

# MEDICAL SCHEMES AMENDMENT ACT

## THE IMPACT ON MEDICAL SCHEMES

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**MEDSCHEME HEALTH RISK SOLUTIONS**

**BHF CONFERENCE 2008**

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# AGENDA

- **Components of SHI**
- **Impact of Basic Benefits**
- **REF equalises PMB's and not Basic Benefits**
- **Other elements**
- **Impact on younger lower risk members**
- **Impact on low income members**
- **Order of implementation**

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# COMPONENTS OF SHI

## 1. Risk cross-subsidies

- Community Rating & Open Enrollment
- PMB's
- Basic Benefits (BBP)
- REF

## 2. Income cross-subsidies

- Removal / re-allocation of TES
- Income based mechanism to fund PMB's / BBP

## 3. Compulsory membership

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# IMPACT OF BASIC BENEFITS

## Change in the benefit / option structure of schemes

- Basic Benefits = PMB's + other treatment while hospitalised
- Same basic benefits for all members in scheme
- Other benefits in Supplementary Benefit Options (SBO's)
- Membership of SBO's are voluntary
  - May only choose one SBO and all beneficiaries on same SBO
- Contributions the same for all members in BBP or SBO,  
except:
  - discounted rates if limiting to preferred providers
  - differentiation by income
  - regulations relating to prescribed categories of beneficiaries

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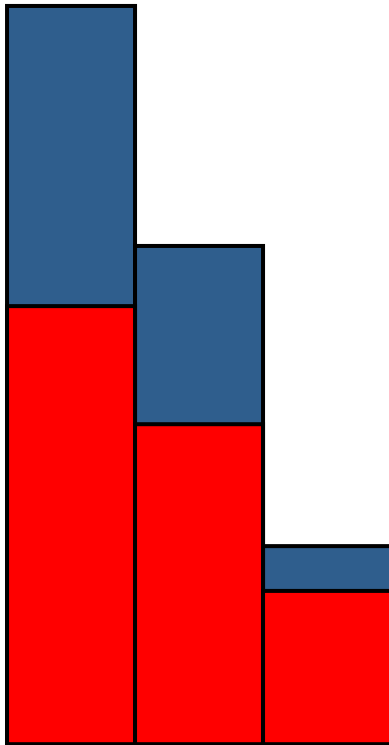


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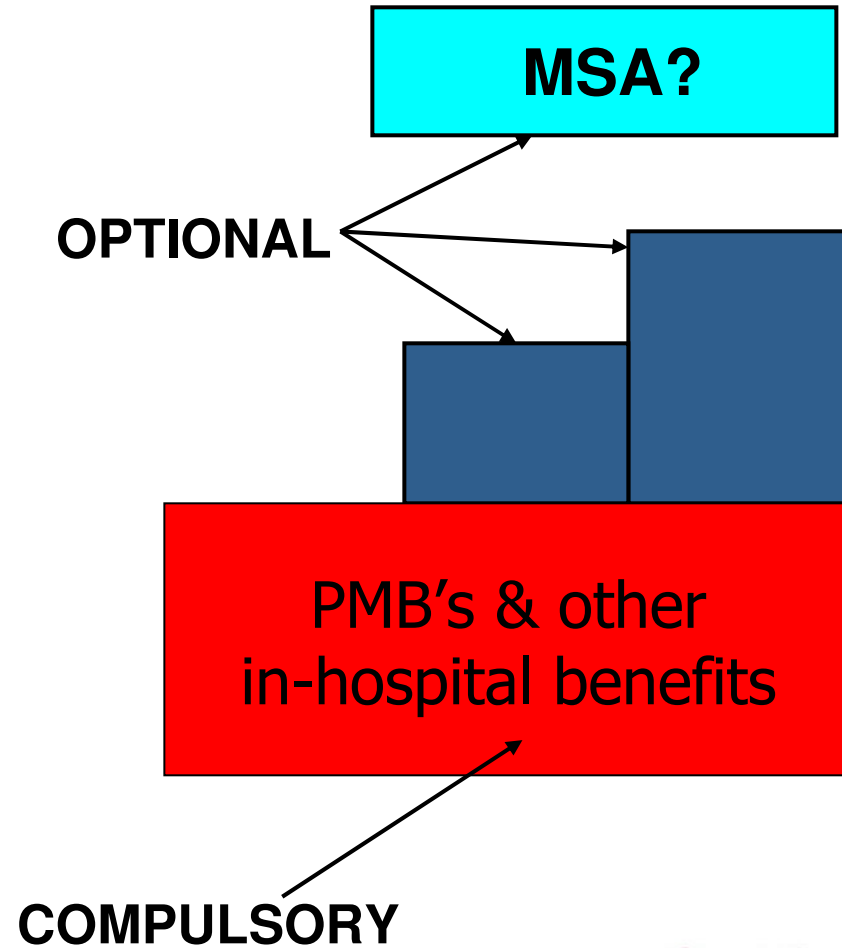


