
**COMMENTS ON THE DISCUSSION
DOCUMENT ON THE PROPOSED TAX
REFORMS RELATING TO MEDICAL SCHEME
CONTRIBUTIONS AND MEDICAL EXPENSES**

**BY THE
PRIVATE HEALTHCARE FORUM
(PHF)**

21 September 2005

Please note:

In the time available for comment, it cannot be asserted that this commentary represents a fully mandated view of all the members of the PHF. However given that qualification, representatives from the PHF tax subsidy working committee and members of the PHF would wish to be afforded the opportunity for enlarging on the views set out in this document and other comments where necessary.

If there are queries with this document please contact:

The Private Healthcare Forum

Tanya Vogt (Director of the Secretariat)

Tel: +27 11 325 4559

Fax: +27 11 325 5791

Cel. +27 83 607 3128

E-mail: phf@tokiso.com

CONTENTS

	PREAMBLE	3
1	INTRODUCTION	5
2	BACKGROUND	7
2.1	The current tax system	7
2.2	Tax treatment of other medical related expenses or benefits	7
3	DISCUSSION	8
3.1	Shortcomings of the current system	8
3.2	Government policy objectives	9
3.3	Proposed amendments	10
4	FINANCIAL AND DISTRIBUTION IMPLICATIONS	15
5	CONCLUSION	16

PREAMBLE

The Private Healthcare Forum (PHF) was established in 2003 as a voluntary organisation to represent the interests of the private healthcare sector and to facilitate the contribution of the private healthcare sector to the overall health system. It is intended that the PHF be used as a platform to articulate sector views and opinions in the interests of sustainable and quality healthcare in the country. The Forum's current members include:

The Board of Healthcare Funders; The South African Medical Association; Hospital Association of South Africa; Innovative Medicines South Africa; The Pharmaceutical Manufacturers' Association of South Africa; The National Association of Pharmaceutical Manufacturers; The South African Medical Devices Industry Association; The South African Dental Association; The National Pathology Group; The South African Society of Physiotherapy; The Pharmaceutical Society of South Africa; The Self-medications Manufacturers Association of South Africa and the Chiropractic Association of South Africa.

The Vision and Mission statements of the PHF are presented below to offer a context for the commentary submitted in this document:

Vision

The PHF stands for:

- Equitable access for all to a minimum package of essential health care services that are affordable within the economic constraints of the country;
- Freedom for citizens to acquire healthcare services in excess of the essential package;
- A regulatory and fiscal framework that promotes sustainability through market efficiencies and continuing investment;
- Continuous and efficient access to the most cost-effective technologies, methods and products available globally;
- Synergy between the public and private healthcare sectors that leads to the efficient distribution and use of resources;
- Continuous improvements in healthcare outcomes through on-going research, education, and information management;
- Transformation towards a sector characterised by:
 - ✓ Equitable access to quality services based on necessity;
 - ✓ Ownership, management and employment structures that reflect the demographic profile of the population.

Mission**The PHF strives to:**

- Enhance the relationship between private sector stakeholders and government through the exchange of information and views relating to matters of policy and regulation;
- Recommend sustainable solutions to address market inefficiencies that impact adversely on the growth and sustainability of the health sector;
- Promote the role of the private health sector within the national health system envisaged by the government;
- Provide a channel for constructive engagement between its members and stakeholders on matters relating to the design and implementation of a Transformation Health Charter;
- Build confidence in the private health sector through informed engagement with the media and the investment community.

The objective of this submission is to constructively highlight certain issues and possible undesired consequences that may occur as a result of the proposed Tax Reforms that have been suggested in the Discussion Document.

This commentary has been structured and numbered in the same manner as the Discussion Document so as to make cross-referencing easier.

1. INTRODUCTION

The 2005 report of the Council of Medical Schemes¹ shows that membership has remained static at about 6.9 million beneficiaries for the past few years. In 2004, while principal members increased by 1.1%, dependants dropped by 1.48%.

