The distribution by salary indicates a significant difference in the distribution. The lowest salary bands appear to be attributable to part-time employees or contract workers. Employees may elect not to purchase cover as a result of coverage on their spouse's medical scheme. The distribution of employees without cover, however, indicates that affordability is a key factor for not taking up cover.

Contributions and subsidy:

We have calculated the average employer and member contribution from the PERSAL data provided for the Top 13 schemes as follows:

Medical Scheme	Average Employer Contribution	Average Member Contribution	% subsidy
Total	**855**	**636**	**57%**

The average subsidy is less than 67% as a result of members reaching the Rand amount maximum subsidy. On the basis of the data provided, 37.3% of employees have reached the maximum subsidy level.

The overall cost of the medical scheme subsidy can be compared to the previous analysis conducted in 2000 as follows:

	2000	**2003**	
Average Total Contribution	1,011	1,473	45.7%
Average Employer Contribution	643	850	32.1%
Average Employee Contribution	368	623	69.3%
Total Covered Employees	420,197	468,441	11.5%
Total Government Subsidy per annum Rm	3,242	4,776	47.3%

Notes:

- The average total contribution has been subject to annual increases for 2001, 2002 and 2003 (average of 13.4% per annum).
- The increase in the employer portion has been lower as a result of more employees reaching the Rand maximum.
- This has resulted in a higher increase experienced by members.
- The number of covered employees has increased by 11.5%.
- The combined effect of the inflationary increases and the increase in the number of covered employees has been to increase the total cost by 47.3%.

Summary of statistics from GEPF

The Pensioner data supplied has split the pensioners into four categories that are primarily based on the date that the pensioner went onto retirement. The pensioners in pensioner category A are fully subsidised and currently belong to Scheme N.

Pensioner category	Pensioner category description	1/3 level of subsidy	2/3 level of subsidy	5/6 level of subsidy	other level of subsidy	total pensioners
A	Pensioners retired prior to 1 July 1992				27,359	27,359
B	Pensioners retired between 1 July 1992 and 30 Nov 1993			8,108		8,108
C	Pensioners retired between 1 Dec 1993 and 30 Apr 1996	3,789	2,810	1,616		8,215
D	Pensioners retired between 1 May 1996		30,424		-	30,424
	No Allocation				794	794
		3,789	33,234	9,724	27,359	74,900

The pensioners have a 50:50 gender split and 54% of the pensioners are indicated as married. We are unable to determine if there are any other dependants. 63% of the members that are included in the GEPF data are pensioners retired before reaching age 60.

By taking the marital status we see that almost 54% of the pensioners are married.

Summary of statistics from Medical Schemes

We received data from the following Schemes:

Medical Scheme	Year	number members (age <61)	number members (age >60)	average age	average family size	average contribution
Scheme O	2002	207,654	11,383	44.49	2.65	1,496
Scheme P	2002	22,606	617	57.31	2.06	1,381
Scheme Q	2002	44	43	68.64	1.52	900
Scheme R	2002	12,937	495	41.71	3.48	2,352
Scheme S	2002	39,951	543	40.50	2.90	751
Scheme T	2002	1,974	1,001	59.96	2.78	2,373
Scheme U	2002	3,609	52	42.47	2.27	1,562
Scheme V	2002	76	5	39.05	3.12	837
Scheme W	2002	24,309	521	41.24	3.97	1,450
Scheme X	2002	29,443	1,313	41.42	2.63	nodata
Scheme Y	2003	31,365	679	37.92	2.49	nodata
Scheme Z	2002	58,852	27,631	58.43	1.77	917
Scheme AA	2002	23,871	836	41.27	2.88	1,011
Scheme BB	2002	10,648	55	40.47	2.88	1,004
Total data received		467,339	45,174	45.44	2.63	

The 467 339 members make up approximately 74% of total members (558 000 active employees+ 75 000 pensioners) currently covered. Based on the information received from the administrators 43% of these members are on the Medical Scheme

CC. Almost 10% of the members are older than 60. These members above 60 years of age are primarily distributed across 2 medical schemes namely Scheme DD and Scheme EE.

