# PROGRESSIVE BENEFIT DESIGN

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Private sector embracing universal healthcare

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ACTUARIES & CONSULTANTS

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# Aim

To present ideas for discussion towards expanding medical scheme benefit design, in an affordable way, to enable schemes to play a meaningful role in Universal Coverage

$$Solve:\ f(expanded\ benefits; lower\ contributions; improved\ equity)$$

# Benefit design includes (broadly)

Benefits

Contribution structures

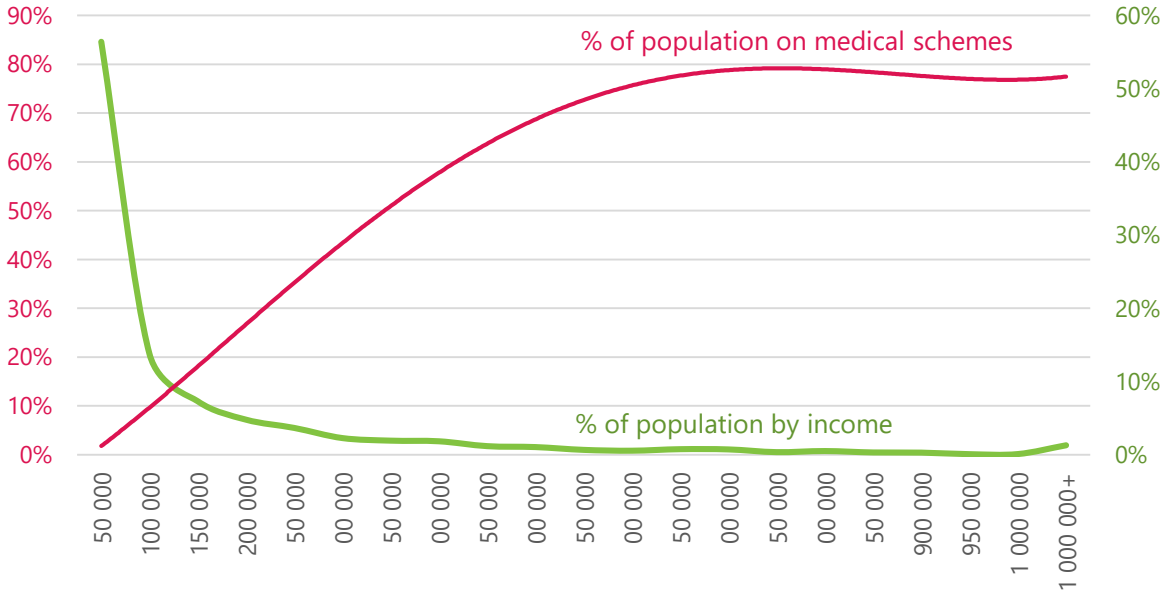
Options

Networks and contracting

Pricing

# Context: Economy

## Income distribution




Household income pa, 2015

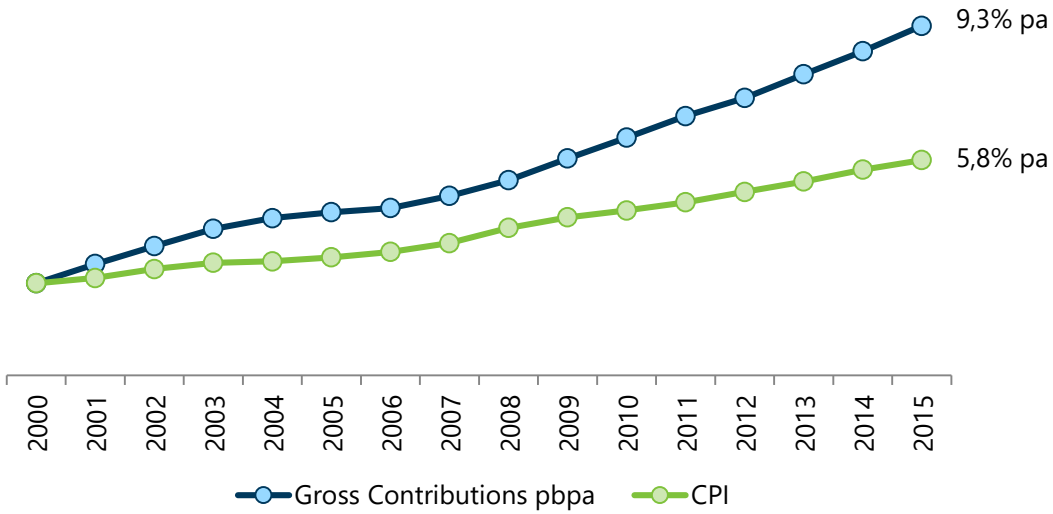