Expenditure data from the Bureau of Market Research (BMR) indicates that at least R16,7 billion is spent by consumers outside of medical insurance/medical schemes sector. This cash expenditure indicates that many people pay direct for medical expenses via either the private or public sector. According to Schussler and Kruger (2005)² the R16,7 billion expenditure represents at least 3 million people. They go on to say that "It is safe to assume that the bulk of the out of pocket expenditure occurs in the private sector and this indicates that a large percentage of the *uncovered* population can pay something towards their health care needs".

Table 1 shows the cash expenditure in context of other private and public health expenditure.

Table 1: Expenditure redone taking consumer cash expenditure into account.

	Public	Private	Total
Cash expenditure. (R Bn)	8.35	8.35	16.7
Government expenditure (R bn)	38.6		38.6
Medical insurance expenditure (R Bn)		45.3	45.3
Total Health Expenditure			100.6
Number of people (in millions)	36.5	10	46.5
Expenditure per person in actual rands	1286.3	5365.0	

Sources: BMR, Government budget data, CMS, and RAIN estimates
Extracted from the paper by Shussler and Kruger³.

In light of the above analysis that shows the potential for growth in the medical scheme sector, the PHF supports the following tax reform objectives:

- To encourage broader medical scheme coverage.
- To extend the tax benefit to self-employed individuals.
- To achieve a more equitable tax treatment.

¹ Council for Medical Schemes Annual Report 2004-5

² Schussler, M. and Kruger, E. Contextualisation of the Health Charter Demographics & health spending in SA. 5 August 2005.

³ Schussler, M. and Kruger, E. Contextualisation of the Health Charter Demographics & health spending in SA. 5 August 2005.

For this reason, the PHF supports an approach which:

- Provides complete tax relief for more affordable medical aid packages for low and middle-income families.

However, the PHF expresses reservations regarding an approach that:

- Aims to restrict benefits for more expensive packages, and
- Removes the “tax-induced reduction in the marginal price of more expensive medical scheme options”

In particular the PHF cautions against an approach that impacts negatively on the viability and sustainability of the private health sector by adversely affecting the following key cross-subsidies established within the medical scheme sector:

- Between healthier and sicker persons.
- Within more comprehensive benefit options in favour of promoting the selection of more limited options, as this may result in dilution of risk pools which in the long term will place upward pressure on medical scheme expenditure

2. BACKGROUND

2.1. The current tax system

2.1.1.A key advantage of tax exemption on the first two-thirds of an employer's contribution (albeit limited by the 20% limit on tax deductibility) is that the employee becomes medically self-funded and is therefore not a burden to the State. Reforms should aim to preserve this advantage both directly and indirectly.

2.1.2.The following advantages associated with the current tax deductibility provisions that should be preserved are:

- Full assistance to persons older than 65;
- Significant assistance for handicapped persons;
- Assistance for all other persons if medical expenses are significant in relation to their level of earnings.

2.2. Tax treatment of other medical related expenses or benefits

2.2.1. The following elements of current tax treatment require revision because they are inconsistent with the current tax treatment of medical scheme contributions, and do not reflect a policy of encouraging persons to pay for their own health services (if they are able to do so):

- Workplace medical treatment of the dependants of employees is not deductible in the hands of the employer;
- Employer subsidised treatment of employees and their dependents at a place other than at the workplace will attract fringe benefits tax.

3. DISCUSSION

3.1. Shortcomings of the current system

PHF recognises the adverse affect of the “tax wedge” pertaining to low-income persons. This anomaly must be removed. Furthermore, pre-funded medical care is less likely to be as high on a low earner’s list of priorities as food, shelter and transport for example. This increases the need to encourage employer support for such expenditure at these levels.

3.1.1.The fact that high-earners benefit more by selecting more expensive packages is not in itself an adverse outcome. This is more likely to arise because these packages offer more comprehensive and necessary medical benefits, and because the contribution tables have been adjusted upwards for higher earners to cross-subsidise low earners.

More costly packages also impact more significantly on discretionary income, and are unlikely to be selected simply because the tax concession is retained at a constant percentage.