3. Benefit Design

The benefit structures have been developed to offer a range of alternatives to cater for employees with and without current coverage. The proposed designs are as follows:

Plan 1: Entry level option
This option is targeted at employees with no current coverage. It is based on a closed hospital network (i.e. benefits may be accessed at the network facility only). It includes chronic medication at the level of the Prescribed Minimum Benefits and the Primary Care benefits are offered through a capitated network arrangement. The network development is a combination of public and public/private facilities that meet the accreditation requirements.

Plan 2: Traditional option
This option is constructed on an open network model. Members may access both network and non-network facilities for hospital services. There is a co-payment of R1000 per admission for non-network facilities in order to encourage the use of network facilities where accreditation and contractual requirements should secure better levels of care at better rates.

Primary care benefits are offered through a set of benefits with financial limits at the provider of choice. This benefit has been modelled on the Scheme FF option which is the open scheme option with the greatest number of public service members.

Plan 3: New Generation option
This option is based on a savings account structure. The hospitalisation and chronic medication benefits are identical to Plan 2. Primary care benefits are covered up to financial limits and augmented by savings which roll over from year to year. The level of cover under Plans 2 and 3 is similar; however the benefit philosophy is different in order to accommodate current member selections.

Plan 4: Comprehensive option
We have proposed two alternatives for Plan 4. In each case the hospitalisation benefit is on an open access with higher levels of cover for chronic medication. The first alternative offers primary care benefits on the same basis as Plan 2 but with higher limits (Plan 4A). The second alternative offers primary care benefits on a similar basis to Plan 3 (with more extensive risk cover) and member savings (Plan 4B). Our recommended alternative is the savings basis as this better reflects the current plans purchased by employees at the higher levels of affordability.

The summary of financial limits per Plan is as follows:

	Plan 1	Plan 2	Plan 3	Plan 4A	Plan 4B
Hospitalisations					

Network coverage	100%	100%	100%	100%	100%
Out of Network	none	co-payment	co-payment	100%	100%
Annual limits	R500 000	R500 000	R500 000	R1 000 000	R1 000 000

Includes: Ward, theatre, consumables and Specialist services for hospital admissions

	Plan 1	Plan 2	Plan 3	Plan 4A	Plan 4B
Chronic Medicine					
Conditions	PMB	Extended	Extended	Extended	Extended
Coverage	Formulary	Formulary	Formulary	100%	100%
Limit per beneficiary	R 6,000	R 6,000	R 6,000	R 10,000	R 10,000
Limit per family	R 12,000	R 12,000	R 12,000	R 20,000	R 20,000

	Plan 1	Plan 2	Plan 3	Plan 4A	Plan 4B
Primary Care	CAPITATION		SAVINGS		SAVINGS
Visits per beneficiary		R 1,500	R 400	R 2,500	R 400
per family		R 5,000	R 1,200	R 6,000	R 1,200
Acute per beneficiary	Formulary	R 2,000	R 700	R 2,750	R 700
per family		R 6,000	R 2,600	R 8,000	R 2,600
Dentistry per beneficiary	Basic only	R 1,500	R 400	R 3,000	R 2,500
per family		R 6,000	R 1,200	R 6,000	R 4,000
Optometry per beneficiary	Formulary	R 1,500	Nil	R 2,000	R 1,000
Limit on frames		R 450		R 800	R 800
Auxiliary per beneficiary	Defined	R 1,000	Nil	R 2,500	R 500
per family	Services	R 3,000		R 6,000	R 1,000

Transition Matrix

We have assessed the distribution of public service employees across current benefit options for those schemes which supplied the relevant data. We have categorised these benefit options by type in order to generate a transition matrix to the proposed benefit options.

Benefit level		number of members	average contribution	average age	number members >60yrs	average family size
Traditional	Medium	224,277	1,923	42.52	12,759	1.98
Traditional	Low	0	0	0	0	0
New Generation	Comprehensive	108,619	3,246	50.45	28,169	2.45
New Generation	Standard	28,562	1,695	42.39	682	3.00
New Generation	Core	47,595	1,124	41.72	1,711	2.82
Hospital	Comprehensive	0	0	0	0	0
Hospital	Standard	14,980	823	39	301	2.84
Managed Care		276	2268	43.3	9	1.96

The application of the transition matrix to the current PERSAL membership (excluding current restricted schemes) gives the following expected profile per benefit option:

	Benefit Plan	Number of members	Average age	Average family size	Average notch (salary pa)	Average notch (salary pm)	Average salary level
1	Entry level	354,137	42.00	3.00	53,067	4,422	6.43
2	Traditional	202,259	41.85	2.74	77,059	6,422	6.26
3	New Generation	211,345	39.76	2.68	75,766	6,314	6.19
4	Comprehensive	55,517	44.49	2.70	107,190	8,933	7.49
		823,258					

The combination of the anticipated member profile, the level of benefits and the claims experience yields the pricing for the benefit plans.

