

MAKING SENSE OF MEDICAL INSURANCE IN SOUTH AFRICA TODAY

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On 5 October 2003 the *Sunday Times* ran a feature on the medical scheme industry, to update readers on a number of changes that are currently taking place, primarily as a result of new legislation. A range of topics was covered in separate articles, and are summarised below.

PUBLIC SERVICE EMPLOYEE MEDICAL SCHEME

The Public Service currently employs approximately 900 000 people, of whom only 500 000 are members of a large range of medical schemes. The balance rely on public facilities for their health care requirements.

Government has announced its intention to have all public service employees covered by one medical scheme, with effect from January 2005. This will have the following effects:

- an increase in the number of people being treated in the private health care sector
- standardisation of benefits provided to employees
- economies of scale for management of the scheme
- increased buying/negotiating power with suppliers of services.

This should result in tighter management and increased affordability of health care benefits. In addition, the public health care sector should be able to allocate current budgets to fewer patients.

The tender to be issued for the administration of this medical scheme will be a catalyst for the required increase in black economic empowerment of the medical scheme industry and address some of the imbalances currently experienced in this sector. Eighty per cent of white South Africans currently enjoy medical scheme cover, while only 20% of the black population do so (a total of 18% of the South African population is covered).

PRESCRIBED MINIMUM BENEFITS

Alterations made to the Regulations of the Medical Schemes Act have made it compulsory for medical schemes to provide funding for the management of chronic illnesses from January 2004.



The addition of a Chronic Disease List (CDL), covering 25 chronic illnesses, to the Prescribed Minimum Benefits will have cost implications for most medical schemes, with schemes having to fund the diagnosis, medical management and investigation as well as medication for listed diseases. These costs may not be subject to co-payments and may not be funded from the savings account portion of a member's benefits. While many medical schemes have in the past provided benefits for chronic medication, the costs of out-of-hospital management of these conditions will pose an additional risk to many schemes.

Schemes most at risk will be those with poor clinical risk profiles, primarily those with a pensioner ratio above the average. These schemes will face additional costs next year that will need to be funded from increased contributions or at the expense of other benefits that may be reduced to subsidise this requirement.

The Risk Equalisation Fund (REF), planned for introduction in 2005, will address the problems posed by variances in risk profiles across schemes. All schemes will pay into the REF, which will be distributed to schemes based on their risk profile, larger disbursements going to those assessed as having higher risk. Concern has been expressed at the asynchronous timing of legislative changes – the implementation of expanded Prescribed Minimum Benefits a full year before that of the REF will put higher-risk medical schemes at a disadvantage during this window period.

RISK EQUALISATION FUND

January 2005 sees the implementation of an REF for the medical scheme industry. The objective of this fund is to 'level the playing fields' with regard to risks that medical schemes are exposed to. A uniform contribution will be made by all medical schemes and disbursements will be made to schemes depending on their level of risk (calculated by analysing membership profile), with higher-risk schemes receiving larger payouts.

The implementation of the REF will lead to a greater level of premium contribution standardisation for a set of health care benefits. As contribution rates are currently used as a competitive parameter by schemes, this will lead to greater competition based on service rather than cost, which will have positive effects on the industry. One of the objectives is the protection of affordability of health care cover – this will need to be closely monitored along with the effects of other legislative changes.

MANAGEMENT OF FRAUD IN THE MEDICAL SCHEME INDUSTRY

The issue of fraud in the medical scheme industry continues to be of great concern and is now being addressed through a collaborative effort. The Board of Healthcare Funders, a body representing member medical schemes, has initiated a Fraud Unit by bringing together industry roleplayers in an information sharing initiative.

It is widely reported that 10 - 20% of the R40 billion spent in the medical scheme industry can be attributed to fraudulent practices, including:

- members receiving benefits to which they are not entitled (sharing membership cards)
- providers claiming for services which are included in benefits after providing services which are not included in benefits after providing services (spectacles claimed for after dispensing sunglasses)
- providers claiming from medical schemes for non-health care services (cash, pots, cookware, audio equipment, etc.)
- providers claiming for patients when no services were delivered.

The commitment shown by the roleplayers, primarily the large administrators, will increase the effectiveness of this initiative. Information will be shared across schemes to track providers and/or members who have unusual claims patterns. Providers found to have submitted fraudulent claims to one scheme will be investigated in other schemes in order to strengthen legal cases. A register of these providers will also be kept for use by medical schemes.

EMPLOYER-FUNDED HIV TREATMENT INITIATIVES

It appears that legislation is preventing employers from providing treatment to HIV-infected workers.

The Council for Medical Schemes, the body responsible for enforcing medical scheme legislation, has indicated that employers who provide treatment benefits for HIV-infected employees are effectively carrying out the business of a medical scheme and need to comply with all aspects of the Medical Schemes Act, including provision of cover for the extensive Prescribed Minimum Benefits. This is based on a technicality where employers outsource the management of this benefit to companies providing HIV/AIDS disease management services. Since employers who wish to offer this benefit feel they are offering a valuable service to their workforce, it has always been expected that the Council for Medical Schemes would grant exemptions to facilitate the process. The Council has indicated that it will not be doing so. One spokesperson has gone as far as to say 'Those companies that are complaining would have had their employees on medical aid if they were genuinely concerned.'

Neil Kirby of Werksman Attorneys points out that most companies involved in this issue do not want to fall foul of the law and the Council for Medical Schemes. This issue may only be resolved when a company follows the legal route (possibly through the Constitutional Court) to address the situation.