An undesirable consequence of reducing the subsidy at these levels is that high earning persons with chronic “first world” conditions may be forced to take out less comprehensive packages and may be forced to accept less effective treatment. In some cases this may force them to avoid preventive treatment and default to costly medical treatment.

3.1.2.It is desirable to improve the affordability of medical scheme cover for low earners. A more appropriate tax structure should be found than the current approach.

3.1.3.The taxable nature of employer-provided on-site medical treatment for dependants of employees must be corrected.

3.1.4.PHF does not believe that the increases in medical scheme expenditure can be materially ascribed to the current tax subsidy system. The cost spiral is a separate issue that needs to be addressed in other ways.

3.1.5. The anomalous treatment of employer expenditure for employee and dependant medical services off-site should be corrected.

3.2. Government policy objectives

The PHF aligns with the following health care related fiscal policy objectives:

- To encourage improved medical scheme coverage.
- To provide affordable medical treatment for most South Africans.
- The harmonisation of tax treatment of medical expenditure by employed persons, self-employed persons and firms into a single consistent framework.
- Risk-pooling.
- All persons should ideally be covered by a medical scheme.
- Employers should be encouraged to supply health services for employee and their families where the medical scheme alternative is unaffordable.
- Beneficial treatment of medical scheme contributions should be retained (especially in the absence of mandatory cover).
- Additional tax relief must be found for low earners to lower the cost of basic medical scheme benefits and facilitate buy-up to more comprehensive benefits.
- To assist persons who are exposed to a costly medical catastrophe (expenditure that is high in relation to earnings).
- To assist elderly and handicapped persons.

The PHF expresses reservations with an approach that aims to:

- Curtail the selection of expensive packages (especially where these facilitate access to comprehensive cost-effective care).
- Encourage buy-downs, especially where this translates into deferred care and subsequent exposure to avoidable costly treatment.

In the event that the impact of the proposed reforms is to cause buy-downs by the higher income individuals, this is likely to have two negative implications:

- ✓ Medical schemes will lose a potential revenue cross subsidy between higher and lower earners and;

-
- ✓ The selection of less comprehensive packages could lead to compromised care with a greater risk of hospitalisation and even a possible higher resulting claims experience in the long term

Both of these negative consequences are likely to translate into increased premiums for the lower and middle income groupings in the long term.

The PHF stands for a sustainable health system that benefits from cross-subsidies between high and low earners, and between healthier and sicker persons. Policy should not have the undesirable consequence of eliminating comprehensive medical scheme benefits that lead to the promotion of appropriate and holistic healthcare delivery. It should also not cause persons to opt out of the pre-funded market in favour of self-insurance. The subsequent tax deductibility of catastrophic care expenses does not safeguard a person from financially crippling events to the extent that a pre-funded healthcare benefit does.

3.3. Proposed amendments

3.3.1. The PHF offers the following comments regarding the implementation of a monetary cap per beneficiary:

- The extent to which the cap improves affordability for low and middle-income earners is welcomed. However, PHF questions whether the resulting tax concession will be large enough to cause low earners to join medical schemes. The low marginal tax rate and low disposable income pertaining to low earners could largely dilute the real impact of the more favourable tax concessions proposed.
- The idea of extending the tax free contribution to each dependant is welcomed because it may help to partially reverse a medical scheme membership trend towards fewer covered dependants. This is more likely to have a meaningful impact in the middle-income categories than in the low earner categories due to the higher average tax rate and higher disposable income enjoyed at the middle-income level.