The above membership distribution can be reconciled back to the total PERSAL data as follows:

PERSAL Total	983 510
Restricted scheme	32 976
Restricted scheme	56 555
Members not taking up cover	70 721
Net membership	823 258

The combination of the anticipated member profile, the level of benefits and the claims experience yields the pricing for the benefit plans.

Cost Projections

Savings assumed:

We have used the following assumptions to develop a realistic projection for costs under the benefit options. The use of the network facilities is compulsory under Plan 1 and voluntary under the other plans with Plan 2 and Plan 3 offering an incentive via a co-payment for admissions to non-network facilities.

For medicine costs we have made some provision for access to COMED pricing. This is more likely to be possible on Plan 1.

The savings assumed are summarized as follows:

	Plan 1	Plan 2	Plan 3	Plan 4
Use of network	100%	30%	20%	10%
Network saving hospitalization	20%	20%	20%	20%
Network saving specialists	40%	40%	40%	15%
Hospital co-payment		5%	5%	
Use of comed	50%	30%	10%	
Comed saving	55%	55%	55%	55%

Benefit costs:

On the basis of the methodology and assumptions outlined in the report, we have developed cost projections per plan as follows (Rands per member per month for single members for 2003):

	Plan 1	Plan 2	Plan 3	Plan 4A	Plan 4B
General Practioners - OUT of Hospital	80	58		72	
Specialists - OUT of Hospital		67		170	
Specialists - IN Hospital	25	43	41	39	40
In Hospitalisation Benefits	165	213	213	325	330
Chronic Medication	35	87	82	162	162
Acute Medication		119		132	
Dental	8	39	44	62	50
Optometry	8	29		35	
Other	20	23	63	36	36
Maintenance in risk			162		180
Total	341	678	604	1034	798

Contribution requirements:

In order to convert these costs to contributions we have used the following assumptions:

- Administration costs of R110 per principal member per month on Plans 2 to 4 and R80 per principal member per month on Plan 1.
- A 5% loading for contribution to reserves.
- Savings accounts of 18% of gross contributions for Plans 3 and 4B.

This gives cost requirements per Plan as follows for 2003:

	Risk			Savings			Total		
	Principal	Adult	Child	Principal	Adult	Child	Principal	Adult	Child
Plan 1	423	338	165				423	338	165
Plan 2	767	575	211				767	575	211
Plan 3	682	512	188	150	113	42	832	625	230
Plan 4A	1,215	911	334				1,215	911	334
Plan 4B	979	734	268	215	162	60	1,194	896	328

The conversion to salary-related contribution tables is shown in section 4.1.

The above contribution requirements give an average contribution per Plan, based on the membership derived from the transition matrix, as follows:

Rands per member family per month (2003)

	The Scheme			2003 coverage
	Risk	Savings	Total	Current Total *
Plan 1	893	-	893	-
Plan 2	1,416	-	1,416	1,455
Plan 3	1,237	275	1,512	1,406
Plan 4A	2,218	-	2,218	2,256
Plan 4B	1,786	394	2,180	2,256

*The current contribution levels on the benefit options that the members are currently covered.

Notes:

1. Plan 3 has been deliberately priced to prevent anti-selection against Plan 2. A large portion of this excess is in the savings portion which accumulates for the members' account.
2. Benefit levels are, on average, higher under the proposed benefits. Thus costs can be reduced by addressing benefit levels and realizing savings in excess of those assumed in section 3.5.4.1