*Stats SA, IES*

55% of the population live in households earning less than R4,200 per month

Income inequality flows into all sectors of the economy, including healthcare

# Context: Affordability

## Inflation

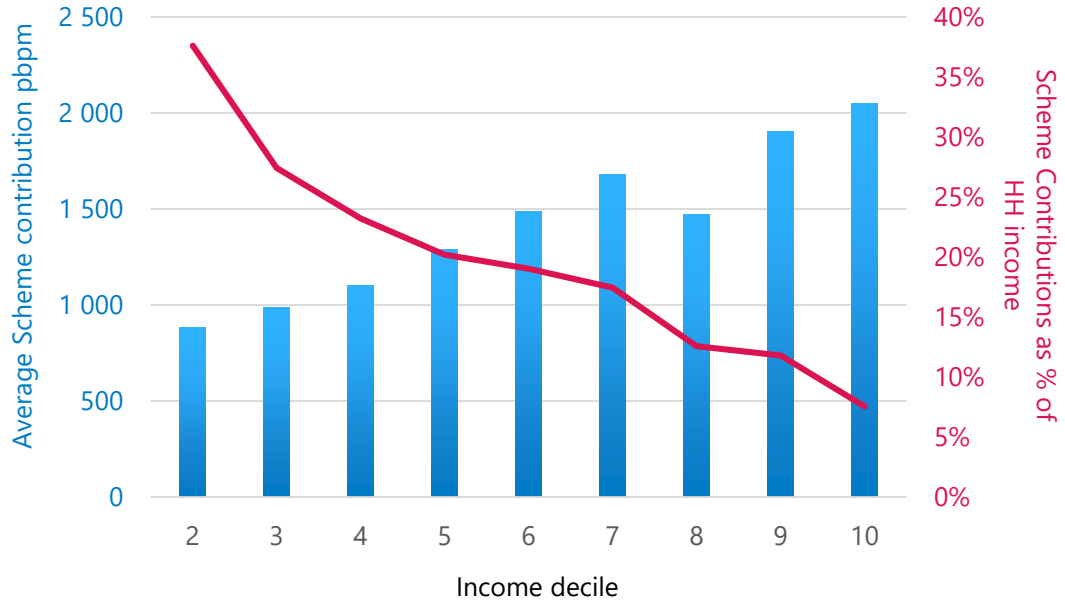



Medical scheme contributions continue to escalate above consumer inflation. The overall extent of which is hidden by 'buydown' which contributes another 1%-2.5% per annum

*CMS annual reports, Stats SA*

# Context: Affordability and household incomes

## Contributions and income



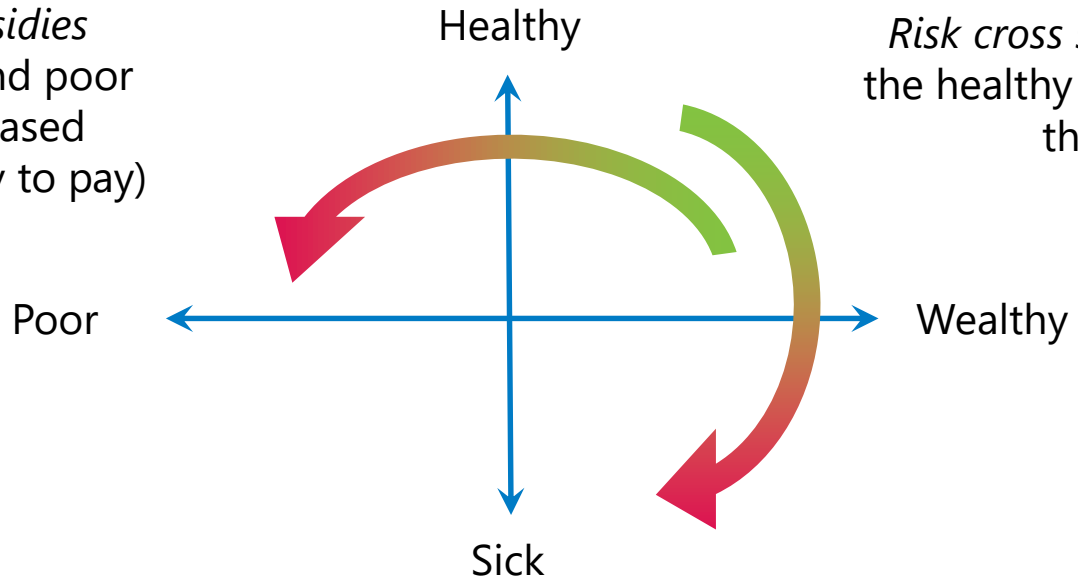

Contributions increase with income, but are regressive (higher % of income for lower income households)

Note that income doesn't tell the whole story – broader means assessment would be more appropriate.