# IMPACT OF BASIC BENEFITS

## Current Structure



## New Structure



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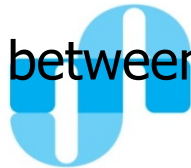
# IMPACT OF BASIC BENEFITS

## Without full REF, schemes will compete **more** on the basis of risk profile than before

- Basic Benefits similar for most schemes
- Competition for Basic Benefits mostly on price
- Price of Basic Benefits highly dependent on risk profile
- REF will reduce importance of risk profile
- But, REF likely only from 2011 and possibly phased in over time
- Actual cost of providing BBP's in 2007 differed greatly
  - Highest cost scheme cost more than 4 times the lowest cost scheme
  - 40% difference between highest and lowest cost open schemes

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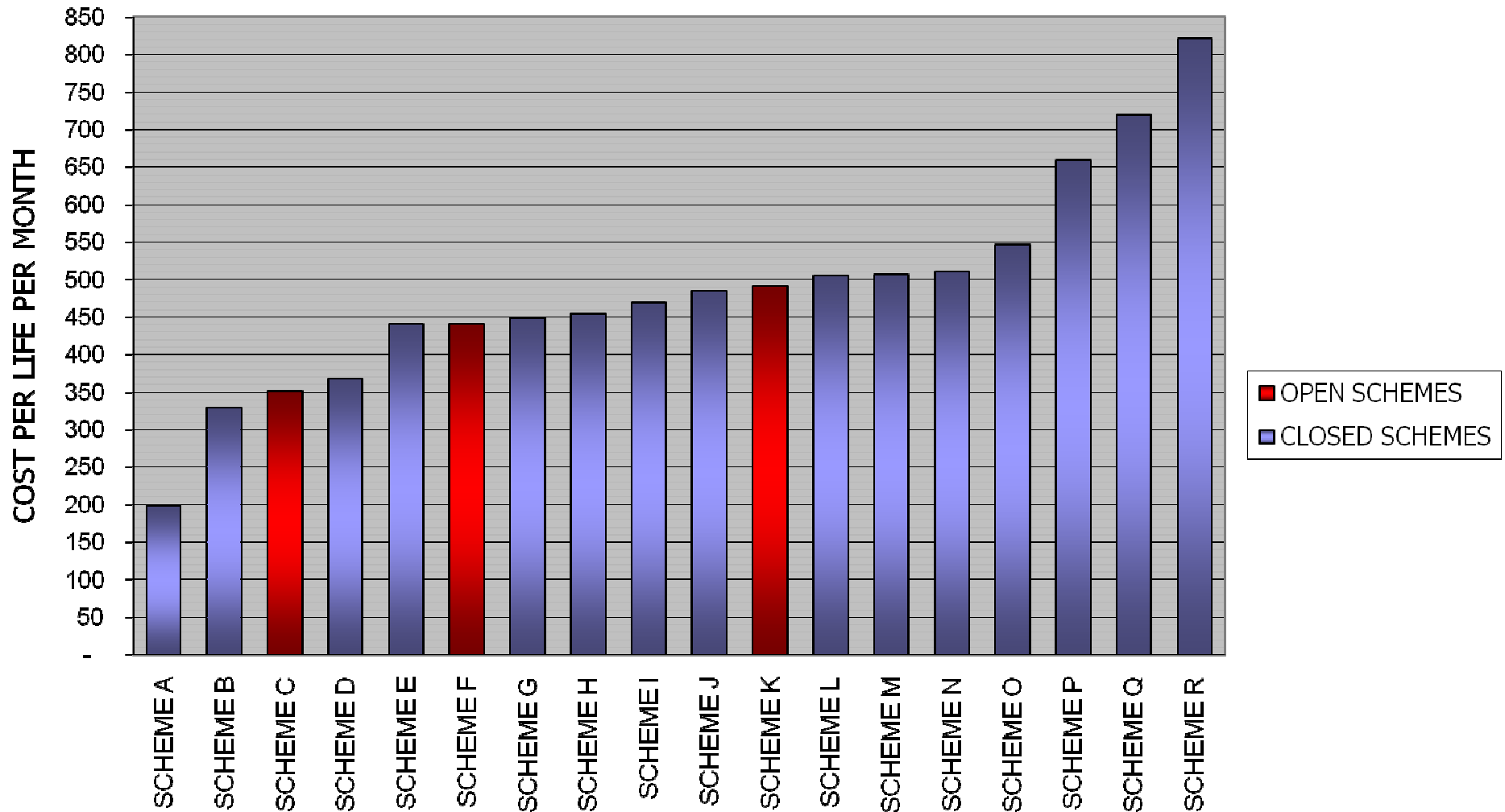