Summary of recommendations

1. The Scheme offers a range of benefit plans to cater for both the employees with existing coverage and the employees who do not have access to cover as a result of affordability constraints.
2. The number of benefit options is limited to four with the most comprehensive option being structured on a savings account basis.
3. Primary care coverage is offered across all options at scheme risk (although subject to financial limits and, in some cases, augmented by savings contributions).
4. All options provide comprehensive hospital coverage at network facilities. Only the comprehensive option offers complete open access for hospital providers. Members on Plans 2 and 3 are incentivised to use network facilities via a co-payment per admission to non-network facilities.
5. The Hospital network should be constructed as a combination of PPI, private hospitals and other facilities (such as mining hospitals) to ensure that all eligible members have access to a network facility. Where private hospitals are contracted, this should be based on regional access requirements rather than including all hospitals in a particular group.
6. The BHF PPI process is highly relevant to the Scheme development and should be monitored.
7. A capitation arrangement can be pursued for the primary care element of the entry level option. This will be based on defined benefits.
8. A capitation arrangement is unlikely to be appropriate for the hospital network at present and so a global fee and discounted fee for service basis. Hospital contracts need to be specific provision for associated costs (such as specialists, anaesthetists, radiology and pathology).
9. The managed care service providers (linked to administrators) will provide a gatekeeper role for options where primary care is not operated on a capitated basis.
10. The disease management programme includes a drug formulary and management process on agreed protocols.

The contribution levels proposed include a modest provision for network savings. As further contractual savings materialise, future contribution increases will be dampened.

4. Contribution tables and employer subsidy

The salary levels for the contribution tables have been set to achieve as uniform a distribution of membership across the salary bands as possible. It is important to ensure that the risk of contributions collected falling below the budgeted level is reduced. This has been achieved by limiting the differential between salary bands.

The assumed membership distribution is as follows:

Salary per month	Principal Members
Plan 1	
< 2501	61,615
2501 - 4500	179,557
4501 - 6500	77,604
6501+	35,361
Overall Plan 1	354,137
Plan 2	
<4000	48,695
4001 - 6000	71,106
6001 - 8000	60,023
8001 +	22,435
Overall Plan 2	202,259
Plan 3	Risk
<4000	61,317
4001 – 6000	68,434
6001 – 8000	62,318
8001 +	19,277
Overall Plan 3	211,345
Plan 4	
Overall Plan 4	55,517

The differentials per salary band have been set at 7.5% to 15% with a higher differential for the highest salary band on Plan 1 to discourage migration by higher risk members.

The proposed contribution tables set to yield the required monthly contribution amount as determined above are as follows:

	RISK			**SAVINGS**			**TOTAL**		
	Principal	**Adult**	**Child**	**Principal**	**Adult**	**Child**	**Principal**	**Adult**	**Child**
Plan 1									
< 2501	381	305	149				381	305	149
2501 - 4500	410	328	160				410	328	160
4501 - 6500	440	352	172				440	352	172
6501+	528	422	206				528	422	206
Plan 2									
<4000	710	530	160				710	530	160
4001 - 6000	760	570	170				760	570	170
6001 - 8000	830	630	180				830	630	180
8001 +	960	720	210				960	720	210
Plan 3									
<4000	630	470	140	150	113	42	780	583	182
4001 - 6000	670	510	150	150	113	42	820	623	192
6001 - 8000	740	560	160	150	113	42	890	673	202
8001 +	850	640	190	150	113	42	1000	753	232
Plan 4A									
All Salaries	1,215	911	334				1215	911	334
Plan 4B									
All Salaries	979	734	268	215	162	60	1,194	896	328

These contributions have been set on the basis of membership by employees. The addition of a 10% pensioner component to the Scheme could increase the contributions by a factor of 5%.

On this basis the contribution costs associated with the first year of membership (at 2003 rates) can be summarised as follows:

		R per employee per month			**Rm**		
	Members	Average Risk Contribution	Average Savings Contribution	Total average contribution	Total Risk Contributions	Total Savings Contributions	Total Contributions
Plan 1	354,137	893.40	-	893.40	3,797	-	3,797
Plan 2	202,259	1,416.16	-	1,416.16	3,437	-	3,437
Plan 3	211,345	1,237.00	274.77	1,511.77	3,137	697	3,834
Plan 4	55,517	1,786.13	393.94	2,180.07	1,190	262	1,452
Total	823,258	1,170.24	97.10	1,267.35	11,561	959	12,520

We have proposed an employer subsidy linked to the contribution tables. This can be set to achieve similar overall costs as the current subsidy basis, but this would lead to a reduction in the subsidy level for currently covered employees. A subsidy basis which preserves the current benefits is as follows:

The contribution subsidy for Plan 1 is set at 75% of the contribution for salary category R4501 to R6000 on Plan 1.
The contribution subsidy for Plans 2 to 4 are set at 64% of the contribution for salary category R6001 to R8000 on Plan 2.

