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# Analysing the structure and nature of medical scheme benefit design in South Africa

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The large number of benefit options available in the medical scheme market, along with the lack of standardisation and the mosaic of confusing terminology employed in scheme brochures, create a highly complex environment that hampers consumer decision-making.

This chapter reports on an analysis of the design of 118 benefit options to provide an overview of the nature and structure of the offerings available in the market in 2014. Observable and verifiable differences existed between the benefits offered in the options, the demographics of the beneficiaries they serve, and their corresponding contribution rates. The findings also demonstrate that schemes use benefit design to `cherry-pick' members and to separate beneficiaries into more homogenous groups, thus reflecting the consequences of the incomplete regulatory environment surrounding the schemes.

The complexity facing the consumer serves a vital purpose in order to ensure the short-term sustainability of schemes' risk pools. However, despite the necessity of complexity, increasing the transparency with which schemes market their benefit options might overcome a number of pitfalls, particularly with regard to the most subtle aspects of benefit design.

The authors conclude that medical scheme benefit design in South Africa requires significant attention in order to facilitate equitable access to medical scheme cover in South Africa.

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### Introduction

The value of medical scheme cover arises to a large extent from the benefits that are offered. Benefit design plays a central role in scheme marketability and competitiveness, the extent of risk pooling within schemes, and the rationing and delivery of care.<sup>1</sup> Despite this, the most recent regulatory change affecting benefit design took place over a decade ago. There has also been a near-complete absence of system-wide research into benefit design.

Medical schemes are the primary private health-financing mechanism in South Africa and operate on a not-for-profit basis.<sup>1</sup> Each medical scheme will have a number of product offerings that they market to consumers, known as benefit options. These benefit options differ in design, both between medical schemes and within each medical scheme.

The benefit design of 118 benefit options available in the openscheme market were analysed with the aim of answering the following questions:

- What common benefit design elements can be observed in the medical scheme market?
- Do differences exist in the benefits offered by the various plan types? If so, in what way?
- Can observable and significant differences be seen in the characteristics of the members who have joined the various plan types?
- What alternatives are available to prospective members in choosing a benefit option?

This research which was approached from the perspective of a prospective medical scheme member, aligns with the regulator's mandate: the Council for Medical Schemes (CMS) aims to maximise access to good-quality medical scheme cover and to protect the best interests of the consumer.<sup>2</sup> The focus on open schemes is a consequence of considering the perspective of a prospective member: restricted schemes are by definition not accessible to all consumers.

## The impact of regulation on benefit design

Each benefit option is required to be approved and registered with the Council for Medical Schemes (CMS); consequently their design needs to meet the requirements set out by the Medical Schemes Act 131 of 1998.

## Self-sustainability and risk pool fragmentation

Medical schemes are regulated on social solidarity principles via the mechanisms of open enrolment, community rating and Prescribed Minimum Benefits (PMBs).

The pooling of risks allows for risk cross-subsidies (those at higher risk are subsidised by those at lower risk). Currently, risk pooling occurs at the option level – schemes are required to treat each option as a separate risk pool for community rating. Each benefit option is required by law to be self-sustaining, <sup>1</sup> resulting in smaller, more fragmented risk pools. The size of the risk pool influences

how predictable healthcare costs are, and the extent to which the scheme can spread its risks, thereby lowering contribution rates and increasing affordability.  $^{\rm 3}$ 

There has been a downward trend in both the number of open schemes as well as the number of benefit options: from 41 schemes in 2007 to 24 in 2013, and from 219 options in 2007 to 140 in 2013. This should, in theory, result in larger risk pools and hence a more sustainable medical scheme industry. However, the absolute number of options on offer remains high.

The average number of options per scheme has declined since 2011 (although there has been an increase in the number of sub-options called efficiency-discounted options or EDOs), and the average number of beneficiaries per option is increasing – a positive result for the sustainability of risk pools. However, averages do not show the entire picture and are potentially misleading as there are substantial differences in sizes between schemes. One open scheme, Discovery Health Medical Scheme, dominates the market with 2 564 313 beneficiaries. This scheme is almost four times the size of its nearest competitor and alone accounts for 53% of the open scheme market and 29% of all medical scheme beneficiaries.<sup>4</sup>

It is argued that medical savings accounts (MSAs) undermine risk pooling within options. "Under this system, members arrange for part of their contribution to be held in a personalised account. The member decides when to use the account to pay for care and any unspent monies can be carried over from one year to the next".<sup>5</sup> Depending on the individual scheme's rules, the balance in the savings account may be used to cover any medical expenses not covered by other elements of the benefit structure, or where those elements have been exhausted. Since MSAs are for the exclusive use of the member who contributed to them, there is no crosssubsidisation between members, and should the member exhaust the funds in the savings account, they will be required to fund medical expenses themselves.<sup>6</sup> In addition, the funds in a member's savings account may not be used to pay for PMBs.

MSAs effectively individualise benefits and reduce risk pooling.<sup>7</sup> The use of MSAs in many South African medical schemes to cover primary care, specialist and out-of-hospital expenditures means that in-hospital risk pools cannot be combined with other risk pools. Because in-hospital claims are larger and less frequent, a greater risk pool is needed to ensure statistical certainty. Consequently, there is a limited number of medical schemes with a risk pool large enough to accurately predict and set pricing for in-hospital claims.<sup>6</sup>

Whilst the optimum medical scheme risk pool size has not yet been studied in South Africa, the minimum size to accept full healthcare risk is considered in America to be 20 000 beneficiaries.<sup>1</sup> This number would be higher for options that primarily offer in-hospital benefits. At the end of 2013, 33% of all open schemes had risk pools with fewer than 20 000 beneficiaries.<sup>4</sup>

A 0.71 correlation coefficient was observed between the size of the scheme (by number of beneficiaries) and the number of benefit options offered – i.e. larger schemes offer more benefit options. The ability of schemes to offer a large number of options allows them to appeal to a wide range of target markets and hence increases their ability to create more homogenous risk pools (i.e. proxy risk-rating). Theoretically, risk pooling could also occur at the scheme level (where the risk pools of the benefit options within a scheme are combined and treated as a single risk pool for community rating), or the industry level (where the risk pools of all schemes are combined into a single risk pool and community rating thus occurs across the industry). Industry-level pooling can be achieved using a Risk Equalisation Fund (REF).