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# IMPACT OF BASIC BENEFITS

## Actual 2007 BBP Cost – Schemes administered by Medscheme



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# IMPACT OF BASIC BENEFITS

## Why will risk profiles be more important than now?

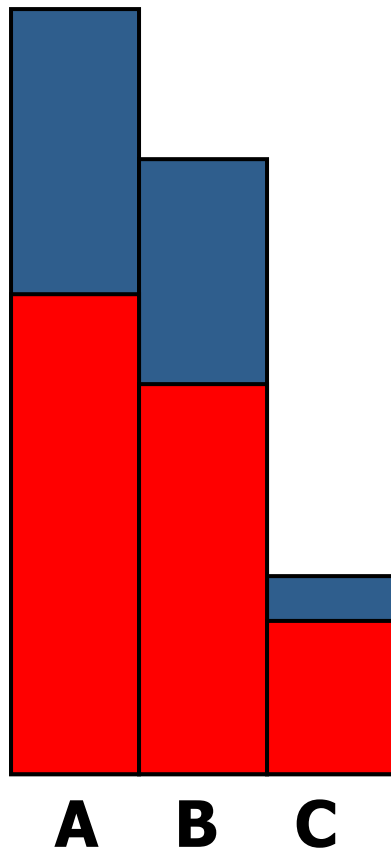
- Benefit differentiation makes direct comparisons more difficult
- Different options within a scheme have different risk profiles
- Options with bad risk profiles not competitive
  - But high risk members don't move easily to other schemes
- Schemes can still compete on their options with good profiles
- Schemes will in future compete on their full risk profile

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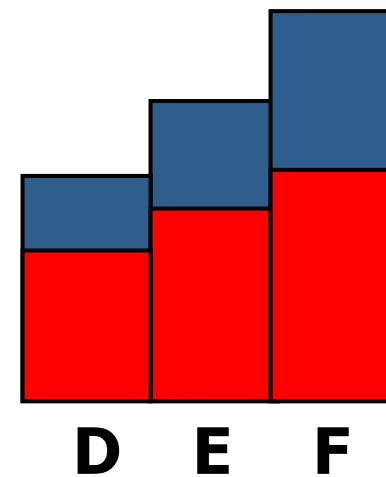