	Principal	Adult	Child
Employer Subsidy			
Option 1	330	264	129
Other Options	479	360	108

Summary of recommendations

1. The contributions for the benefit plans are differentiated on the basis of Principal member, Adult dependant and child dependant with a maximum charge of 3 children.
2. Salary differentiation is included on Plans 1 to 3 with the highest salary band on Plan 1 set as a disincentive for currently covered employees to buy-down. The objective is to achieve a stable member distribution between benefit plans.
3. The employer subsidy is related to defined contribution levels. Members will be responsible for the cost of buying up to more comprehensive cover.
4. The level of the employer subsidy can be determined based on funding available. The subsidy per employee can range from R556 to R850 per month.
5. The cost implications presented do not include existing restricted schemes in the public service membership.

5. Scheme Infrastructure

This report provides an overview of the IT structure and interfaces and proposes the key features of the administration model. Once the principles proposed have been ratified, a tender process will be conducted for the:

- administration services; and
- development and management of the central data base and related scheme functions.

The key recommendations for the proposed IT and administration infrastructure for the closed medical scheme for public service employees are as follows:

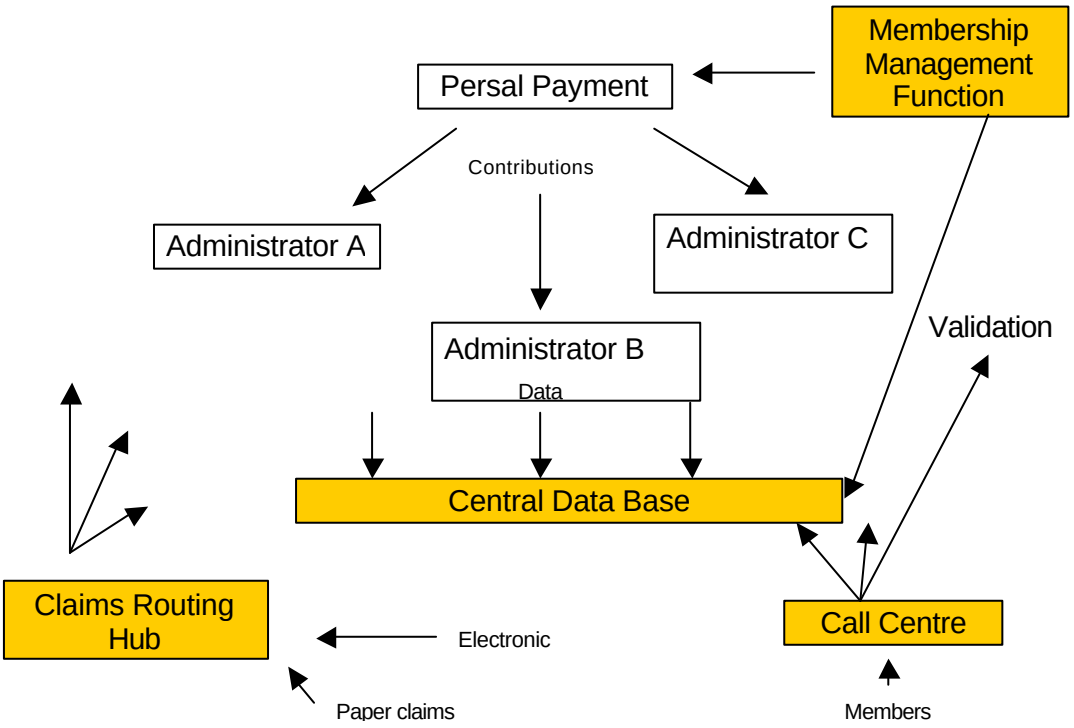
1. A Multiple Administrator Model is adopted under a Single Scheme structure.

   The administrators would perform the full administration services in respect of contribution collection, processing and payment of claims, and managed health care.

   A key principle is that the membership is not affected by the administration allocation. This means that the members must experience consistent service from all administrators and their interface for correspondence, claim submission and enquiries is with the Scheme and is not dependent on the administration allocation.