In order to increase risk cross-subsidisation within medical schemes whilst reducing risk selection, Circular 8 of 2006 published by the CMS proposed scheme-wide pooling of certain benefits but was never implemented.<sup>8</sup> A potential consequence of these proposed reforms was that younger and healthier members would have faced increased contributions to the extent that they have benefited from fragmented risk pools. In a voluntary environment, this could have resulted in these members exiting the medical scheme environment and driving up the community rate.<sup>1</sup>

The Risk Equalisation Fund was planned for implementation in South Africa to reduce fragmentation and enable schemes to compete on the basis of cost-effective healthcare delivery and not on the basis of risk selection.<sup>7</sup> In addition, the REF was intended to be used as a vehicle for income cross-subsidies under a mandatory health insurance system.<sup>7</sup>

However, in November 2011, the Council for Medical Schemes published a circular announcing that it was highly unlikely that a risk equalisation system would be implemented in the near future.<sup>9</sup> There is thus a strong incentive to use benefit design to `cherrypick'<sup>a</sup> healthy members which can result in vulnerable members on schemes with relatively higher risk profiles facing increasingly unaffordable contribution levels relative to other schemes.<sup>10</sup>

#### Prescribed Minimum Benefits

The Medical Schemes Act (131 of 1998) re-introduced a mandatory minimum level of benefits that all benefit options are required to provide: Prescribed Minimum Benefits (PMBs). The package covers 270 diagnosis-treatment pairs, emergency treatment, and cover for a set of chronic conditions according to the Chronic Disease List (CDL). The package focuses on major medical and catastrophic cover and is fairly hospital-centric. The CDL was introduced into the PMBs from 1 January 2004 in an attempt to improve the cross-subsidy between the healthy and the chronically ill. However, its inclusion resulted in schemes moving away from providing cover in excess of the CDL in order to avoid attracting older and less healthy members.<sup>1</sup>

According to the Act, schemes must pay for the diagnosis, treatment and care costs of these PMBs, in full, without any co-payments or the use of deductibles. 'Payment in full' is complicated by the absence of any national guideline for how much providers can charge for their services. The Act does, however, allow for the use of managed care techniques to limit the impact of PMBs on affordability.<sup>11</sup> Such techniques include:

- formularies or medicine lists;
- Cherry picking (also called 'preferred risk selection' or `cream-skimming') is the selection that occurs because health plans prefer low-risk consumers to high-risk consumers.<sup>3</sup>

- > treatment protocols<sup>b</sup> which includes clinical entry criteria;<sup>c</sup>
- treatment algorithms;
- > benefit confirmation for procedures; and
- designated service providers.

The Low-Income Medical Schemes (LIMS) report found that the scope of benefits offered needs revision, since the PMBs create a high-base cost of cover in addition to driving the price of cover upward.<sup>12</sup> Many experts agree that in their current form, PMBs are unsustainable owing to "current healthcare reform, regulation, system failures and abuse by service providers".<sup>13</sup> PMBs also limit the freedom of schemes to design an appropriate and affordable package of benefits. Circular 9 of 2015 published by the CMS contemplates the possibility of exemption from covering PMBs to enable access and affordability.<sup>14</sup>

#### Treating Customers Fairly

A recent development, whilst not directly affecting medical scheme regulation, is Treating Customers Fairly (TCF). TCF was implemented by the Financial Services Board (FSB)<sup>d</sup> and is an outcomes-based regulatory and supervisory approach "designed to ensure that specific, clearly articulated fairness outcomes for financial services consumers are delivered by regulated financial firms".<sup>15</sup> However, since medical schemes are supervised by the Council for Medical Schemes and not the FSB, they are not required to demonstrate a commitment to TCF principles.<sup>e</sup> Importantly, there has been little commentary on TCF within the medical scheme environment.

Whilst medical schemes do not fall directly under the scope of TCF regulations, they do fall under the scope of the Consumer Protection Act (CPA).<sup>f</sup> The following CPA rules, inter alia, impact on medical scheme benefit design:

- The CPA prescribes that any representation made to the consumer should be in plain language so that it can be understood by any ordinary person with average literacy and understanding;
- The Act prohibits discriminatory marketing, i.e. excluding persons from any goods or services or targeting particular communities for exclusive supply of goods or services.<sup>16</sup>

Although the Registrar of Medical Schemes assesses any new benefit option, the assessment is not done explicitly in terms of fairness and responsibility to the members.<sup>16</sup> Furthermore, "there is no prescription in terms of language in the Act and the Act puts the responsibility of the understanding of the rules on the member, irrespective of the industry complexities".<sup>16</sup>

- c Diagnostic or laboratory tests confirming the diagnosis.
- d The Financial Services Board is an independent institution established by statute to oversee the South African Non-Banking Financial Services Industry in the public interest.
- e Organisations falling under the supervision of the FSB are expected to demonstrate six TCF outcomes in delivering services to customers, ranging from the appropriate and accurate marketing of services to consumers, to products performing in the way firms have led customers to expect.<sup>15</sup>
- f "The Consumer Protection Act is a set of legislation designed to protect the South African consumer in general by establishing a legal framework that will achieve and maintain a fair, accessible, efficient, sustainable and responsible consumer market".<sup>16</sup>

b "Protocol means a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways."<sup>11</sup>

Rusconi therefore highlighted the design of benefit options as a major issue in the medical scheme environment in that "there exists improper and inefficient regulation at present which has led to medical schemes trying to capitalise on these opportunities with the consumer bearing the brunt of these initiatives".<sup>17</sup> Rusconi also states that members' needs and perspectives have not been considered with sufficient attention, in that "the quality of services provided by the administrator are inadequate or the fees paid for these services inappropriately high".<sup>17</sup>

## Benefit design mechanisms

#### Rationing

Benefit design can be seen as the rationing of medical scheme resources. Rationing is defined as "allocating healthcare resources in the face of limited availability, by withholding beneficial interventions from some individuals. It is socially inevitable and prevalent".<sup>18</sup>

Rationing can be either explicit or implicit. "With explicit rationing, the basis, or criteria, that are used in making the resource allocation decisions are clearly, openly, and directly specified".<sup>19</sup> On the other hand, "under implicit rationing, the criteria to be used to ration resources are implied, indirect, or not clearly expressed".<sup>19</sup> Rationing by inconvenience, rationing by policy, or rationing by contract<sup>g</sup> are all examples of implicit rationing.<sup>18</sup> Medical schemes use a combination of explicit and implicit rationing. However, it can be argued that the complexity of scheme rules shifts explicit rationing to being implicit, due to the burden of comprehension placed on the member.