-
- The extent to which the cap reduces affordability for high earners is regrettable. More specifically the level at which the tax-free employer contribution is set will have direct bearing on the following:
 - ✓ The choice of options, regardless of the income category of the individual. If the levels are too low, less comprehensive benefits may be favoured to the detriment of treatment quality and timeous access to necessary care. Pressure on disposable income is not likely to have a significant impact on the cost of healthcare delivery.
 - ✓ An erosion in cross subsidies between higher and lower earners and between healthier and sicker persons, especially if the annual adjustments do not reflect appropriate medical cost escalation attributable to factors such as technology enhancement, demographic changes and epidemiological shifts, for example.
 - ✓ The number of covered dependants, which is also a function of the disposable income of the principal member.
 - A higher cap for the first and second beneficiaries is favoured and therefore Option 1 is favoured over Option 2, because:
 - ✓ This tends to be more reflective of claiming patterns of the principal member and an adult dependant.
 - ✓ It is essential to retain the participation of the breadwinners in each family who contribute to the health of other dependants through access to food and shelter, for example.
 - ✓ Compared to the lower cap of R300 per beneficiary, the R500 cap will reduce the likelihood of high risk members buying down to less comprehensive packages.

However there is a risk that families with more than two beneficiaries will join different schemes in order to increase the total value of the tax-free benefit. This can be overcome if the R500 cap is allowed for all adult beneficiaries and the R300 is allowed for all child dependants. Alternatively an average rate could be found for all beneficiaries that is higher than R300 but lower than R500.

-
- Reforming the current tax system needs to be done in a manner that encourages employers to become more involved in post retirement medical scheme funding.

3.3.2. The PHF views the provision for additional medical expenditure as commendable, but the point must be made that these expenses will be incurred before any tax benefit can be obtained. In the case of a medical catastrophe this will therefore provide little, if any, assistance and leave the person exposed to financial hardship. Therefore, it is better to facilitate participation in a pre-funded health financing system.

For this reason, PHF favours an approach whereby all medical expenses including contributions to medical schemes, should qualify for income tax deductibility. In this regard **Option B** is favoured.

However, the raising of the threshold is regrettable. If it is decided to raise the threshold, the fiscus should:

- Consider phasing this in over a few years to minimise the impact on high risk persons; and
- Consider eliminating the threshold for low earners in the same way as it is not applied for persons over 65.

An example of how the higher threshold could be phased in, is presented below:

<u>Phase 1:</u>	5% threshold	(Tax Year 2007)
<u>Phase 2:</u>	6% threshold	(Tax Year 2008)
<u>Phase 3:</u>	7% threshold	(Tax Year 2009)
<u>Phase 4:</u>	7.5% threshold	(Tax Year 2010)

3.3.3. The proposed amendments on employer provided medical services are supported in principle because they more accurately reflect the policy attributable to medical scheme contributions and contribute to government policy supported by PHF.

3.3.4. In terms of the overall impact, it is difficult to predict the changes that will occur in consumer behaviour, but it is likely that these will range from:-

- A retention of the *status quo* with medical scheme cover remaining unaffordable for the low-income groups. This may be partially due to the flexibility of medical schemes to negate the effect of the tax subsidies by increasing contributions for low cost options and decreasing contributions for high cost options.
- A retention of the *status quo*, but with more individuals from the low-income groups purchasing medical scheme cover;
- Only the high-income groups maintaining the *status quo* with the middle-income groups buying down and more individuals from the low-income groups purchasing medical scheme cover; or
- The middle-income groups buying down with the low-income groups accessing the market and the high-income groups electing to self-insure and exiting more comprehensive options, in which case the latter will still get a tax benefit through the 5% or 7,5% income tax deductibility provisions.

In three of the four possible scenarios, and the list is not exhaustive, the degree of cross subsidisation between the high and the low-income groups could be adversely affected, with a resultant potential failure in achieving at least one of the objectives of the proposed Tax Reform.

Based on the preceding commentary, PHF favours an approach that has the following key elements, and the combinations/scenarios should be evaluated with reference to these elements:

- Monthly cap per beneficiary with higher caps for adult beneficiaries;
- No limitation on the number of beneficiaries per member/family;
- No change in the 5 per cent threshold, except PHF concedes that the capped subsidy should not be double counted. If for financial reasons the fiscus is forced to raise the threshold, this should be phased in.