2. The Scheme will require the following infrastructure to be under management:
   - Membership Management
   - Central Data Base
   - Claims Routing Hub
   - Call and query resolution centre

   The interface between these functions (and the administrators) is illustrated as follows (the highlighted functions are under the direct control of Scheme management):



3. The scheme employs expertise to manage the administration contracts, monitor the financial position and scheme experience and provide reporting to scheme management.

4. Administration services are grouped with managed care and disease management services for contractual purposes.

5. Administration contracts are distributed on a departmental basis.

We have included recommendations regarding the services required from a strategic consultant for the implementation and management of the Scheme.

An implementation budget will be required to establish the Scheme infrastructure prior to the implementation date.

The contributions presented in Chapter 4 have included a provision of R110 per member family for administration expenses. This translated to approximately 10% of the risk contributions to the Scheme (2003 rates).

Our estimation is that this should be allocated as follows:

	% of contribution	Per member per month	Total Rm per annum
Administration fees	4.1%	48	474
Scheme management direct expenses	0.9%	10	99
Scheme infrastructure	2.6%	30	296
Infrastructure management	1.4%	16	158
Strategic partners	0.3%	4	40
Miscellaneous	0.2%	2	20
Total	9.4%	110	1,087

Notes:

1. Scheme management includes costs associated with the board of trustees and related functions.
2. Scheme infrastructure relates to the maintenance of scheme systems.
3. Infrastructure management relates to staff costs associated with the scheme infrastructure.
4. A portion of the scheme infrastructure and management budget may be allocated to outsourced contracts.

Summary of recommendations

- The scheme is administered via a multiple administrator model. The model has been constructed to allow seamless administration from a member perspective i.e. the member interacts with the Scheme rather than the administrator. Administrators will compete on the basis of defined benchmarks and membership can be transferred based on performance (or lack thereof).
- The Scheme retains control of central functions which may be provided internally or outsourced. The functions include:
  - i. Membership management
  - ii. Central database
  - iii. Claims routing
  - iv. Call centre
- The administration tender process should be based on service requirements, IT interface and DPSA requirements. The administration fee basis is set on a uniform basis across administrators and includes a (retained) bonus element for service standard achievement. The service standards will be measured and benchmarked using the central database.
- An implementation budget will be required to fund the development of the retained functions from a staffing, hardware and software perspective.
- Contracted services will be required to assist scheme management with functions such as
  - i. Actuarial
  - ii. Statistical analysis
  - iii. Protocol development
  - iv. Medical management

6. Scheme Management and Governance

The Scheme will be registered under the Medical Schemes Act as a restricted membership scheme. The scheme will be required to have a Steering Committee at implementation and then elect a Board of Trustees.

Reserving Strategy

The regulations to the Medical Schemes Act effective January 2003 clarified the requirements for new schemes to be as follows:
The ratio of accumulated funds to gross contributions is subject to a minimum of:

(a) 10% during the first year after the scheme was registered;
(b) 13.5% during the second year;
(c) 17.5% during the third year;
(d) 20% during the fourth year; and
(e) 25% thereafter.

It is proposed that the strategy for building reserves to be adopted by the Scheme is as follows:

i. A loading in member contributions to a maximum of 5%.
ii. The provision of a bond issued by the employer to cover a maximum of 25% of the net assets to meet the total minimum reserving requirement at any time. This bond would need to be recognised by the Registrar of Medical Schemes as an admissible asset.
iii. The injection of reserves obtained from other schemes where employees currently constitute a significant proportion of membership. This will require the co-operation of the schemes identified and may require the intervention of the Registrar of Medical Schemes.

Summary of recommendations

1. An interim Steering Committee is required to proceed with the Scheme development. The Steering Committee will adopt the fiduciary responsibilities of the Trustees until such a board is elected.
2. The Steering Committee will need to oversee the implementation process including contracting with service providers, member communication and registration of the Rules.
3. The Scheme reserving strategy is based on sourcing reserves from:
    i. Loading in contributions
    ii. Reserves transferred from other Schemes
    iii. Bond issued by the employer
4. The input from the Council for Medical Schemes on the governance and reserving strategy is required.
5. All Scheme funds will be held in the name of the Scheme with separate accounts operated by the appointed administrators.
6. An accreditation body is required for the establishment of the network. This should be constructed in co-operation with the Department of Health.

7. Post-retirement assistance

The State as employer currently offers post-retirement medical assistance by means of a contribution subsidy after retirement.