The primary rationing tool used by medical schemes is price rationing: goods and services are allocated to the individuals who have the ability and willingness to pay the price.<sup>19</sup> The 'price' in this case is the contribution rate and the extent of out-of-pocket payments that arise from co-payments, levies, deductibles and tariff shortfalls. The impact of price rationing is offset in some benefit options by the use of income-rated contributions. The tax credit that medical scheme members receive also reduces the financial impact, albeit only for those earning in excess of the income-tax threshold. Price rationing could be further offset by regulatory interventions to enable income cross-subsidies.

Rationing can also be seen as structured according to demandside or supply-side orientations. "Any rationing mechanism which prevents patients from freely expressing demand for healthcare", such as co-payments and benefit limits, are described as demandside rationing.<sup>18</sup> "Supply-side rationing involves a number of different strategies for impacting the choices made by the providers of healthcare services and often involves the regulation of providers in an effort to influence or control the provision of healthcare services".<sup>19</sup> Examples of supply-side rationing include the regulation of the pharmaceutical market and alternative reimbursement mechanisms for providers.

#### Demand-side mechanisms

Before the introduction of PMBs, schemes relied heavily on limits, co-payments, levies and deductibles as benefit design tools.

Benefit limits can be defined as "any provision, other than an exclusion, that restricts coverage in the evidence of insurability, regardless of medical necessity".<sup>20</sup> These limits may either be monetary or non-monetary. A possible disadvantage of limits is that they may be viewed as norms rather than extreme levels of utilisation by the members or beneficiaries of the option.<sup>21</sup> Benefit limits can be effective in controlling utilisation of low-cost and high-frequency healthcare events, for example, dental and optical services.<sup>22</sup> In the case of high-cost events, benefit limits may penalise those with the greatest need.

Levies and co-payments are applied to individual claims and are intended to deter unnecessary utilisation but, like monetary limits, they can become a financial burden and reduce access to appropriate care. This occurs typically in a situation where high prices prevail.<sup>5</sup>

The use of co-payments is common-place in medical scheme benefit design, particularly in cases where the member seeks treatment outside of a preferred provider network (PPN) or obtains treatment before the treatment or procedure has been authorised. There are large variations in the amounts charged between schemes and benefit options.

A deductible makes the member responsible for all healthcare costs up to a defined threshold. Once the member reaches the threshold, the benefits may still be subject to other cost-sharing methods.

Pre-authorisation is another form of demand-side rationing. Hospital and chronic benefit pre-authorisation are common in current benefit design structures.<sup>5</sup> A clinical motivation is sometimes needed from the patient's doctor. If authorisation is not granted, the claims are either not reimbursed or only reimbursed for a certain percentage, the exact terms of such reimbursement being specific to the particular scheme.

#### Supply-side mechanisms

Supply-side mechanisms include those that limit the providers that can be used, and that attempt to influence the decision-making of providers. Many managed care interventions can be thought of as supply-side mechanisms as they attempt to influence the clinical decisions made.

Managed care is defined in the Medical Schemes Act 131 of 1998 as:

Managed healthcare means clinical and financial risk assessment and management of healthcare with view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical managementbased programmes.<sup>h,11</sup>

Medical scheme members may be restricted to obtaining their healthcare services from a network of providers. These networks are

h Rules-based and clinical management-based programmes are "a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of healthcare services, procedures or settings on the basis of which appropriate managed healthcare interventions are made."<sup>11</sup>

g "Stating within the contract what services are covered at each level, with the patient deciding which level and amount he or she wishes to pay".<sup>18</sup>

referred to as Designated Service Providers (DSPs) when they relate to the provision of PMBs.<sup>i</sup> Preferred Provider Networks are frequently established with the aim of reducing the cost of healthcare, through negotiating volume discounts from the providers or by securing agreements with providers to practice cost-effective medicine according to a defined set of clinical protocols.<sup>22</sup> However, a recent trend of paying higher fees to providers within PPNs has been seen. This makes sense where schemes are able to secure price certainty for PMB claims, and where increased engagement with and profiling of providers necessitates higher fees.

In theory, public hospitals should be attractive preferred providers for schemes, since the cost of care and the rate of cost escalation is comparatively low in this sector.<sup>5</sup> However, perceived quality differences between public and private hospitals has resulted in very few schemes contracting with the public sector.

Efficiency Discounted Options (EDOs) are benefit options with network arrangements for healthcare provision. Introduced in 2008, EDOs allow monthly medical scheme contributions to be differentiated on the basis of the healthcare providers that are utilised to provide benefits.<sup>23</sup> This practice is in conflict with the statutory principle that contributions may be differentiated only on the basis of income or family size, or both. A scheme's benefit option must therefore obtain exemption from section 29(1)(n) of the Medical Schemes Act before it can operate as an EDO.<sup>23</sup> EDOs were established with the intention that the discounted contributions reflected the efficiencies of the PPN rather than the demographics and claims propensities of the beneficiaries who were expected to participate in the discounted structure.

Traditionally, providers of health care have been reimbursed on a fee-for-service (FFS) basis. FFS reimbursement contains incentives for increasing the volume and cost of services (whether appropriate or not), encourages duplication, discourages care co-ordination, and promotes inefficiency in the delivery of medical services.<sup>24</sup> In response to these inefficiencies, alternative provider reimbursement arrangements are becoming increasingly common and more widely used by medical schemes as a tool to align the incentives of the provider and the scheme. This is done by transferring varying degrees of risk from the medical scheme to the provider and/or the member. It is important to note that different mechanisms will be appropriate for different providers; however, the goal is to structure the payment to providers in such a way that costs are reduced whilst a high-quality level of care is maintained.<sup>22</sup>

Some examples of managed care interventions include case management, disease management, treatment protocols and formularies. The limitations that schemes face in controlling the cost of PMBs have supported the development of these interventions.

"Case management is the active monitoring of patients once in hospital with the aim of ensuring that the patient receives clinically appropriate care in the appropriate setting".<sup>5</sup> Furthermore, this intervention attempts to manage claim costs by setting best-practice clinical protocols for the treatment of patients once they have been admitted to hospital.<sup>6</sup>

A disease management programme (DMP), on the other hand, "involves active management by the scheme administrators of the prevention, diagnosis and treatment of specific conditions such as asthma or diabetes".<sup>5</sup> In addition, it involves identifying members at risk, intervening where necessary and measuring the outcomes, all whilst providing continuous quality improvement.<sup>25</sup>

Treatment protocols are "a set of guidelines in relation to the optimal sequence of diagnostic testing and treatment for specific conditions".<sup>11</sup> Most medical schemes provide services in the form of a basket of care that lists all the services included in the protocol, for example, the number of annual consultations allowed at a specialist. The Council for Medical Schemes dictates that "all managed care protocols be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability".<sup>2</sup> If a member voluntarily chooses to use a different treatment protocol, the scheme may charge a co-payment.