Furthermore, the PHF supports the following proposals in the discussion document:

- Benefits for employees receiving medical treatment provided by employers should be tax free;
- Medical scheme contributions by self-employed persons should be tax deductible. Limiting these to the proposed caps is understandable.
- We support no changes for tax payers of 65 years or older.
- Medical expenses (including medical scheme contributions) for the taxpayers 65 years and older, should be fully deductible.
- The R500 *de minimus* rule for handicapped persons should be scrapped.
- The pooling of bulk contributions to medical schemes and in-house funds to calculate the tax-deductible amount for the employer should remain.
- The current fringe benefit exemption for medical services provided at the employer's premises should be retained but should be extended to incorporate dependants of employees.

Finally, PHF believes that if necessary, the tax reform proposals should be reviewed to support other health sector reform initiatives aimed at implementing government policy, such as:

- The Low Income Medical Scheme Initiative (LIMS);
- Risk equalisation;
- Government employee medical scheme (GEMS).

PHF support is based on the proviso that there should be no further changes made to the tax subsidy system in the short to medium term.

4. FINANCIAL AND DISTRIBUTION IMPLICATIONS

PHF offers the following comments on this section:

- The technical analysis that has been provided indicates that the proposed Tax Reform will have a cost impact on the fiscus.

This cost impact is net of the reduction in the tax benefit that high-income earners are currently receiving. However, none of the scenarios that are provided in the technical analysis make provision for a reduction in uptake by the high-income earners and therefore a reduction in the “subsidy” of the projected cost to the fiscus.

As has already been stated, there is a real likelihood that the high-income earners will buy-down (to less comprehensive options) or self-insure in response to the impact of the employer expenditure capping and proposed upwards revision of the tax deductibility threshold.

Furthermore, the calculations do not reflect the possibility that low earners may not take up cover due to low levels of disposable income and the relatively low tax benefits that will arise from the low marginal tax rate applicable to this group.

- The fiscus must be certain that the middle income low risk group is not adversely affected by the reforms, because they provide significant financial cross subsidy advantages in the current risk pooling environment.

5. CONCLUSION

In conclusion, the PHF wishes to reinforce the following points:

- The principle of making medical scheme cover more affordable and therefore more accessible to low-income earners is supported.
- It is also acknowledged that at least some degree of Tax Reform will be required to achieve this objective.
- However, the proposals that are made in the Discussion Document are based upon a number of assumptions that have a high risk of turning out to be incorrect, namely:-
 - ✓ That low-income earners will have the disposable income to purchase medical scheme cover, if they are supported by an additional tax benefit;
 - ✓ That low-income earners will have the disposable income to add more beneficiaries to their medical scheme cover, if they are supported by an additional tax benefit;
 - ✓ That the current tax benefits coerce high-income earners into purchasing more expensive medical scheme options;
 - ✓ That the proposed tax reform will put downward pressure on the cost of medical scheme cover in general and the non-medical cost of medical schemes;
 - ✓ That equal medical scheme cover will be made available at lower contribution rates, or that the lower or middle income groups will have the disposable income to upgrade to more comprehensive medical scheme packages; and
 - ✓ That all high-income earners will retain their current medical scheme cover, given the proposed reforms.
- It is submitted that the risk of one or more of these assumptions being wrong is high and that added to the high sensitivity of the scenario models to the relatively low number of high-income earners, the estimated impact of the reform proposals needs to be confirmed with further in-depth research before implementation.
- The introduction of a monetary cap may create a bias towards certain (less comprehensive/deficient) benefit options, rather than provide assistance to specific income groups.

-
- If medical scheme cover is made less affordable to the middle-income low claiming group, this could impact very negatively on risk-pools and sustainability of medical schemes.

As alternative for consideration:

- Medical scheme contributions should be made 100% tax deductible for the low income groups;
- Employer provided medical services should be fully tax deductible, regardless of whether the services are rendered at workplace facilities or off-site; and
- In order to reduce the sensitivity of the models, a broader tax base should be considered for the subsidisation of the improved tax benefit to the low-income groups. The discussion paper largely suggests that the high-earner tax subsidy should be eroded to subsidise the low-earner subsidies.