*Stats SA, IES*

# Context - Solidarity

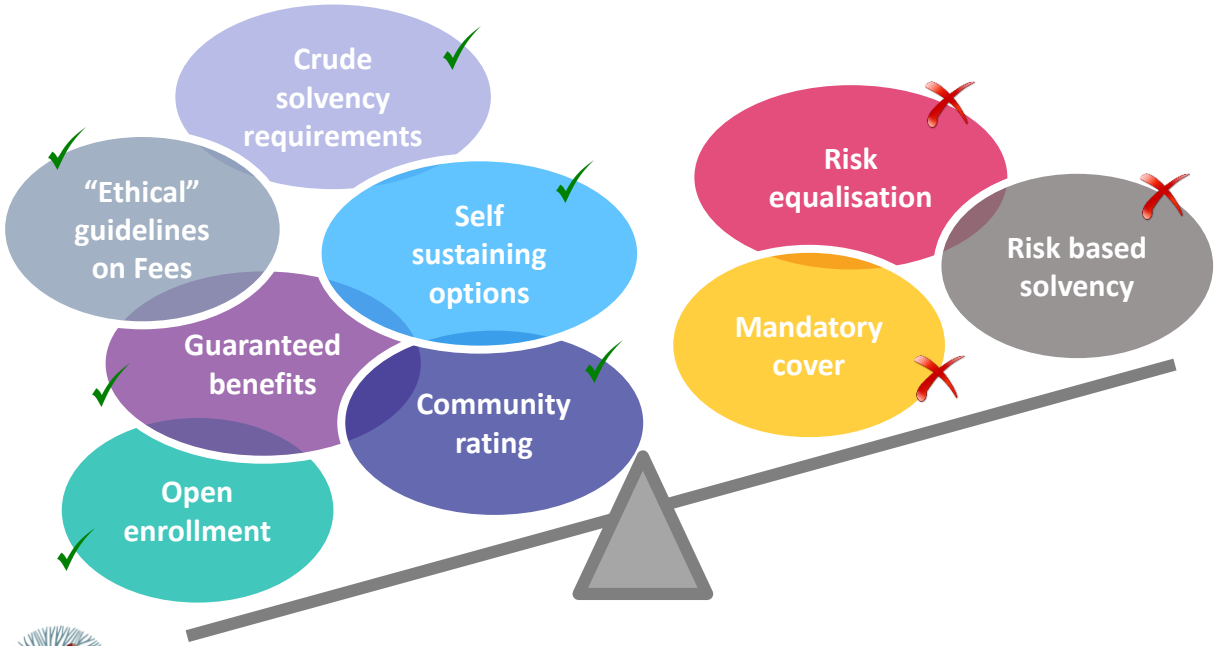
*Income cross subsidies* between wealthy and poor require income based contributions (ability to pay)




*Risk cross subsidies* require the healthy to pay more than they need

*Solidarity: Each should contribute according to their ability and receive according to their need*