A formulary is a list of prescription drugs determined to be clinically appropriate and cost-effective and that are approved for use and covered by a medical scheme.<sup>20</sup> Reimbursement by schemes is then restricted to items (or price levels) on the formulary, although frequently, members can obtain other products if they are prepared to pay the difference or incur a levy.<sup>5</sup>

Many of these interventions can be thought of as 'hard' or 'soft'. With 'soft' interventions, the member is able to pay to access the care that they want, whereas with 'hard' interventions, the scheme is more prescriptive. 'Soft' interventions are easier to market but less effective in controlling costs. They are also less equitable because they introduce an additional element of price rationing.

## Methods

Only those open schemes that contained at least 30 000 beneficiaries (i.e. 'large' schemes) and offered at least four registered benefit options were included in the analysis.

#### Analysing benefit design

The analysis of benefit design assumed a family with a single member and one child dependant (1A1C), with the principal member earning R10 580 per month. Family size is only relevant where a scheme imposes limits – most schemes increase limits for each additional dependant included. Scheme brochures were obtained for each benefit option and subsequently analysed. The benefits offered under each option were classified and recorded under five main categories. These categories were then broken down into further sub-categories to capture all benefits on offer,<sup>i</sup> as illustrated in Table 1.

## Table 1: The grouping and categorisation of the core aspects of benefit design

Benefit Category	Benefit Sub-category	
Day-to-day Benefits	Extent and form of day-to-day benefit coverage	
Hospital Benefits	Limits applicable to in-hospital benefits	
	Hospital reimbursement rate	
	Choice of hospital	
	Co-payments for hospital admissions	
	Co-payments for specific in-hospital procedures	

 Conditions' here denotes terms of usage and any limits, risk-management or managed care techniques employed.

The term 'Designated Service Provider' was introduced in the PMB legislation. 'Conditions' here denotes terms of usage and any limits, risk-management or managed care techniques employed.

Benefit Category	Benefit Sub-category	
Chronic Medicine Benefits	Number of diseases	
	High-cost medication	
	Formularies	
Cancer Benefits	Oncology limits applicable	
	Choice of provider	
	Provision of high-cost oncology medicine	
Additional Benefits	Coverage for in-room procedures	
	Post-hospital benefit	
	Preventative screening tests	

In order to assist with comparison, homogenous characteristics identified across the offerings were grouped together into further categorisations (for example, all options offering "cover at any hospital of choice" were grouped, options offering "cover within a PPN only" were grouped, options offering "cover within state facilities only" were grouped, etc.). The homogenous groupings were then assigned a unique identifier (for example, all options offering "cover at any hospital of choice" were assigned a 1, options offering "cover within a PPN only" were assigned a 2, options offering "cover within state facilities only" were assigned a 3, etc.).

The process undertaken is a necessary simplification of a complex and intricate environment. As such, further analysis through observation of each benefit option was done by examining the schemes' brochures. Any outliers or other findings identified were included in the results.

#### Plan types

In order to overcome the complexity associated with the benefit design environment and to facilitate comparison, options were grouped according to plan type. The plan type provides an indication as to how the day-to-day benefits are covered:

- Traditional options offer both compulsory insured majormedical benefits (such as hospitalisation and chronic medicine benefits) and insured day-to-day benefits (such as GP consultations, dentist visits and over-the-counter medication).<sup>26</sup>
- New Generation options combine insured major-medical benefits with a medical savings account.
- Hospital Plans provide insured major-medical benefits and limited cover for out-of-hospital and day-to-day expenses. The term `hospital plan' is a misnomer since all options must provide cover for PMB conditions.
- Hybrid options are a mixture between Traditional and New Generation Plans, with insured major-medical benefits and the majority of day-to-day benefits paid out of a savings account. However, certain out-of-hospital and day-to-day benefits are insured.
- Networked options are those requiring the member to obtain, either or both, of their major medical benefits and out-ofhospital benefits through a PPN.

## Results

Figure 1:

The 118 benefit options analysed are offered by 11 medical schemes, administered by seven administrators and cover approximately 4.5 million beneficiaries (representing 92.63% of the open-scheme market). The five largest options in the sample are all part of Discovery Health Medical Scheme. New Generation plans have the highest market share even though more options offer Hybrid benefit design (Figure 1). This is due to Discovery offering New Generation plans and their high level of market share.

Share of options analysed versus beneficiary market



The average beneficiary age per option (weighted by option market share) varies considerably across the plan types, with Networked plans having the lowest average age (29.2) and Hybrid plans having the highest average age (38) (Figure 2). This pattern is repeated in the weighted average pensioner ratio<sup>k</sup> by plan type, with Networked plans having the lowest average pensioner ratio (5%) and Hybrid plans having the highest average pensioner ratio (11.5%).

#### Figure 2: Weighted average age and pensioner ratio across the plan types



k Proportion of members of medical schemes who are 65 years or older.<sup>27</sup>

On an unweighted basis, Hospital plans have the lowest average monthly contribution rates, whilst Hybrid plans have the highest average monthly contribution rates (Figure 3) with a differential of 118.2%. Networked plans were found to have lower average monthly contribution rates than New Generation plans, despite offering insured day-to-day benefits. It is important to note the broad range of contribution rates within each plan type, particularly for Traditional and Hybrid plans.





There is a 10% differential in the average contribution rate between Hospital and Networked plans, a 21% differential between Networked and New Generation plans, a 53% differential between New Generation and Traditional plans, and only a 7% differential between Hybrid and Traditional plans. If one weights, by option market share (Figure 4), the price difference between New Generation and Traditional plans narrows significantly – on this basis Hybrid plans are clearly more expensive than other plan types.

Figure 4: Weighted average monthly contribution rates across the plan types



A 0.67 correlation coefficient was observed between the average age and contribution rates of the individual benefit options: options with higher average ages have higher average contribution rates.

#### Day-to-day benefits

Owing to the presence of PMBs, all medical schemes must pay the cost of certain consultations and diagnostic tests associated with the 25 conditions on the Chronic Disease List. However, it is frequently not clear from scheme brochures that there is some coverage provided for day-to-day (DtD) benefits.<sup>28</sup>

Due to the manner in which the plan types were defined, the overall structure of DtD benefits offered is in line with the plan type.