The current legal arrangement with the pensioners in receipt of subsidies does not permit a compulsory transfer to the Scheme for Public Service employees. This means that a policy is required to encourage these members to transfer. This will require the balancing of the following effects:

- Adding pensioner members to the Scheme will increase the costs of contributions;
- The cost of subsidising pensioners will be reduced if Scheme contributions are lower than open scheme contributions.
- The present value of future subsidies can be reduced by the exposure to future savings through provider contracting.

At the same time, the increased access to medical scheme coverage will increase the cost of future subsidies as more employees will be retiring with medical scheme coverage. This will require the revision of the post-retirement subsidy policy to ensure that it is affordable and adequately provided for.

A further strategic consideration is that if the existing (and future) pensioners are not provided for within the Scheme, there is additional risk placed on the open scheme market which will be forced to accommodate these pensioners (in terms of current legislation).

We have recommended as follows:

- The most urgent requirement is to address the costs of the non-contributing members on Scheme GG. The contractual arrangements with these members should be investigated to determine whether they can:
  - Be moved to the new Scheme;
  - Have their limits capped under the existing arrangement.
- The next issue is the subsidy policy for future retirees. This needs to be documented and agreed at the same time that the employee subsidy policy is determined. The level of this subsidy should be consistent with the subsidy during employment although the level may be set according to available resources.
- The third issue is the balance of current pensioners. Some of these pensioners will be affected by the amalgamation process described under the reserving strategy. We recommend that an initial option is provided to these pensioners to move to the Scheme and then repeated one year after implementation. The option should not be open-ended as this may encourage anti-selection.
- A further issue arises in that pensioners may have retired but not taken up membership. This risk could not be evaluated from the data provided but should be assessed.

- We are concerned about the precedent which may be set by the acceptance of groups such as the Transmed pensioners. This is an additional burden to the Scheme and it would be difficult to turn down future applications if this one is accepted.

8. Interim HIV Programme

It is our view that an interim programme is appropriate for the following reasons:

1. There is an urgent need to enroll employees on to such a programme and a phased implementation of the scheme may delay the process further.
2. The implementation of such a programme is a very useful dry-run for the scheme implementation.
3. The providers of such services are specialized and so a separate contract for HIV/AIDS is likely for the scheme as well.
4. Although employees currently covered by medical schemes have access to AIDS benefits, there is a very low registration rate for these benefits.

This development is therefore conducted on the basis that the interim programme will be incorporated into the scheme once the scheme is in place. This means that the tender process will include provision of services to the scheme once it exists.

On this basis the ***indicative*** cost of providing a programme to the ***employees without cover*** is as follows:

R'000 per annum	Wellness CD4>350	Wellness CD4<350	Wellness Total	ART	Grand Total
Management	4,100	2,300	6,400	3,800	10,200
Pathology	5,700	3,100	8,900	28,700	37,600
Medication	2,500	5,300	7,800	74,900	82,800
	12,300	10,800	23,200	107,500	130,600

This is in the order of R307 per employee per annum and R1537 per infected employee per annum. These costs will inflate year by year as the prevalence progresses. These costs do not include dependants.

These costs do not include infrastructural costs associated with programme delivery. They can be considered as conservative as enrollment rates are likely to be low when the programme is first implemented and then build up over time as benefits become evident.

We suggest a combined approach in employing external service providers to assist in implementing this programme. This can be initiated via a workshop of the service providers who made submissions (similar to the multiple administrator model).

Steps required:

1. Determine services to be included in programme;
2. Workshop of service providers;
3. Refine programme budget;
4. Set up implementation programme;
5. Develop education programme;
6. Establish infrastructure for delivery (possibly through pilot sites);
7. Implement programme.

9. Implementation Outline

The suggested next steps can be summarized as follows:

Preliminary

1. The decision to proceed: agreement from all stakeholders
2. Clarification of objectives to finalise benefit design and infrastructure.
3. Taking an Inventory of Internal Resources to assess initiatives which can contribute to the implementation process.
4. Determine the role and requirements for an internal administrator and related functions controlled by the Scheme.

Developmental

5. Define Incentives and Penalties for contractual arrangements
6. Provider workshops to optimize interests of all parties.
7. Development of measures for monitoring and benchmarking
8. Establish Accreditation and auditing process
9. Dry runs to test provisions
10. Training workshops

Implementation

11. Project planning
12. Pilot Study