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ANALYSING THE STRUCTURE AND NATURE OF MEDICAL SCHEME BENEFIT DESIGN IN SOUTH AFRICA

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This KWIK SKWIZ:

summarises Chapter 13 of the 2014/15 South African Health Review.

- The large number of benefit options available in the medical scheme market, along with a lack of standardisation and the mosaic of confusing terminology employed in scheme brochures, create a highly complex environment for consumer decision-making.
- 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.
- Medical scheme benefit design requires significant attention in order to facilitate equitable access to medical scheme cover in South Africa. The complexity facing the consumer serves a vital purpose, i.e. ensuring 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.
- Currently, risk pooling in medical schemes theoretically takes place at the level of individual benefit options (although in practice, there is some cross-subsidisation that occurs between options). In the absence of a Risk Equalisation Fund, the community rate for Prescribed Minimum Benefits (PMBs) within an option varies depending on its age and health profile. Consequently, members are paying different prices for the PMB package in different options.
- The wide range 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.
- Although PMBs 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, and to be sustainable, these require a larger risk pool. Even assuming 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.
- 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. Pre-authorisation, 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.

- A complex range of co-payments and deductibles is 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.

- Analysis of benefits by plan type, and the breakdown of benefits into the major aspects of benefit design, provide 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.

- The inherent complexity of South Africa's health system, and the complicated medical terms and jargon that are characteristic of the regulations surrounding medical schemes and health care 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.

SOURCE:

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