All Networked plans made use of a limited monetary amount to pay for DtD claims, on condition that these services were obtained from a PPN. This amount was applicable only for certain benefits, such as GP consultations, optical, dental, radiology and day-to-day medicines included on the scheme's medicine list. Furthermore, visits to a provider outside of the network resulted in additional copayments or a reduction in how much the scheme was willing to cover (for example, only covering GP visits at 50% of the scheme's tariff).

Both Hospital plans and New Generation plans offer no insured DtD benefits. Hospital plans exclude coverage for DtD claims altogether, whilst New Generation plans pay claims from the member's MSA. Across all options offering MSAs, the maximum per annum savings level for a 1A1C family was R14 628 and the minimum was R264. This large variation adds to the difficulty that consumers face in choosing an appropriate option.

For the Traditional plans, the amounts covered vary depending on the number of dependants included on the option. Four Traditional plans also offer an Above Threshold Benefit (ATB), such that once the member has used up available DtD risk benefits, they enter a self-payment gap. If the member's accumulated claims exceed the threshold, they would again be eligible for insured benefits. The ATB is limited, and ranges from R8 900 to R19 900 per beneficiary, per annum.

All 34 Hybrid plans make use of a combination of a dedicated MSA and risk benefit to cover DtD claims. However, the form of the insured benefit varies across the options. Ten options cover certain benefits from available funds in the MSA and other benefits are covered from available funds in DtD risk benefits. The remaining 24 options first make use of the MSA to cover DtD benefits. If these benefits are depleted, the member moves into a self-payment gap, and then an ATB.

The accumulation of claims in order to access an ATB is particularly complex. As an example, for Discovery Health's Classic Comprehensive option (which has the highest market share of all Hybrid plans, with 421 848 beneficiaries), claims are added up as follows:<sup>29</sup>

- For GPs and specialists, claims accumulate based on 100% of the Discovery Health Tariff Rate (and not the actual amount charged by the doctor).
- Claims accumulate at 100% of the Discovery Health Rate for medicine on their list.
- For medicine not on their list, claims accumulate at 75% of the Discovery Health Rate for medicine.
- Over-the-counter medicines, vaccines and immunisations do not accumulate or get paid from the ATB.

Across all plan types, 25% (29) of options offer an ATB. These options are more expensive on average (R3 991.83 a month compared to R2 743.16 a month). Of the 29, 15 options offer ATBs that are unlimited overall (albeit with sub-limits on certain benefit categories, and potentially with a PPN in place). The remaining 14 options have varying levels of ATB thresholds and limits (limits range from R8 500 to R19 900 per annum).

#### Hospital Benefits

Almost all options (96%) offer unlimited<sup>1</sup> hospital cover. The remaining five options that have overall limits all require members to obtain services from a network hospital.

Whilst schemes may have stated that they offer unlimited hospital benefits, certain procedures generally had limits in place including, inter alia:

- > Cochlear implants, auditory brain implants and processors;
- > Hip, knee and shoulder joint prostheses;
- Mental health benefits;
- Alcohol and drug rehabilitation;
- Compassionate care; and
- Chronic dialysis.

In addition to limits being placed on hospital benefits, all schemes reimburse providers (hospitals and healthcare professionals) at their own tariff rate. Since healthcare professionals are entitled to set their own tariffs, some will charge the scheme rate whilst others may not. In cases where the service provider's rate was more than the scheme's rate, the member would be required to pay the difference. Options incorporating an MSA, and where the balance in the MSA is in credit, generally allow for the difference to be paid from these funds. Where options offer an ATB, this difference would typically not accumulate to the threshold level and would cause an increase in the members' self-payment gap.

The reimbursement rate for in-hospital claims ranges from 100% of the scheme's rate to 300%. Sixty-five per cent of all options reimburse at 100%, and 31% reimburse at a rate between 150% and 250%. Only 4% of options reimburse at 300% of the scheme's rate. Figure 5 shows a breakdown of the reimbursement rate by plan type.

Figure 5: The number of options that reimbursed at the different scheme rates by plan type



Hybrid and Traditional plans (which have the highest average monthly contribution rates) are more likely to reimburse at a higher rate: 9% and 10% of their options reimburse at 300% of the schemes' rate. By contrast, Networked plans all reimburse at 100% of their scheme's rate. A high number of New Generation plans (43%) reimburse at a rate between 151% and 200%. This could potentially be explained by the fact that New Generation plans free up resources by not providing insured DtD benefits and are consequently able to provide more generous in-hospital coverage.

A reimbursement rate of 100% for hospitalisation on one scheme might not equate to a reimbursement rate of 100% on another scheme. For example, one medical scheme reimbursed GP consultations at a tariff of R299.5, whilst another reimbursed at a tariff of R355.7.<sup>31</sup> However, an inflation-adjusted National Health Reference Price List is used as a benchmark for a large number of schemes.

All options require pre-authorisation for hospital admissions. Members are required to obtain authorisation at least 48 hours before being admitted or within two working days after admission or treatment in an emergency. In addition, members are required to visit their GP or specialist before obtaining authorisation so as to confirm the admission being medically necessary. Failure to obtain pre-authorisation results in claims not being paid or a reduction in the amount schemes would normally cover. For example, Discovery Health reimburses at 70% of their tariff if authorisation is not obtained, whereas on Bonitas Standard, no benefits are paid.

There are three choices on offer with regard to selection of a hospital. Fifty-nine per cent allow members to visit any hospital, 39% make use of a network of hospitals and only 2% require members to visit a State hospital. Figure 6 provides a breakdown of choice of hospital by plan type.

I 'Unlimited' means that no overall annual limit (benefit amount) or period (e.g. a three-year cycle) applies to the specific service/procedure. This does not refer to the number of days spent in hospital or the number of procedures applicable.<sup>30</sup>



Figure 6: Proportion of options within each plan type that made use of the different hospital networks

The Networked plans that allow their members to visit any hospital are classified as Networked based on their day-to-day benefits. The two options that utilise the State (Discovery's KeyCare Access option and Momentum's Ingwe Hospital State option) offer unlimited cover for emergencies, trauma and childbirth in the schemes' network of private hospitals.

