Prescribed minimum benefits raise costs

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A legal battle is in progress between the Board of Healthcare Funders (BHF) and the Council for Medical Schemes (CMS). At the heart of the dispute are PMBs (prescribed minimum benefits) and how medical schemes are to interpret the stipulation in the Medical Schemes Act that schemes are required to "pay in full" for PMBs.

PMBs are a politically determined list of 271 medical and 25 chronic conditions. For all PMBs, medical schemes are expected to cover the full cost of the diagnosis, treatment and any additional care. In the past the CMS has threatened to revoke the accreditation of medical schemes and administrators if they are found to routinely break the law by denying patients full cover for PMBs.

Why do medical schemes take such a risk? Because, if they were to obey to the letter and pay the full expenditure associated with covering the costs of the PMBs without any limitations, they would very quickly go insolvent.

Medical scheme member contributions cover a defined list of benefits. These are set out in the member's agreement with the medical scheme. Medical scheme administrators in turn are compelled to guard the interests of all members by ensuring that in carrying out their administrative duties they adhere strictly to the terms of the contract between the individual member and the medical scheme. If they routinely pay for treatments that have no cost limitations, they will end up bankrupting the medical scheme and failing in their duty to the entire pool of members.

PMBs were first promulgated by the Medical Schemes Act of 1998 with cover of the 25 chronic conditions such as hypertension, diabetes, asthma, etc, being added in 2001. The Medical Schemes Act of 1998 was a dramatic departure from the previous legislation governing the operation of private medical schemes in SA. More specifically, the government slowly began to lay the foundations for a mandatory health insurance type system. As noted by Professors Heather McLeod and Shivani Ramjee, "Since 1994 there has been a substantial return to solidarity principles although medical schemes still operate in a voluntary environment. The fully re-written Medical Schemes Act, No 131 of 1998, which has been applicable since 1 January 2000 has prepared the environment for Social Health Insurance".

The current court battle over the definition of paying "in full' for PMBs merely diverts attention from the root of the problem, namely, whether private medical schemes should be forced to cover certain benefits at all. By forcing medical schemes to provide a comprehensive package of minimum benefits, the PMB regulation attempts to stop risk selection through product design.

For beneficiaries at the low end of the market, typically the young and healthy, PMBs are neither necessary nor appropriate. Instead, policies that predominantly cover accidental risks tend to appeal to younger people. Policies covering mainly chronic conditions tend to appeal to older people. However, the government's list of PMBs applies to all individuals regardless of age, sex or health status and whether or not they actually need the cover. Like any kind of insurance, for medical schemes to provide extra cover, they have to charge higher premiums, and therefore, not surprisingly, these prescribed minimum benefits raise the predicted costs of every option. The probability then of people at the low end of the market seeking private medical coverage is greatly reduced and people at the margins will leave.

PMBs prevent medical fund actuaries from devising schemes to suit particular categories of members and circumstances, and, especially important, ones with limited costs to cater for low income earners. Christoff Raath recently stated, "We are witnessing several medical scheme options and sub-populations where the cost of delivering PMBs alone is in excess of R800 per life per month, due solely to the poor demographic profile of these risk pools".

In order to pursue the so-called act of 'social solidarity', the Medical Schemes Act of 1998 introduced four major changes: open enrolment, community rating, statutory solvency requirements, and PMBs. Open enrolment is the practice whereby medical schemes are compelled to accept all individuals, regardless of age, sex or health status (subject only to their income and number of dependents or both). Community rating made it compulsory for every scheme to charge the same premium to every member within an option, despite their age or state of health. Stipulated in the statutory solvency requirements is the minimum amount of accumulated funds that each scheme should hold as a reserve. Finally, it is compulsory for every scheme to provide PMBs.

'Social solidarity', therefore, has the unintended consequence of driving lower-income and healthy people out of the market or preventing them from even entering it. This causes the risk pool of insured people to shrink and to consist of less healthy individuals, thus driving up contribution levels even further, which makes health insurance more and more unaffordable. This vicious cycle could eventually lead to a situation where the entire health insurance market disappears altogether.

To complete the 'social solidarity' process, the architects of the Act of 1998 envisaged further mechanisms to be introduced at a later date. These included the establishment of a risk equalisation fund (REF) and income cross-subsidies in order to move towards a Social Health Insurance (SHI) type system and ultimately National Health Insurance (NHI). A REF essentially aims to transfer money from schemes that have more low-risk members towards schemes with higher risk members – where risk is measured along several key, pre-specified dimensions.

The government's recent pronouncement of its intentions to introduce a NHI seems to indicate that it has by-passed the idea of introducing a SHI type system and opted to go straight for the more comprehensive NHI. The main difference between the two systems is that a SHI compels all formal sector employees (above the minimum tax threshold) who are not already covered by a scheme to pay on a monthly basis into a SHI fund. This targeted group of individuals would not be allowed to opt out of the scheme or be excluded and their premiums would be based on their incomes. Only those who contribute to the SHI fund would be entitled to a predefined list of basic benefits in addition to access to free primary health care services. A NHI system in contrast, is a universal system that covers the entire population irrespective of whether contributions are made.

Our public sector is already overstretched. To relieve some of this burden, government should allow the private sector to play a more important role. Government should be doing its utmost to increase the number of beneficiaries of private healthcare. If it would remove all statutory requirements on private medical schemes, let them compete against one another for business, and let individuals decide for themselves what to do with their money, the cost of healthcare insurance would become affordable for all and not require government to act as manager. At the very least it should allow certain schemes to be exempted from PMBs so that they can cater for those at the low end of the market. More desirable would be the option for members to vote on whether their scheme should include the PMB requirement. This would give actuaries the scope to devise schemes that cater specifically for low income individuals.

Recent announcements and the direction of policy, however, suggest that government is going to continue to compel medical schemes to move away from economic and actuarial realities and move us into a situation that cannot be anything but unsustainable.

To avoid that catastrophe, people need to be allowed to take responsibility for their lives. Being forced to pay premiums commensurate with their risks would give people an incentive to be more careful. Private medical schemes need to be in a position to compete in the market and offer either positive incentives such as reduced premiums or special discounts to members and policyholders who exercise regularly, drink in moderation, or do not smoke, etc, or create disincentives and charge higher premiums to those who do. A healthier and more self-reliant population would emerge and South Africa would be able to consider strong economic growth an attainable possibility.

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