# Context: Regulation

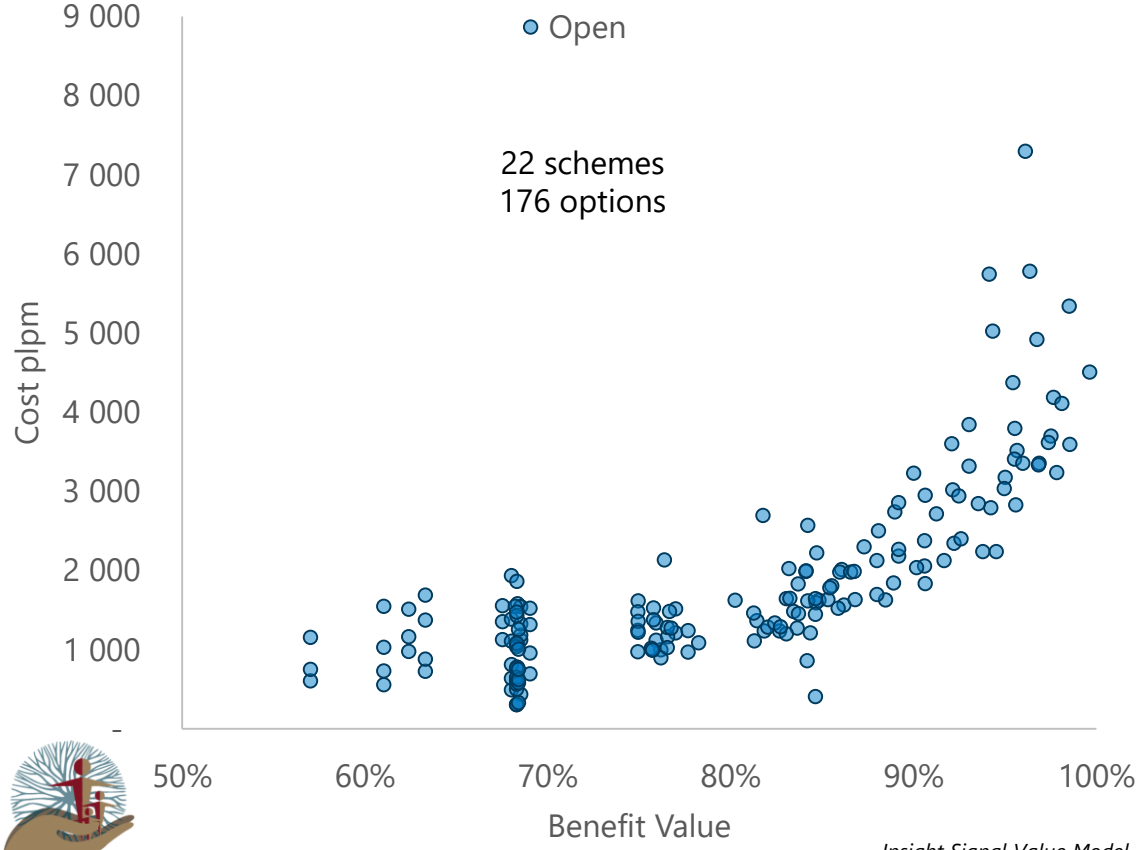



"Market Failure" is rather a failure to develop and implement a balanced and complete regulatory framework.

We have a compounded actuarial death spiral over a 17 year period.

There is no other way the medical scheme market could look given the regulatory pathway we have followed.

# Open scheme landscape – choice & fragmentation




*Insight Signal Value Model*

Open schemes need to attract young and healthy lives, and compete (partially) based on risk profile in the absence of *virtual pooling*.

Higher cost options often loss making as sick beneficiaries select higher benefits.

This is what results in segregated risk pools.

Anti selection into the scheme environment, between schemes, and within schemes.

Can't be first mover on income bands due to risk of losing high income members.

# Restricted scheme landscape


*Insight Signal Value Model*

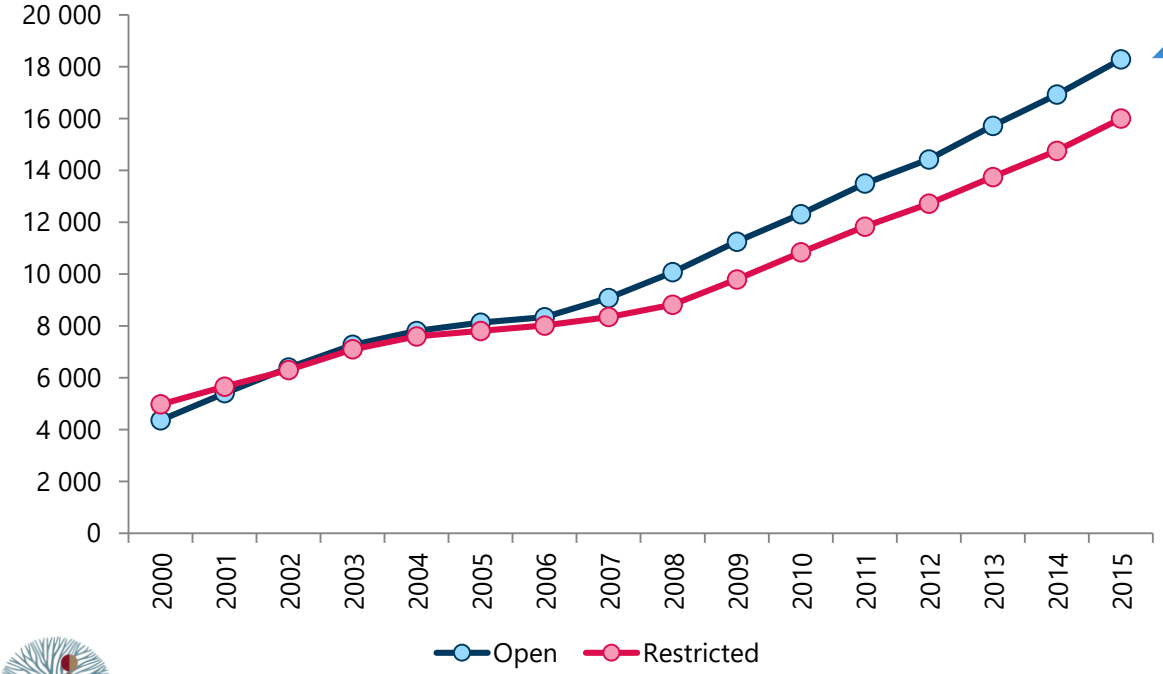
Restricted schemes have far fewer options on average (2 versus 8 on open schemes).