All options that make use of a hospital PPN require the member to obtain services inside the network. Failure to obtain services from a PPN results in a range of potential penalties, ranging from the scheme paying only 80% of the health plan entitlement, to covering none of the costs at all. The following examples illustrate such penalties:

- On Discovery Health's options, the following relates to hospital admission for a CDL condition: "Where a member voluntarily uses a non-DSP, we pay at 80% of the Discovery Health rate or the health plan entitlements, subject to benefits. The copayment which the member is liable for is equal to 20% of the Discovery health rate and any amount the provider charges above that rate".<sup>32</sup>
- Discovery's Classic Delta Comprehensive option states: "For planned admissions outside of the Delta Hospital Network, an upfront payment of R5 950 must be paid to the hospital".<sup>29</sup>
- Liberty's Hospital Select option states: "Any planned admission to a hospital outside the Liberty Network (or Designated Service Provider (DSP) in the case of a PMB condition) is subject to a co-payment of R8 000".<sup>33</sup>
- On Momentum's Ingwe options, "If you choose Ingwe Network hospitals as your preferred provider for Major Medical Benefits and do not use this provider, you will have a co-payment of 30% on the hospital account".<sup>34</sup>
- Discovery's KeyCare Core option states: "If you do not use hospitals in your plan's networks, you will have to pay all costs".<sup>35</sup>

Co-payments for specific in-hospital procedures, in either a hospital or day-clinic, exist in 79% of options. The following procedures often required a co-payment:

 Endoscopic investigation (gastroscopy, colonoscopy, sigmoidoscopy, hysterectomy and proctoscopy)

- MRI and CT scans;
- > Joint replacements and prostheses
- > Laparoscopic procedures

Every benefit option had its own set of rules with regard to these co-payments, which made analysis and comparison a highly complex task. For example, 33% of Networked plans, 100% of Hospital plans, 96% of New Generation plans, 76% of Hybrid plans and 70% of Traditional plans require co-payments for specific in-hospital procedures. Counterintuitively, Networked plans seem to offer the most comprehensive benefit for this aspect of benefit design. However, the use of co-payments is a highly effective tool that schemes employ to prevent anti-selection. Networked plans are marketed at a younger and healthier target market and there is therefore less need for the scheme to employ co-payments for specific procedures. By contrast, the more comprehensive plans utilise more co-payments to discourage anti-selection.

While these aspects represent the primary hospital benefits offered, certain procedures, medicines or new technologies are covered but need separate approval during hospitalisation. It is also important to note that each scheme and benefit option applied their own rules, limits, clinical guidelines and policies which had be followed in order for claims to be paid. These more subtle aspects of benefit design are less visible to the consumer.

#### Chronic disease benefits

Chronic diseases are long-term conditions requiring treatment on an ongoing basis, for example, asthma, hypertension and HIV and AIDS. The following aspects of chronic benefits included in benefit design were examined:

- > The number of chronic conditions covered by the benefit option
- Whether or not the benefit option paid for high-cost specialist medicine
- > The different formularies utilised by medical schemes

All schemes are required by legislation to cover the diagnosis, treatment and care costs of 25 chronic conditions as specified in the PMB Chronic Disease List (CDL). The diseases included in the CDL were chosen as "they are the most common, they are life-threatening, and are those for which cost-effective treatment would sustain and improve the quality of the member's life".<sup>36</sup>

Importantly, a medical scheme does not have to pay for diagnostic tests that establish that the beneficiary is not suffering from a PMB condition. In addition, schemes can require pre-authorisation for the beneficiary's treatment. This means that beneficiaries have to meet minimum clinical requirements in order to access the benefit. Conditions may also be subject to disease management interventions and periodic review.

Cover for additional conditions is frequently subject to a financial limit (either monthly or annual), which may vary per condition.

In order to facilitate comparison, the number of chronic conditions covered above the CDL on each option are counted and grouped into six categories. Table 2 displays the distribution of covered conditions across all options.

Table 2: Distribution of chronic conditions covered above the CDL

0	56.8%
[1:10]	10.2%
[11:20]	5.9%
[21:30]	6.8%
[31:40]	15.3%
>41	5.1%

The majority of options only provide cover for CDL conditions. Interestingly, a relatively high percentage of options (15%) provide cover for between 31 and 40 additional conditions – these are predominantly Hybrid options.

Figure 7: Average age, pensioner ratio and monthly contribution rates for options offering coverage for additional chronic conditions



Figure 7 shows that options offering cover for 21 or more additional conditions have higher average ages, pensioner ratios and contribution rates compared to options offering cover for less than 21 additional conditions. The distinction is less clear between the three sub-categories within each of these groupings.

A 0.78 correlation coefficient was observed between the number of conditions covered on an option and the corresponding contribution rate. This makes sense when the relationship between plan type and number of conditions covered is taken into account. Networked and Hospital plans seldom cover any additional conditions (only 7% and 8% respectively). The majority of New Generation options cover 10 or fewer additional conditions (91%). Just over half of the Hybrid plans cover more than 31 conditions. Interestingly, 40% of Traditional plans only cover the CDL conditions.

It is important to note that the list of additional conditions covered varies considerably between options.

A high-cost specialty medicine benefit is intended to provide coverage for expensive medicines required to treat certain chronic conditions, for example, biologicals. It was found that 34% of options provide cover for specialty medicines. All schemes offering this benefit placed an annual limit on the amount they would cover. As an example, the Fedhealth Ultimax option (Hybrid plan) provided an annual limit of R280 370 per family for specialty medicines, whereas Discovery's Executive option (Hybrid plan) offered an annual benefit of R200 000 per beneficiary.

All schemes make use of drug formularies. However, each scheme has its own formularies or list of medicines for which cover is provided, and sets provisos dictating whether or not claims will be reimbursed. The large variation in formularies, as well as amounts covered, make it complex to undertake a quantitative comparison across schemes. Some schemes will only reimburse drugs on their formulary lists, whilst others allow members greater choice if they are willing to incur out-of-pocket payments.

#### **Oncology** Benefits

All schemes analysed included a separate category for oncology benefits. Three aspects of the oncology benefit were analysed from each benefit option:

- > The limits that are applied to oncology benefits
- Whether or not the member has a choice as to which provider to visit
- > Whether high-cost, specialist oncology medicines are covered

Twenty per cent of options cover only oncology benefits that are included as part of the PMB package. Forty per cent of options (47) impose a monetary limit for non-PMB benefits. Of these 47 options, 37 place a limit that ranges from R9 000 to R300 000 per beneficiary per annum, whilst 10 options place a limit between R300 000 and R475 000 per annum. In 32% of options (38), an annual monetary limit is placed, after which a co-payment applies if the member exceeds this limit – this monetary limit ranges from R200 000 to R400 000 and the co-payment ranges from 10% to 20%. Only 8% of options (9) provide unlimited cover for oncology benefits. However, these options require oncology services to be obtained from a provider in their network. All options require the member to obtain pre-authorisation from the scheme's Oncology Management Programme and for a beneficiary to follow their set of treatment protocols.

