An affordable means of widening the Medical Aid net?

By David Brown
AGENDA

1. Traditional Medical Aid
2. Medical Schemes Act
3. Day-to-day Doctor Plans
4. What’s in it for the Doctor/Dentist
5. Pathology / Radiology
6. Hospital Plans-vital component in the chain
7. Traditional Insurance Hospital Cash Plans

Medical Insurance – An affordable means of widening the Medical Aid net? By David Brown
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## 1. Traditional Medical Aid

### Open Enrolment

**May not refuse membership**

The MSA 131 of 1998 sought to redress the inequities of previous provisions of earlier Acts with the introduction of idealistic doctrines of

- community rating means that all members belonging to an option pay the same contributions
- open enrolment – schemes must admit anyone as a member

### Late Joining Fee

**Can charge late joiner fee**

The Starting age for penalties is 35 years of age. The penalty is based on the number of years after 35 years an applicant was without medical scheme cover. The late joiner fees follow you eg you cannot join a scheme for two years and then hop to another scheme hoping that the two year membership with the previous scheme will absolve you from the penalty.

Foreigners over the age of 35 cannot claim creditable coverage for membership of schemes registered outside of RSA and the maximum penalty can imposed.

### Cross subsidising

**Depends on cross subsidising i.e. young and strong financing the old and frail**

The latest CMS annual report published 2 weeks ago reveals two interesting points:

1. that there has been no significant shift in average age of membership which is still at 32 years, the same as it was in 2004.
2. the annual increase in contributions over past 12 years is (CPI+4%points). The fact that a Pensioner with an income or R5000 per month is faced with paying 23% of their income (R1,138) the average monthly contribution for healthcare.

### Limited Flexibility

**Limited flexibility in respect of benefits and hence costs**

Medical Schemes are non-profit organisations. They do not have shareholders and therefore do not pay dividends and if profits are made the money carried forward to the following year. When members are denied care for medical problems in terms of the rules of the scheme, the Brokers/Financial advisors must be able to explain the non profit legal structure and status of the scheme.

Scheme rules and new options can only be amended and approved by the Registrar on an annual basis.
2. Medical Schemes Act

a) PMB’s – what this means to the member

Essential benefits that by law all schemes must cover. They cover all medical emergencies, 270 conditions that if left untreated would have a significant impact on your life and 25 common chronic conditions.

In the MSA 131 of 1998 the Minister of Health introduced Prescribed Minimum Benefits – enforceable via ICD 10 codes ensuring that members had a safety net and were not denied care for serious illnesses, with the minor exception that schemes may reduce the extra cost associated with paying for the minimum benefits by the use of formularies, protocols and designated service providers.

However the overall result being that service providers can charge what they like knowing that a deep pocket in the form of a medical scheme will be footing the bill the moment anything becomes life threatening.
b) Cash reserves - 25% – Draconian solvency/ reserving rules

Schemes are obliged by law to hold 25% of their contributions in reserve in order to protect themselves against large claims and no relief is expected in the proposed Medical Schemes Amendment Bill as proposed by the CMS to the Department of Health.

Many Medical Scheme industry experts say this percentage is unnecessary high and that scheme reserves should be aligned to their exposure to risk.
2. Medical Schemes Act - Costs vs Expectations

Private Hospital Facilities vs becoming a burden on the State!

Expectation of private facilities vs cost. It is common for a person to spend 15% of their monthly income on a medical aid and if current trends continue in 10 years time people will be spending 22% of their income on medical aid contributions.

Total number of Private Hospital Beds: 37 869 servicing 10.5 million

- Netcare 9 266 (25%)
- Life Healthcare 8 044 (21%)
- Mediclinic 7 130 (19%)
- National Hospital Network (NHN) 7682 (20%)
- Independent 4 353 (11%)
- Clinix 1 394 (4%)

Public Sector Beds: 47 051 servicing 40 million
2. Medical Schemes Act

(Continued)

d) Fraud – endemic – 5% of medical aid spend

1. Wastage – 30% of medical aid spend
2. Excessive charging (Gap Cover )
3. Over servicing

Christoff Raath, an actuary and CEO of the Health Monitor Company stated at the recent BHF conference in CT that it is estimated that providers and members defraud medical schemes of between R3 billion and R22 billion every year. Annual contribution income R117,5 billion.

Time to rethink this model don’t you think? Certainly more leniency is needed for the 82% of the population (42 million) less fortunate uninsured members who cannot join this privileged country club.
3. Day-to-day Doctor Plans

1. Becoming extremely popular with even the Medical Schemes taking up the opportunity e.g. Discovery KeyCare launched its GP Benefit in 2006

2. In 2003 DAY1 Health (Pty) Ltd commenced its business operations by being the first Non Medical Aid, i.e Health Insurance Product Provider to couple a Stated Benefit Hospital Plan with a Day to Day Doctor package that it negotiated and obtained from Medicross.