# IMPACT OF BASIC BENEFITS

## Scheme 1



## Scheme 2



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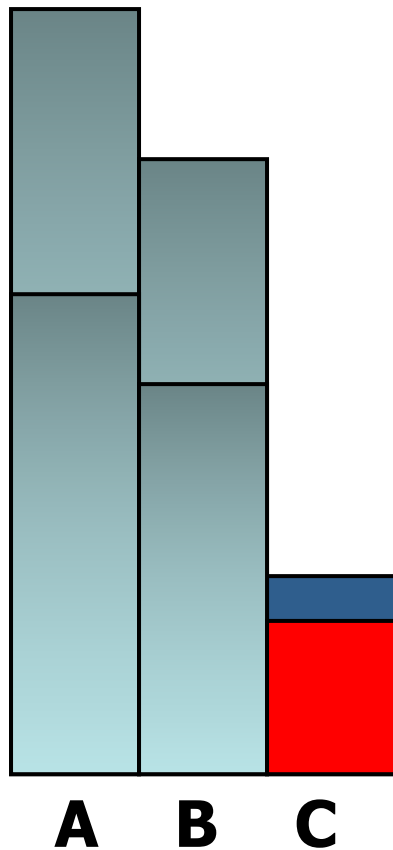


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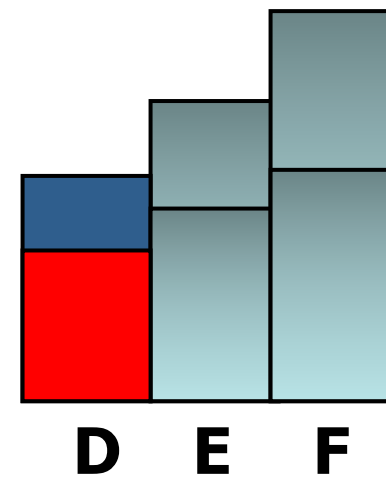
## Scheme 1



Option C competes with Option D



## Scheme 2



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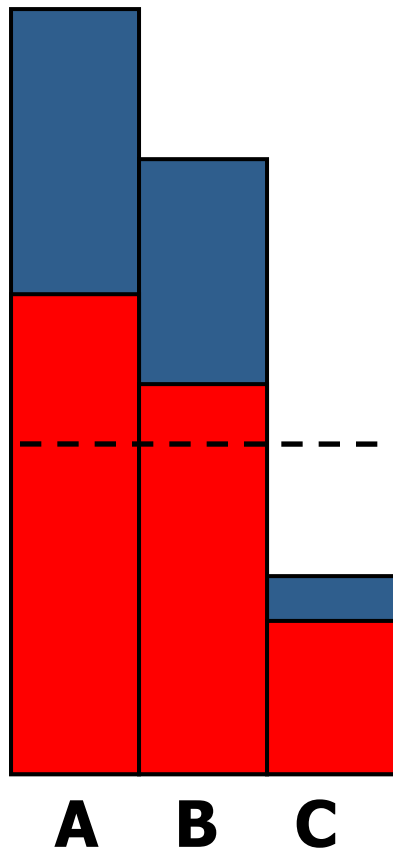


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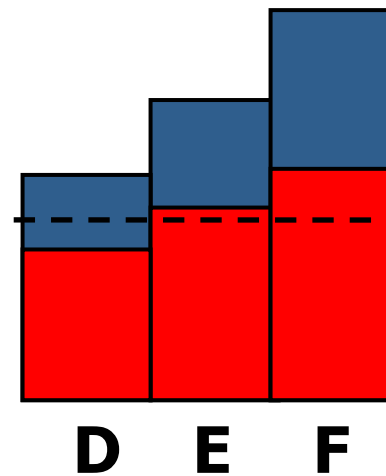