Seven out of the nine options that offer unlimited coverage for oncology benefits are Hybrid or Traditional plans. However, 20% of Traditional plans provide coverage only for PMBs. Eighty-one percent of all Networked plans provide coverage only for PMBs, and those that do offer additional benefits have relatively low annual limits.

The Independent Clinical Oncology Network (ICON) protocols are applied by many benefit options. In essence, ICON is a managed care organisation with a network of oncology specialists (80% of South African oncologists are registered with ICON).<sup>37</sup> Whilst ICON was not examined in detail, they are notably prevalent among schemes, with 38% (45) of benefit options and nine out of the 10 administrators examined utilising ICON. Interestingly, most schemes did not use the ICON network for all options (i.e. not for their more expensive options).

Only 5% of options use the State as a designated service provider for oncology services (all Networked plans). However, 60% of options did make use of a private-sector network to provide their benefits. The remaining 35% (41) of options allowed their members to obtain services from any provider. The specialised medicine benefit gave members access to specific high-cost oncology medicines. Seventy-eight per cent of options did not provide cover. The 22% that did provide cover are higher-cost options on average (R4 012.96 a month compared to R2 743.16 across all options). Furthermore, these options appear to be catering to the older segments of the population with an average age of 47.8 (38.9 across all options). In addition, of the 22% that provided coverage, 9% provided a limited monetary amount per beneficiary per annum (ranging from R103 000 to R322 500 per beneficiary per annum) and 13% provided a benefit as a sub-limit of the overall oncology benefit (with large variations).

#### Additional Benefits

Additional benefits included all in- and out-of-hospital benefits that could not be classified into the other benefit categories, including:

- cover for in-room procedures;
- any post-hospital benefit available; and
- > any screening and prevention benefits on offer.

Cover for in-room procedures displayed broad coverage with only 2% of options offering no benefit. Owing to the reduced costs of covering in-room procedures, their use is encouraged by many schemes. Consequently, only in exceptional cases would the beneficiary be authorised for hospital admission for a procedure that could rather be performed in the doctor's rooms. As an example, endoscopies were not performed in the doctor's rooms in the past; however, endoscopic procedures such as colonoscopies, vasectomies, diagnostic laparoscopies and gastroscopies are now performed in the doctor's rooms with the doctor's own equipment. Furthermore, co-payments that were charged for having the procedure performed in-hospital are not charged if procedures are performed in doctor's rooms. For example, on Liberty's Hospital Plus option, endoscopic investigations had a co-payment of R1 600 if performed in-hospital and no co-payment if performed in the doctor's rooms.<sup>33</sup>

As with hospital admission, beneficiaries were required to obtain pre-authorisation for procedures performed in the doctor's rooms. The options that did offer this benefit covered it either from available funds in the MSA (2%), or from available day-to-day risk benefits (14%), or from available funds in the major-medical risk benefit (82%).

All New Generation plans pay for this benefit out of available funds in major medical risk benefits – a surprising result in the light of the medical savings account structure. However, many schemes use this benefit to deter beneficiaries from hospital admission, since this would require reimbursing both the hospital and associated medical staff performing the procedure.

Importantly, each benefit option specifies the exact in-room procedures it covers and the list varies between options.

A post-hospital benefit refers to cover after the beneficiary has been released from hospital, including, supportive and rehabilitative services. The intention of this benefit is to improve the physical, psychological, emotional and social wellbeing of beneficiaries after an in-hospital event. This benefit is broadly covered across options, with 79% of options offering some form of benefit. The remaining 25 options do not offer any form of post-hospital benefit. Of these, three are Networked plans and 22 are Hospital plans. Limits, sub-limits of overall day-today benefits as well co-payments all varied across options.

A screening and prevention benefit is common across all schemes, with 100% of New Generation, Hybrid and Traditional plans offering some form of benefit. Only three Networked and one Hospital plan require their members to pay for this benefit themselves.

#### Discussion

The structure of the medical scheme environment, as it stands, is incomplete. Open enrolment, community rating and prescribed minimum benefits have been implemented without mandatory cover and without any form of risk equalisation mechanism. Schemes that can attract a lower-risk profile can charge lower contributions – a clear incentive to use benefit design as a means of 'cherry-picking'.

The impact of this incomplete regulatory framework is compounded by the presence of medical savings accounts (which reduce the size of risk pools), an ageing medical scheme population, the absence of a risk-based capital approach, and disparity in the size of different schemes.

#### Option design as a means to create more homogenous sub-pools

Currently, risk pooling in medical schemes theoretically takes place at the level of individual benefit options (although there is some cross-subsidisation that takes place between options in practice). In the absence of a Risk Equalisation Fund, the community rate for PMBs within an option differs depending on the age and health profile of that option. Consequently, members are paying different prices for the PMB package in different options.

Community rating at an option level creates the incentive for schemes to use option design to split their risk pool into more homogenous sub-groups. This is evidenced by large variations in the demographic profile within schemes. For example, the average age of Discovery's KeyCare Plus option is 27.2, compared to the average age of their Essential Comprehensive option of 40.9; and the average age of Bestmed's Pulse 2 option is 69.8 compared to the average age of their Beat 2 option of 27.8. Larger schemes tend to offer more benefit options than smaller schemes and thereby have a greater ability to approximate risk-rating.

This goes against the spirit of the Medical Schemes Act which seeks to foster social solidarity. However, this is a rational response to an incomplete regulatory environment that offers insufficient protection to schemes.

#### Risk pool fragmentation

The large number of benefit options on offer results in a fragmented risk pool and undermines risk cross-subsidies. Regulatory measures to improve risk pooling (such as risk equalisation) would increase the extent of risk cross-subsidisation. However, in the absence of mandatory membership, this could increase the risk of the young and healthy selecting out of medical scheme cover. In this sense, the proliferation of benefit options may assist with the sustainability of schemes in the current environment. Efficiency-discounted options (EDOs) have contributed to risk-pool fragmentation by effectively creating sub-options. At present they make up 7.2% of the open scheme market, and achieve an average discount of R523. More research is required to establish the effectiveness of these options – it can be argued that they are merely a form of price rationing.

