



COUNCIL FOR MEDICAL SCHEMES

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CONSULTATION ON A REVISED BENEFIT DESIGN STRUCTURE FOR MEDICAL SCHEMES

PART A: INTRODUCTION

Purpose

1. This document outlines a revised benefit configuration for medical schemes as a basis for consultation with stakeholders.

Problems with existing benefit configuration

2. The existing "silo-type" benefit option framework for medical schemes allows for *de facto* risk-related pricing for common benefits offered by medical schemes. This contradicts the intention of the Medical Schemes Act, as well as of health policy in general. Correcting for this requires that common benefits be offered, and priced, according to the risk pool of the scheme and not a sub-set of that risk pool.
3. Section 29(1)(n) of the Act limits the potential pricing configurations for medical schemes to variations in income or number of dependants. This limitation, for instance, prohibits the Council from registering arrangements where pricing varies exclusively on the basis of alternative provider contracts. This prohibition is inappropriate and prevents schemes from creating and pricing benefits in a manner that promotes reasonable provider competition.
4. The implementation of the Risk Equalization Fund (REF) requires that an industry-wide community rate be applied for prescribed minimum benefits (PMBs). These benefits are the common benefits of the industry and should not vary in price except to account for different service provider contracts.

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PART B: PROPOSED FRAMEWORK

Objectives of the revised framework

5. To remove the fragmentation of risk pools resulting from the registration of benefit options as virtual medical schemes.
6. To completely remove risk-selection activity in respect of essential health care.
7. To improve transparency of scheme designs to aid members in making informed decisions.
8. To ensure that scheme contributions are transparent and fully differentiated between health care risk contributions, medical savings account deposits, and non-health expenditure.
9. To improve the access to PMBs for members.
10. To remove opportunities for any arbitrary denial of benefits by medical schemes.
11. To improve price competition between medical schemes.
12. To foster the development of selective contracting between medical schemes and medical service providers.

Overview of recommendations

13. The recommended framework proposes a movement away from the silo-type options in existence today toward the establishment of “scheme benefits” (i.e. scheme-wide common benefits with a single contribution table) with buy-up “supplementary benefit options”.
14. It is therefore recommended that a distinction be made between benefits that are common to all options at present and benefits that are not, or do not have to be, common. This distinction would be achieved by requiring that common benefits be provided and priced by a scheme across the entire membership, i.e. not by ‘option’ as occurs at present. Additional benefits should be purchasable on a voluntary basis by members, subject to the reasonable application of waiting periods.
15. This proposal would result in a single risk pool for each scheme for common benefits and be distinct from risk pools for supplementary benefits.
16. The common benefits would be mandatory for all members joining the scheme.
17. The common benefits would include both PMBs and other benefits common to all members of the particular scheme.
18. Risk equalization would affect the pricing of PMBs only.

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Benefits

19. It is recommended that the term 'benefit' be defined distinctly from the "medical service provider" that provides the benefit. As such a benefit refers exclusively to the cover offered, and not how the cover is offered. Given this, it is recommended that "benefits" be defined as "the specified medical conditions or 'relevant health services' for which the medical scheme offers to provide cover."
20. It is recommended that "cover" be defined as "the liability established by the scheme, in respect of a member, whereby specified expenses incurred by a member in respect of a relevant health service, are to be defrayed."

Scheme ("common") benefits

21. It is recommended that "common benefits" be defined as "benefits which are available on a mandatory basis to all members of the scheme". It is recommended that scheme benefits be made up of the following:
 - 21.1. Prescribed minimum benefits in totality; and
 - 21.2. All benefits that are common to all members of that scheme, irrespective of whether or not they are prescribed minimum benefits.

Supplementary benefits

22. It is recommended that "supplementary benefits" be defined as "benefits which are made available by the scheme on a voluntary basis for members".
23. It is recommended that supplementary benefits be offered via "benefit options" each of which will offer a specified set of benefits.
24. It is recommended that all supplementary benefit options be in respect of out of hospital services and that hospital benefits be provided as common benefits subject to the community rated contribution.
25. It is recommended that a fixed set of supplementary benefit options be permitted.

