Regulatory reforms could benefit medical scheme members

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Medical schemes will find it increasingly difficult to remain financially sustainable, and members will continue to experience steep contribution increases, if proposed reforms remain on the back-burner, medical scheme experts say.

The Medical Schemes Act introduced "social solidarity", which means that your contributions are unrelated to your health risks and, in general, your claims are paid according to your needs, not what you can afford to pay. But the introduction of community rating (all members who belong to the same option pay the same contributions), open enrolment (schemes must admit anyone as a member) and prescribed minimum benefits without the implementation of measures to ensure the sustainability of the medical scheme industry has been "toxic", Christoff Raath, an actuary and joint-chief executive of Insight Actuaries & Consultants, told a medical scheme conference.

The required sustainability measures include risk equalisation (equalising the cost of providing minimum benefits across schemes) and compulsory membership, at least for employed people, he says.

To strengthen the private healthcare system, policymakers discussed the introduction of low-income schemes, a package of common benefits that was priced for an entire scheme rather than by option, and income cross-subsidies (where high earners subsidise the contributions of low earners). These measures were scheduled to be implemented, but fell off the radar when the government shifted its healthcare policy focus to the implementation of National Health Insurance (NHI), Raath says.

It is estimated that it could take at least 25 years to implement NHI.

Barry Childs, a healthcare actuary with Insight Actuaries & Consultants, told a medical scheme conference that the absence of mandatory membership for those in formal employment is a significant reason for high contribution increases each year. He has estimated that introducing mandatory membership could save existing members between nine and 14 percent of the contributions they currently pay.

Compulsory membership would prevent anti-selection (people join schemes only when they need health care and leave thereafter) and reduce contributions, Childs says.

Making membership mandatory would also reduce the average age of the lives covered by medical schemes, he said. It is estimated that utilisation of healthcare services by members increases by 2.5

percent a year, and this can, in part, be attributed to the ageing, and worsening risk profile, of the medical scheme population.

One of the obstacles to making membership mandatory is the high cost of contributions relative to household income, Childs says. Income cross-subsidies are needed to ensure that scheme membership is affordable for lower-income households. Wealthier households spend a far lower proportion of their income on contributions.

He says 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.

Restricted schemes use income cross-subsidisation effectively to ensure that low-income earners can afford the contributions, but open schemes tend to differentiate contributions by income band only for their low-cost options, Childs says. For open schemes to make greater use of income-rated contributions, all schemes would have to be compelled to introduce such bands, he says. Ways would have to be found to verify members' incomes, he says.

He says these reforms, together with other reforms that were proposed earlier but have been ignored since the focus turned to NHI, could:

• Reduce the average cost of membership for high-income earners;

• Result in about 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 increase by nearly 20 percent the annual amount spent on each person who uses the public healthcare sector.

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