Although Prescribed Minimum Benefits cater for some day-to-day benefits, they focus largely on in-hospital care and chronic illness. Consequently, a high proportion of options do not offer insured day-to-day cover (other than the PMBs). New Generation plans currently have the highest market share, and New Generation and Hospital plans combined make up 42% of market share. Options that do not cover day-to-day benefits require a larger risk pool to be sustainable. Even if one assumes that risk pooling occurs at scheme level, and that full healthcare risk was always covered, a third of all schemes are currently of a sub-optimal size.

Scheme amalgamations would increase the size of risk pools and support industry sustainability. Whilst the number of schemes and options has reduced over time, there remains scope for further amalgamation. Risk-based capital requirements would increase the incentive for schemes to consider amalgamation.

#### Plan types

There is a complex inter-relationship between benefit richness, demographic profile and the cost of cover. It makes intuitive sense that different benefits will appeal to different target markets. For example, options offering cover for a greater number of non-CDL chronic conditions tend to have an older risk profile. Although the causal relationship cannot be surmised from the data, common sense would indicate that richer benefits attract the less healthy and these options are therefore more expensive, both due to risk profile and due to the cost of the additional benefits. However, this only holds to the extent that benefit richness is correctly perceived and valued by members.

Plan types are distinguishable based on the day-to-day benefits offered. These appear to be a reasonable proxy for benefit richness in that there is a clear relationship between plan type, demographic profile and option pricing, albeit not entirely as expected. New Generation plans were found to be more expensive than Networked plans despite not offering insured day-to-day benefits. Hybrid plans were found to be more expensive than Traditional plans, despite Traditional plans historically offering the most comprehensive cover.

A high proportion of Hybrid plans (70.5%) offer an automatic threshold benefit (ATB). In addition, Hybrid plans were also found to be more likely to reimburse at a higher tariff rate, to cover a large number of additional chronic conditions, to cover high-cost speciality medicines, and to provide generous oncology benefits. Hybrid plans (particularly those offerings ATBs) are by nature more complex than other plans.

#### Benefit design complexity

Prescribed Minimum Benefits have reduced the ability of schemes to rely on financial limits to ration benefits. Consequently, the use of more clinically based rationing tools is clearly visible. Preauthorisation, chronic disease management and formularies are used almost universally across the industry. There is also extensive use of treatment protocols (including clinical entry criteria) and Designated Service Providers. While these tools may be more equitable (in that they direct resources towards those with the greatest need), they introduce an additional layer of detail and complexity.

Detailed clinical protocols are frequently not visible to the member. There are numerous possible clinical circumstances. For example, for a patient diagnosed with cancer, the multiple varieties of cancer all require specific treatment and different combinations of medication. This makes it difficult, when benefits are rationed using clinical criteria, for a medical scheme brochure to present every detail of clinical scenarios and to include all the related terms and conditions of available cover.

Numerous other examples of benefit design complexity were identified in the analysis, including the rules for accumulating claims to access Above-Threshold-Benefits, sub-limits for particular procedures, and a wide range of rules governing out-of-pocket payments.

Whilst the findings of the analysis show the deep complexities involved in analysing benefit design, it is also evident that this complexity might be necessary and serve an important purpose in the current regulatory framework. Due to the medical schemes' limited resources, benefits have to be rationed, so that complexity in benefit design acts as a form of implicit rationing. In addition, in a hypothetical medical scheme environment where members can easily compare benefit options, it is inevitable that there will be a large anti-selection effect: if beneficiaries could easily compare available alternatives, they would choose the option that best meets their needs for the least cost which would, in all likelihood, result in a destabilisation of risk-pools.

From a consumer perspective, this product complexity makes it difficult to compare medical scheme options and make purchasing decisions based on value (i.e. the relationship between the cover provided and cost).

#### Price rationing

It was found that schemes use price rationing mechanisms extensively. Contribution rates differ significantly between options and plan types (from R1 117 to R8 533 a month). In addition, there exists a broad spectrum of rates within each plan type (for example, Hybrid plans have contribution rates ranging from R1 710 to R8 533).

A complex range of co-payments and deductibles are used by schemes – penalties for non-compliance with scheme rules, for using non-formulary medicines, for utilising out-of-network providers, for particular procedures and so on. In many cases, the implementation of managed care interventions is 'soft' – members can bypass restrictions by paying additional amounts.

## Prescribed benefits - minimum or maximum?

The proportion of options that cover only the CDL chronic conditions has increased from 42.5% of options in 2006 to 56.8% of options in 2014. In 2003 (before the implementation of the CDL), 86.2% of beneficiaries had cover for more than 40 diseases; in 2004, 83.4% of beneficiaries were covered for 40 or fewer diseases, and in 2014, 99.8% of beneficiaries were covered for 40 or fewer diseases.<sup>38</sup> The proportion of beneficiaries with no cover for non-

CDL conditions has increased from 13.5% in 2003, to 53.0% in 2004, and to 69.6% in 2014.  $^{46}$ 

Given the strong relationship between chronic disease and propensity to claim, it is not surprising that schemes have moved away from offering additional cover for chronic conditions, as this benefit has an adverse impact on demographic profile. This is a clear example of using benefit design as a means of 'cherry-picking'.

## A useful framework for benefit comparisons

Whilst the methodology presented in this paper faces a number of limitations, it also presents a useful framework for decision-making by highlighting the key dimensions of benefit design. The analysis of benefits by plan type, and the break-down of benefits into the major aspects of benefit design, provides a useful tool with which to convey key results and to explore benefit design further. Despite the challenges in carrying out a full, extensive comparison of benefit design, and the possibility of omitting differences between options (owing to subtle elements of benefit design), there is value in undertaking a high-level comparison using the dimensions identified in this chapter.

### Conclusion

The inherent complexity of South Africa's health system, and the complicated medical terms and jargon characteristic of the regulations surrounding medical schemes and healthcare in general, make it a daunting task to market a benefit option to a consumer in an accessible manner. Clearly, however, medical schemes can do more to enable their members to make wiser and more informed decisions for example, by not marketing medical savings accounts as a benefit, and by producing brochures in a range of languages.

With 180 options on offer, complex terminology used in brochures, different protocols, rules and terms of coverage in place, and no form of standardised benefit design across schemes, the need for advice is evident. Given this complexity, consumers may not have the capacity, time or technical expertise to accurately judge which option is best for them. However, a reliance on brokers to act as intermediaries for prospective members creates its own set of challenges. In a system where brokers are relied upon to sell products, access to a distribution network and remuneration of brokers are key drivers of scheme success.

It is unlikely that the industry would comply with the principle of Treating Customers Fairly if it were to be applied to the industry. This raises serious questions for the industry on its ability to deliver value to the consumer.

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