No need to provide as much choice with income banded contributions (almost all restricted scheme options are income banded compared to only lower options on open schemes).

Better risk and income cross subsidy on restricted schemes.

Tend to be smaller – risk of pursuing larger risk pools (size) will undermine currently effectiveness.

# Open and Restricted schemes - consequences




1.9% pa difference

In 2017:
15% lower contributions
5% richer benefits

*GCI increases pbpa, CMS annual reports*

# Lessons learned (1)

- Proliferation of options, especially on open schemes a direct result of MSA 33(2). Relaxation of “self sustaining options” requirement would allow schemes to pool common benefits, have better cross subsidies, and would likely result in fewer options naturally.

- Restricted schemes provide a working example of (greater) solidarity, which can be followed by open schemes, given the right regulatory changes (mandatory membership, income based contribution tables).

# Progressive Benefit Design – Rationale - NHI


322. Amendments to the Medical Schemes Act will be initiated as part of the broad phased implementation. Medical schemes will evolve and consolidate during this phase to provide complementary cover. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme.

Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS). The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI.

# Progressive Benefit Design – Rationale - PMBs

CMS
Council for Medical Schemes
CIRCULAR

**Circular 42 of 2017: PMB Review consultative meetings update**

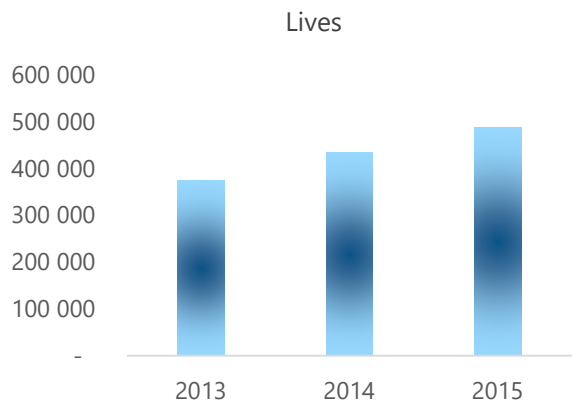
The Council for Medical Schemes (CMS) would like to inform stakeholders that the consultative meetings on the review of the prescribed minimum benefits (PMBs) will resume during the month of July. The aim of these consultation sessions is to ensure that there is a better understanding by all stakeholders regarding how the review process will unfold; and to get inputs and suggestions regarding the initiative. The ultimate objective of the review exercise as stated in previous communiqués, is to ensure that the PMBs are improved to include primary healthcare services, and to ensure that they are aligned with the National Health Insurance (NHI) policy developments. Stakeholders are invited to attend the meetings in line with the schedule outlined below.

# Lowering the cost of care while expanding benefits

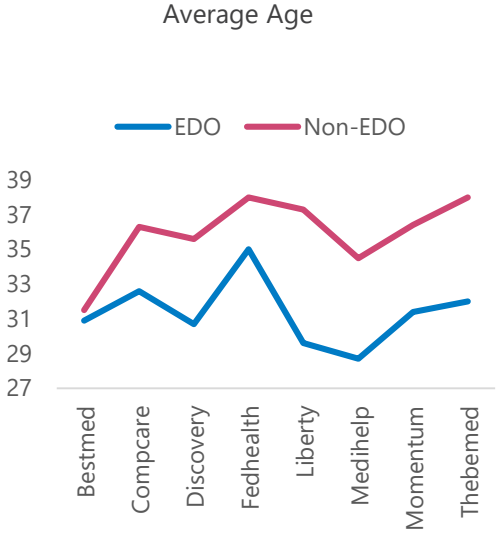
"Efficiency Discount Options"

- Parallel benefit design restricted to a provider network
- Price discounts and efficiencies for provider selection
- Pass cost efficiencies onto members via lower contributions
- Require exemption from the Medical Schemes Act