3. This was followed by OCSACare and Workers plans from Universal and some variations thereof in 2010. These day to day Doctor plans require that the member go to a contracted network doctor

4. These Doctor Health Networks support in excess of 3000 practices of which the majority are GP practices and some 250 Dental practices c/wide
### 4. What’s in it for the Doctor / Dentist

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5. Pathology / Radiology

1. Allied service of Healthcare.
3. X-Rays.
6. Affordable Hospital Plans – a vital component in the chain

COSATU in its end of year message issued on the 20\(^{th}\) of December 2011 in support of the NHI initiative acknowledged that ‘Most of our public health facilities are a disaster – derelict, under-staffed, under-resourced and short of essential supplies of drugs and equipment’.

1. Government hospitals a disaster.
2. Even lower paid employees want better for their families.
3. Private hospitals expensive if not on a medical plan.

‘In the absence of lower income medical scheme option - type covers (LIMS cover) insurance policies offering hospital cover provide an affordable entry point to those seeking care outside of the public sector’. Liz Still Health Care in South Africa 2013

Between 2007 and 2011 the medical scheme industry lost the impetus to continue reforms because of government’s change in direction – NHI.
7. Traditional Insurance Hospital Cash Plans – low premiums

1. Minimal premium – with 2 or 3 day franchise
2. Really an income protector.
3. Pays R300 – R500/day whilst in public hospital.
8. Hybrid products

a) Offer Primary Care Packages
b) Hospital Pay out rate covers normal hospitalisation.
c) Additional booster benefit to cover potential shortfall.
d) Employee signs waiver on admission to ensure payment of hospital.
e) Subject to pre-authorisation.
f) Limits abuse.
g) Pushing the boundaries because we can and we care.
9. Risk Evaluation

Each Employer group risk evaluated regularly

Medical service provider constantly re-evaluated

Employer invited and encouraged to participate in risk audit
10. Hospital Plans - Unexpected

1. ER24 – pre-authorisation (gatekeeper)
2. Illness Cover 1\textsuperscript{st} Day R6500, 2\textsuperscript{nd} Day R4500, 3\textsuperscript{RD} Day R4500 thereafter R1500 up to 21 day per illness event
3. Illness Top Up up to R40,000 per family per annum
2. Accident cover – R150,000 per individual and R300,000 per family per incident
3. Dread Disease (R250,000) annual
4. Gives access to private medical care in cases of emergency
### Medical Insurance

- Medical Insurance governed by Life and Short term Insurance Acts
- Pays a stated benefit – lump sum to the member however a signed letter of authority ensures payment to hospital/ provider
- Premiun are not linked to Salary bands. Community rating doesn’t necessarily apply. Affordable Premiums linked to Capped Stated Benefits not required to cover PMB’s and can decline members from joining.
- Greater flexibility can adjust benefit design and include Dread Disease, Disability and Funeral benefits and adjust premiums monthly etc
- Stated Benefits limit Service Provider Abuse

### Medical Aid

- Medical Aids governed by Medical Schemes Act
- Pays the service provider and in respect to PMBs expected to cover 100% of costs
- Community rated premiums linked to salary bands. High premiums due to PMB’s and open enrolment.
- All options have to be self-supporting, be financially sound and not jeopardise the financial soundness of any existing benefit option within the medical scheme. Medical schemes are obliged to conduct business so as to be in a position to meet its liabilities at all times. Premium increases have to be agreed by the CMS annually.
- PMB’s encourage service provider abuse – can charge what they like.

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12. Practical Solution

1. Two vital pillars of Healthcare provision:
   Medical Schemes (affluent and can afford)
   Medical Insurance (Cost effective)

2. You have a right to choose the option that fits you best

3. You can have a combination of both – that is the FUTURE
13. Target Market

1. Employees that need everyday 1\textsuperscript{st} world medical benefits but cannot afford traditional Medical Aid
2. Product not salary band designated
3. Not designed to REPLACE existing medical aid
4. Makes medical care available to a much wider pool of employed and self-employed people - cost effectively and congruent with Section 27 of the Constitution which provides the right for every citizen to access healthcare services as opposed to Medical Schemes that support the fortunate few.
5. Designed to cover day-to-day, necessary hospitalisation and emergency hospitalisation
14. In Summary

1. Traditional Medical Aids concerned by Insurance due to cost effectiveness and popularity
2. Designed to address two DIFFERENT markets
3. Insurance allows for the addition of at least 12 million members to be added to the primary and hospital health care system
4. NHI is going to become a reality if Medical Insurance is not allowed to flourish – current demarcation issue
5. Tax benefits (PAYE) not applicable when cost savings taken into account
6. Let private enterprise set parameters – ICASA classic example of government inability to modify free enterprise behaviour and thus costs and benefits
THANK YOU!