# IMPACT OF BASIC BENEFITS

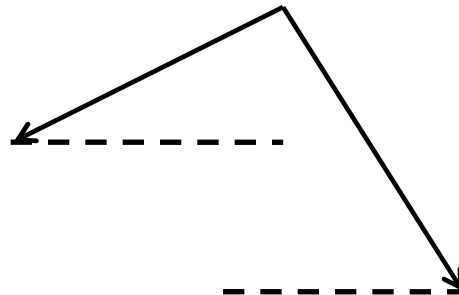
## Scheme 1



## Scheme 2



Average BBP cost



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# AGENDA

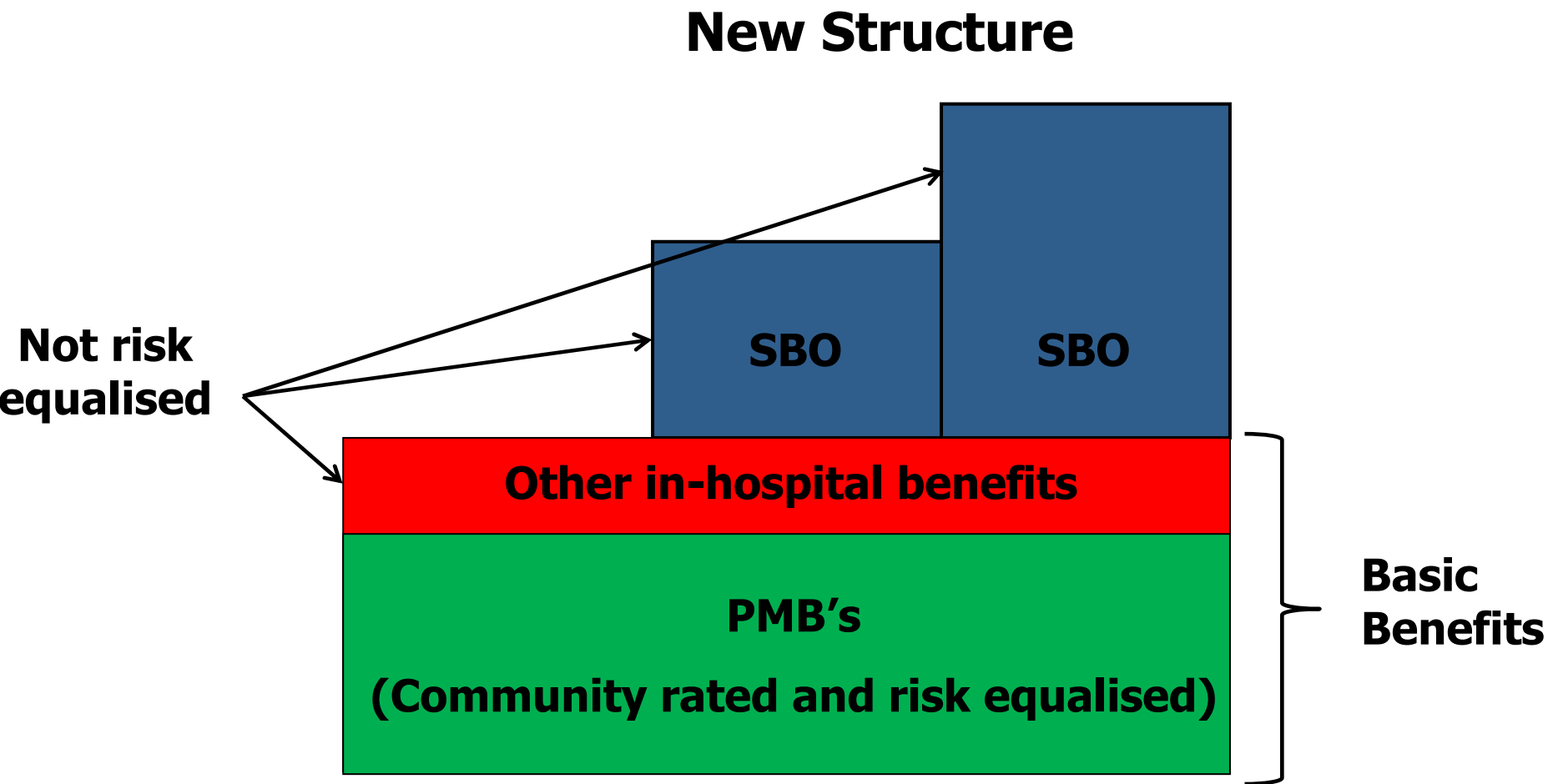
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# REF EQUALISES PMB'S AND NOT BBP'S



