You could pay less for medical scheme cover

MEDICAL scheme members could pay lower contributions, more low-income earners could afford to join schemes and much-needed funds could be freed up for use in the public healthcare sector if a few reforms were introduced. Barry Childs, a healthcare actuary with Lighthouse Actuarial Consulting and CareGauge, told delegates to the Hospital Association of South Africa's annual conference that there was a relatively quick way to bring relief to users of both the private and the public healthcare systems while waiting for National Health Insurance (NHI) to be fully developed. Childs said the reforms included making medical scheme membership mandatory for people in formal employment and increasing income cross-subsidisation among members. He said these reforms, together with other reforms that were proposed earlier but have been ignored since the focus turned to NHI, could:

- Reduce by 15 percent the average cost of medical scheme membership for high-income earners;
- Result in another 13 percent of the country's population becoming scheme members at contribution rates that are less than half the current average; and,
- Benefit the public healthcare system, because it would have to treat six million fewer people. This would have the effect of increasing by 19 percent the annual amount spent on each person who used the public healthcare sector.

Not only would these reforms bring short-term relief to medical scheme members while government pursued the longer-term goal of introducing universal coverage through NHI, but they would also help to bring about the conversion to NHI. On average, R11 395 a year (R949 a month) is paid in contributions for each medical scheme beneficiary, whereas government spends R2 835 a year (R236 a month) on each person who uses public healthcare facilities, Childs said. The average amount spent on medical scheme contributions could be reduced to R9 686 a year (R807 a month) - a decrease of 15 percent - for high-income earners, while low-income earners whose contributions are cross-subsidised by high-income earners could be brought in at a contribution rate of R5 854 a year (R487 a month). Childs said this would encourage about 13 percent of the population to join low-cost medical scheme options, which, in turn, would increase from 17 percent to 30 percent the percentage of the population covered by schemes. This would reduce the number of people who relied on the state for healthcare and enable government to increase the average amount it spent on users of public healthcare facilities from R2 835 per person a year to R3 377 per person a year (R281 a month) - an increase of 19 percent.

Mandatory cover

Childs said that in order to achieve all these things, government should complete the reform of medical scheme regulations that was proposed when it was pursuing a social health insurance system (SHI) for South Africa. In terms of SHI, everyone who could afford to do so - typically those in formal employment - would be expected to join a medical scheme. However, the move to SHI was halted in 2005, and in 2007 government announced its intention to pursue NHI. Childs said that making scheme membership compulsory for people in formal employment would prevent anti-selection and reduce contributions. Making membership mandatory would also reduce the average age of the lives covered by medical schemes. It is estimated that utilisation of healthcare services by medical scheme members increased by 2.5 percent a year, and this could, in part, be attributed to the ageing - and worsening risk profile - of the medical scheme population. The absence of mandatory membership for those in formal employment was a notable contributor to medical scheme contribution increases each year, and Childs estimated that introducing mandatory membership could save existing members between nine and 14 percent of the contributions they currently paid. Another reform that was proposed previously, a risk equalisation fund that would equalise the cost of providing benefits to members across medical schemes, would encourage schemes to compete on efficiency rather than on their membership profile.

Greater cross-subsidisation

Childs said that one of the obstacles to making medical scheme membership mandatory was the high cost of contributions relative to household income. The high cost of providing the prescribed minimum benefits (PMBs) was a major hurdle to making contributions more affordable. On average, it costs R1 064 per family to provide the PMBs to scheme beneficiaries.

Income cross-subsidies were needed to ensure that medical scheme membership was affordable for lower-income households. Currently, wealthier households spent a far lower proportion of their income on medical scheme contributions. He said that the introduction of greater income cross-subsidisation in medical schemes could make contributions more affordable, which would encourage more low-income earners to join schemes. Childs said restricted schemes used income cross-subsidisation effectively to ensure that low-income earners could afford the contributions, but open schemes tended to differentiate contributions by income band only for their low-cost options. Employers also achieved income cross-subsidisation by giving higher subsidies to lower-income employees. He said that for open schemes to make greater use of income-rated contributions, all schemes would have to be compelled to introduce such bands. Ways would have to be found to verify members' incomes.

Smarter healthcare buying

Childs said a saving of between 20 and 30 percent in contributions could be achieved if the regulations were reformed, while, at the same time, more co-ordinated strategies were implemented to manage fraud and schemes adopted a "smarter" approach to choosing the healthcare services they provides for their members. If medical schemes, administrators, managed care entities and healthcare providers collaborated more, they could do more to eliminate fraud, which, by conservative estimates, costs schemes five percent of contributions. Schemes that use data collected about healthcare providers in order to contract with those that had been identified as providing services cost-effectively had achieved a significant saving on claims payouts, and more schemes should be encouraged to follow suit. Schemes could make greater use of alternative reimbursement methods, which incentivised healthcare providers to take some of the financial risk of providing services to members. Currently, providers charged for each service, which could result in the over-servicing of members. Child said that if schemes passed on to their members only half of the potential saving of 30 percent in contributions, members' contributions could be 15 percent lower. The remaining saving of 15 percent could be used to subsidise the contributions of low-income earners. He said the healthcare system must be reformed to bring about affordable healthcare cover for all. But implementing previously proposed reforms for medical schemes would keep contributions affordable in the meantime, while increasing the amount available to spend on public healthcare. This, in turn, would facilitate the development of NHI.

'NHI will address mandatory membership'

In response to the proposals from Childs, Dr Monwabisi Gantsho, the Registrar of Medical Schemes, said mandatory membership of medical schemes would be addressed through National Health Insurance. He said the medical scheme industry had indicated on numerous occasions that it was hamstrung in doing more to improve access and affordability, and medical schemes membership was growing at a "dismal" 1.8 percent a year. This might be a function of unaffordability, and thus a call for an alternative and innovative healthcare funding model. Gantsho said the Competition Commission's 2003 ruling prohibiting negotiations to set tariffs and the absence of guideline tariffs had left a vacuum within the private healthcare sector, where providers were now charging at rates as much as 700 percent above what medical schemes could afford. Concerning Childs' call for regulatory reforms, the registrar said the Council for Medical Schemes had proposed amendments to the Medical Schemes Act to the Department of Health. However, these amendments did not extend to mandatory cover, a risk equalisation fund or income cross-subsidisation. In response to the suggestion that more should be done to eliminate fraud, Gantsho says the council was concerned about the lack of good governance in schemes and had been conducting training for trustees. He also referred to the council's opposition to unregulated gap cover and hospital cash plans and said it was engaging with National Treasury on these matters.

Laura du Preez: Personal Finance, 2 November 2013