Provider contracts

26. Where a medical scheme permits a choice of service provider for the obtaining of any benefits for scheme benefits, it is recommended that a reduced contribution be permitted off the scheme risk contribution. This is appropriate as no barrier to medical scheme participation results and it serves to promote significant provider competition.
27. Where a medical scheme permits a choice of service provider for the obtaining of any benefits for supplementary benefits it is recommended that a reduced contribution to the relevant specified supplementary benefit risk contribution be permitted. The rationale for this is the same as that applying to the provision for scheme benefits noted above.

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28. As anti-selection is possible where members choose an alternative provider, the following requirements should accompany the above recommendations:
- 28.1. Hospital benefits: a member should be able to choose their provider annually, but be subject to a pre-existing condition waiting period of 12 months. The waiting period will apply to the treatment of all conditions diagnosed in the preceding 12 months. The waiting period will not result in a denial of benefit, but rather it will require that the member make use of the provider selected in the year in which the condition was originally diagnosed. This provision should however only apply where a member moves from a restricted choice to an open choice.
 - 28.2. Primary care services: a member should be able to choose their primary care provider annually on a voluntary basis. No pre-existing condition waiting period should apply to an annual shift.
 - 28.3. Chronic benefits: these benefits cannot be treated in the same manner as hospital benefits. It is proposed that the discount to the scheme resulting from the choice members *with chronic conditions* make about service providers accrue in part to all members and in part to the chronic members who choose cost-effective providers. Consequently, the only members able to benefit from a provider choice will be those with chronic conditions. Members without chronic conditions would not be eligible for a discount based on their choice of a chronic service provider. The scheme would have the discretion to decide on the degree of differentiation.

Financial requirements

29. It is recommended that no cross-subsidisation occur between the scheme common benefits and supplementary benefit options. Cross subsidisation may be permitted in respect of supplementary benefit options.
30. It is recommended that the funding of non-health expenses be separated from the funding of benefits.
31. It is recommended that schemes not be entitled to use the benefit reserves (i.e. reserve accumulated from risk benefit contributions less claims) to fund shortfalls in non-health expenses.

Contributions

32. It is recommended that the contribution applying to scheme benefits be defined as the "scheme risk contribution" in the Act.
33. It is further recommended that the pricing of these benefits be offered on the following basis:
 - 33.1. Full community rating: no variation between principal member, adult dependant or child dependant be permitted. For the purposes of scheme benefits the 'community' is the 'scheme'.
 - 33.2. Ceiling on additional charges for additional dependants: the maximum variation in contributions be limited to a family of three.

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- 33.3. Family: a family be defined so as to include: married couples; couples in a committed long-term relationship; single adults; and all children for whom a 'burden of support' exists with any adult in the family.
- 33.4. Child dependant: the age for classifying a member as a child should be related to the age of majority, i.e. 21. It is recommended that this period be extended to 29 for all individuals who can prove they are full-time students. (This latter category could be extended if verifiable criteria could be identified of people who are in low-paid work because of educational requirements and consequently have insufficient means to join a scheme).
- 33.5. Dependants outside of the 'family': adult dependants outside of any family unit be regarded as a separate family for the purpose of calculating contributions.
34. It is recommended that the contribution applicable to supplementary benefits be defined as the "supplementary benefit risk contribution" in the Act.
35. It is proposed that supplementary benefit option contributions be community-rated by option.
36. It is recommended that all non-health contributions be reflected as a uniform flat Rand contribution for all beneficiaries / family. A separate flat uniform Rand contribution, related to actual costs incurred can be charged for supplementary benefits.

PART C: REQUEST FOR COMMENT

37. It is requested that comment be provided to the Office of the Registrar of Medical Schemes on all the issues raised in the above framework by no later than 30 March 2006.
38. All comments should be addressed, or emailed to **Patrick Matshidze**. The address for mailing is **Private Bag X34, Hatfield 0028**. The email is p.matshidze@medicalschemes.com.



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