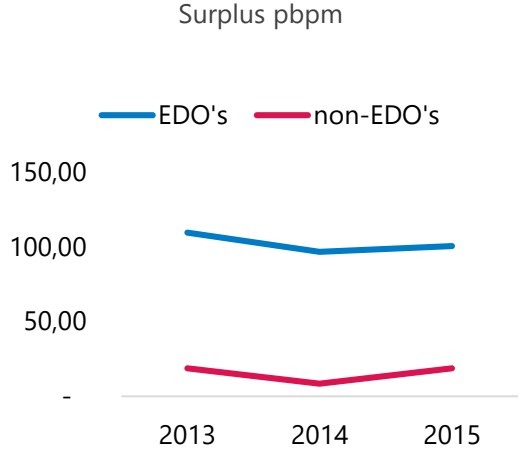
# EDO performance generally




Hold 24% of beneficiaries of schemes with EDO's




Lower age profile (On average 4.6 years younger than mainstream option)




Overall surplus generating; Contribute over 63% of the surplus on the 8 schemes with these options

# A new EDO case study

gems
Government Employees Medical Scheme

## EMERALD VALUE OPTION

Tender for Efficient hospital network, on cost and quality

+

General Practitioner nomination

+

General Practitioner to Specialist referrals

10% contribution discount to members

10% reduction in doctor hopping

22% reduction in specialist consultations

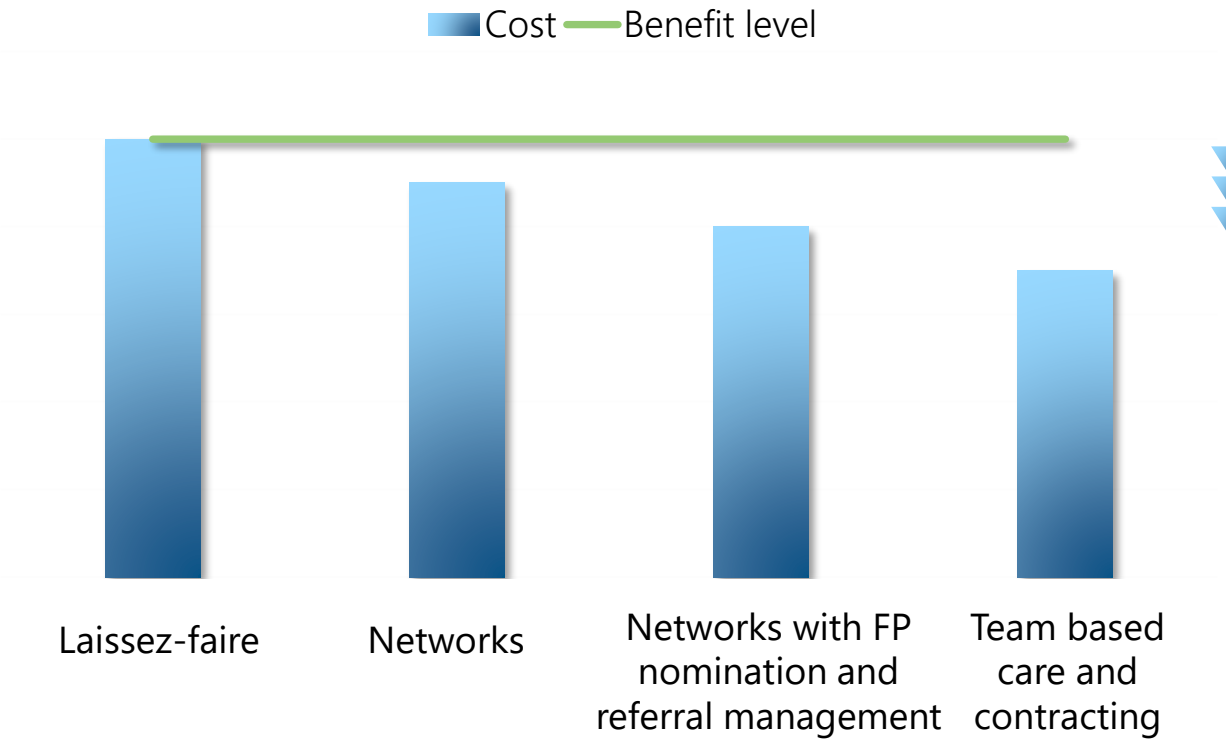
16% reduction in hospitalisations

12% lower costs, **despite worse risk profile**

21% increase in FP consultations relative to specialist consultations

113,000 beneficiaries in 6 months

# Future generation options

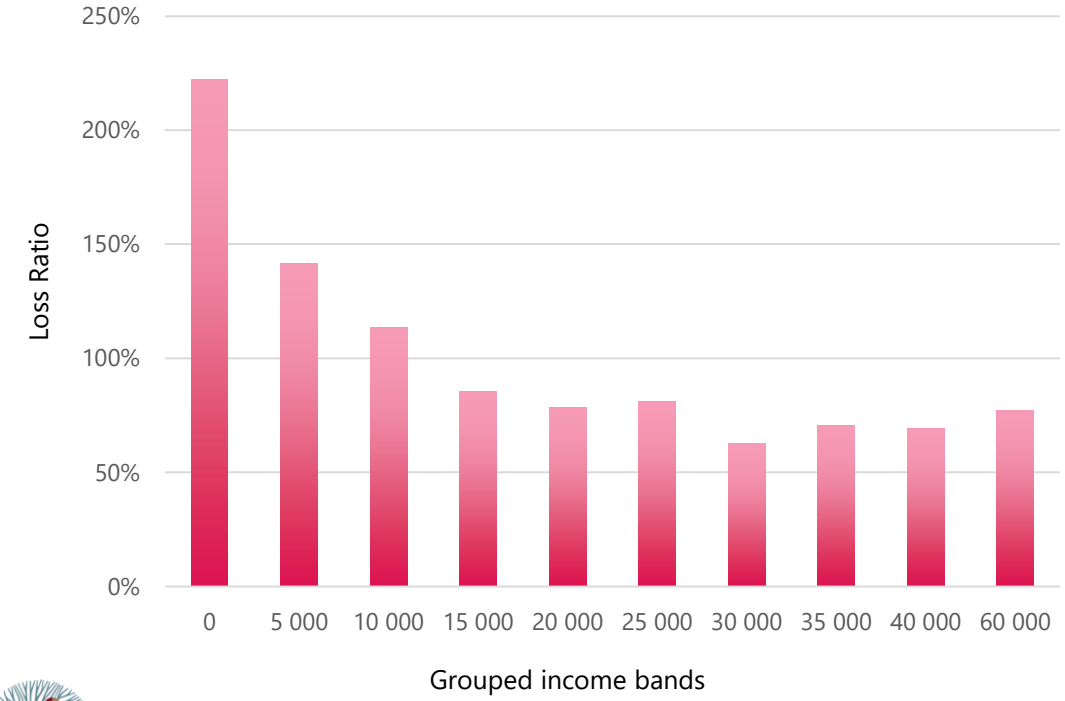



Could / should result in 30% price spread Without the need to create new options or separate risk pools (EDOs are the same option).

# Lessons learned (2)

- Benefit richness is not only a function of limits. EDO thinking can replace differentiation by limits.
- Cost for options with no OH benefits and young and healthy lives will increase if benefits are to be expanded to include primary care.
- Which can be mitigated through income based tables, greater use of networks, and care coordination.

# Income cross subsidies




*24 schemes, 40 options, 3m lives, overall loss ratio 93%*

Open schemes typically use income bands on lower options, a tool to limit buydown. Typically these top out at around R10,000 per month. Some restricted schemes go up to R60,000.

Restricted schemes have many more income bands than open schemes to smooth the contribution tables (average of 7 vs 3).

Income bands work better in restricted schemes because incomes are easier to verify and income based contributions tables are part of the remuneration package.

Note the juxtaposition of charging people different contributions based on their income, compared to different contributions for different benefit options.

# Lessons learned (3)

- Fewer options, with affordability achieved at lower incomes via income based tables on all options is feasible
- Costs for higher income earners will increase. The level of increases depends on the policy decisions taken
- But mandated membership and virtual pooling of risks will be necessary to avoid greater anti-selection into and risk selection within the environment

# A medium term future might look like…

A more standardised benefit package(s) across the market

Accessible through different levels of networks, care coordination and supply side models (basis of competition)

Means based contribution tables

Mandatory membership to limit anti selection and lower overall per capita costs

Virtual pooling to minimise risk selection

Resulting in:

Improved equity

Expanded Benefits

Lower contributions

Larger risk pools

# Obstacles

**DEPARTMENT OF HEALTH**

**NOTICE 435 OF 2017**

**COUNCIL FOR MEDICAL SCHEMES**

**MEDICAL SCHEMES ACT, 1998**

**FINANCIAL INSTITUTIONS (PROTECTION OF FUNDS) ACT, 2001**

**INVITATION TO INTERESTED PERSONS TO MAKE WRITTEN REPRESENTATIONS CONCERNING THE FOLLOWING INTENDED DECLARATION OF CERTAIN PRACTICES BY MEDICAL SCHEMES IN SELECTING DESIGNATED HEALTH CARE PROVIDERS AND IMPOSING EXCESSIVE CO-PAYMENTS ON MEMBERS AS IRREGULAR OR UNDESIRABLE PRACTICES BY THE MEDICAL SCHEMES, IN TERMS OF SECTION 7 OF THE FINANCIAL INSTITUTIONS (PROTECTION OF FUNDS) ACT, 2001 READ WITH SECTION 61 OF THE MEDICAL SCHEMES ACT, 1998**

3.1 The selection by a medical scheme of a healthcare provider or group of providers as the preferred provider or providers to provide to its members the diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions, namely as designated service providers without engaging in a tender process which is fair, equitable, transparent, competitive and cost-effective.

3.2 Imposing a co-payment in terms of Regulation 8(2)(b) that exceeds the quantum of the difference between that charged by the designated service provider of the medical scheme and that charged by a provider that is not a designated service provider of such scheme.

In its current form the UBP declaration would severely happen a scheme's ability to establish a compelling DSP network.

Circular 9 of 2003 stated that a provider DSP contract is not necessary.

On 3.1 – its not feasible to expect meaningful proportions of thousands of GPs or Specialists to respond to a tender.

On 3.2 – the limited co-payments suggested will expose competitor prices, and limit the incentive to make competitive offers for the prospect of volumes. Also allows no room for non price based criteria e.g. Quality)

# Obstacles

CMS
Council for Medical Schemes
CIRCULAR

**Circular 45 of 2017: Guidance on benefit changes and contribution increases for 2018**

The CMS is also concerned by the impact of product proliferation of benefit options especially since a significant number of these options are running at a loss. It is against this background that the CMS will be undertaking research with regards to risk pooling and consolidation, analysis of the Efficiency Discounted Options (EDO's), and benefit option classification. These research initiatives will be supported by a review of the Amendments to the Act. Until then, medical schemes are cautioned against further fragmentation of their current risk pools through the introduction of additional benefit options including EDO's.

There is a selection issue which can be mitigated through virtual pooling.

But EDO's are not separate risk pools, and they are (overall) running at a surplus.

They present lower price points for new market entrants who would otherwise buy less benefits.

Early evidence on GEMS EVO suggests that with some additional leverage, real change to healthcare delivery can be achieved.

# Obstacles

HPCSA
Health Professions Council of South Africa

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**Invitation to the HPCSA symposium on Global Fees**

**11 May 2017**

Dear Practitioners

The HPCSA invites you to a symposium to discuss the matter regarding global fees. This discussion is aimed at engaging with the relevant stakeholders in addressing concerns expressed by healthcare professionals in relation to global fee and similar arrangements by medical schemes.

Due to the importance of ensuring cost-effective care, but doing so in a manner that protects patients and ensures appropriateness of care, the HPCSA will host roadshows to engage with practitioners and relevant stakeholders on these matters, after which, Council will provide guidance to practitioners in fulfilling the Council's role of Protecting the Public and Guiding the Professions.

The dates for the upcoming symposiums are as follows:

| DAY | AREA | VENUE |
|---|---|---|
| Tuesday, 16 May 2017 | Johannesburg (Midrand) | Gallagher Estate |
| Thursday, 18 May 2017 | Durban | Greyville Exhibition Centre |
| Tuesday, 23 May 2017 | Cape Town | The West Inn |
| Wednesday, 24 May 2017 | Bloemfontein | University of Free State |

To register to attend the symposium, click here

Regards
Dr K Letlape
HPCSA President

Protecting the public and guiding the professions
President: Dr TKS Letlape, Vice President: Mr. LA Malotana, Acting Registrar/CEO: Adv P Khumalo

The HPCSA stance on global fees, if maintained is going to set us back years in provider payment reforms.

We have the two extremes of reimbursement operating in South Africa but cannot agree on a middle ground approach.

Current incentives between patients, providers and funders are not aligned.

We need to be able to create alternative reimbursement models to encourage provider side innovation and reorganisation.

$$Solve:\ f(expanded\ benefits; lower\ contributions; improved\ equity)$$

| ✓ | ✓ | ✓ |
| --- | --- | --- |
| Consolidate options | Progressive networks and care coordination | Think about “options” differently, and relax 33(2) |
| Add primary care | EDO option levels | Add primary care |
| Allow networks and care coordination | Mandatory membership above specified income | Means based contribution tables |
| | | Virtual pooling of risk |

# THANK YOU

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