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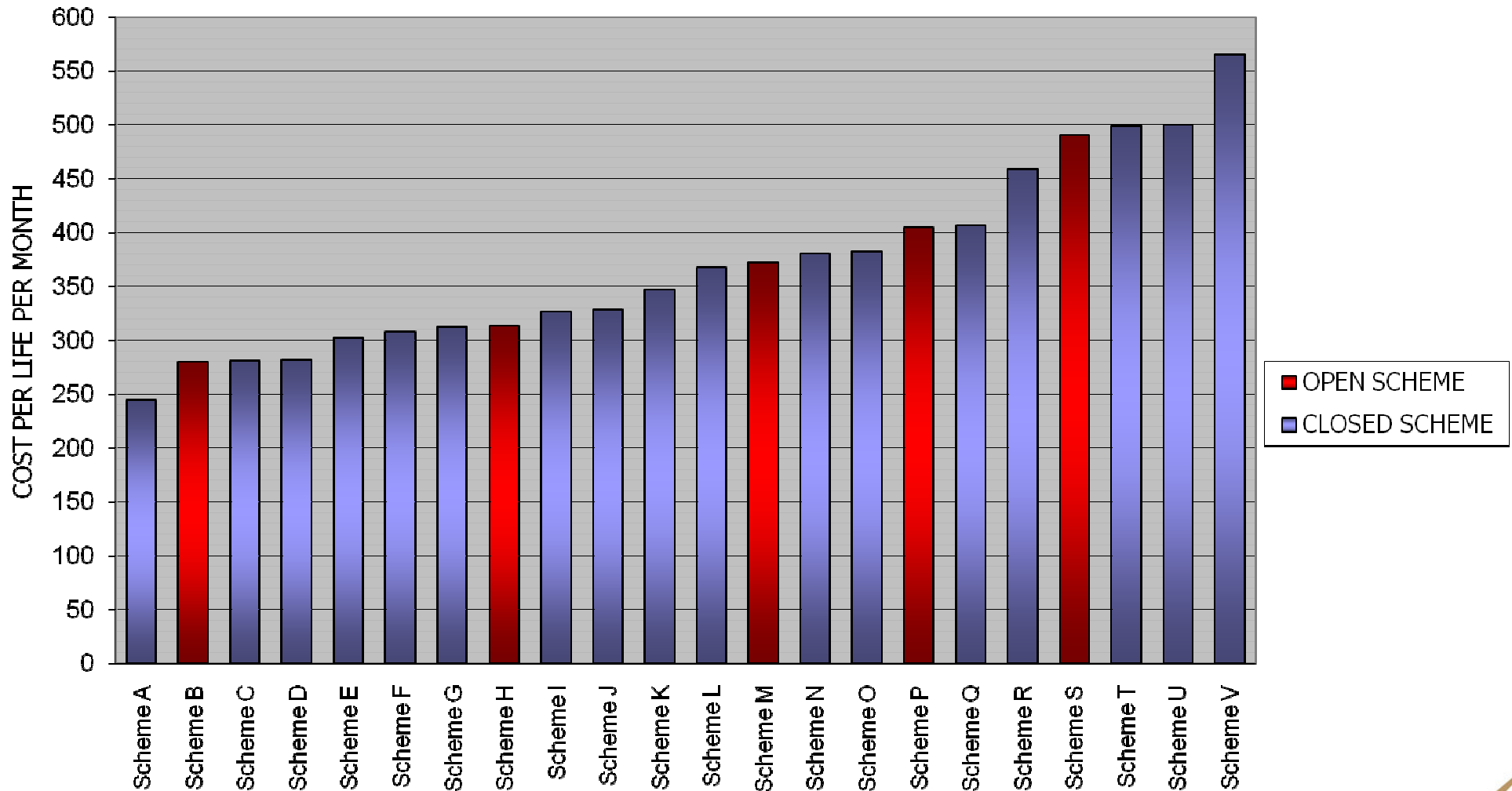
# REF EQUALISES PMB'S AND NOT BBP'S

- All Basic Benefits are community rated & sensitive to risk profile
- Only PMB's are risk equalised
- Medscheme 2007 experience – PMB's only 72% of BBP
- Simplified theoretical model to illustrate impact:
  - Schemes to which Medscheme provided MHC services in 2007
  - BBP set by assuming PMB's = 72% of BBP
  - BBP cost adjusted for each scheme to reflect age profile
  - REF tables used with age as only factor (REF on scheme level)
  - Cost of BBP calculated after allowing for REF

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# REF EQUALISES PMB'S AND NOT BBP'S

## Model 2007 BBP Cost – Schemes MHC from Medscheme

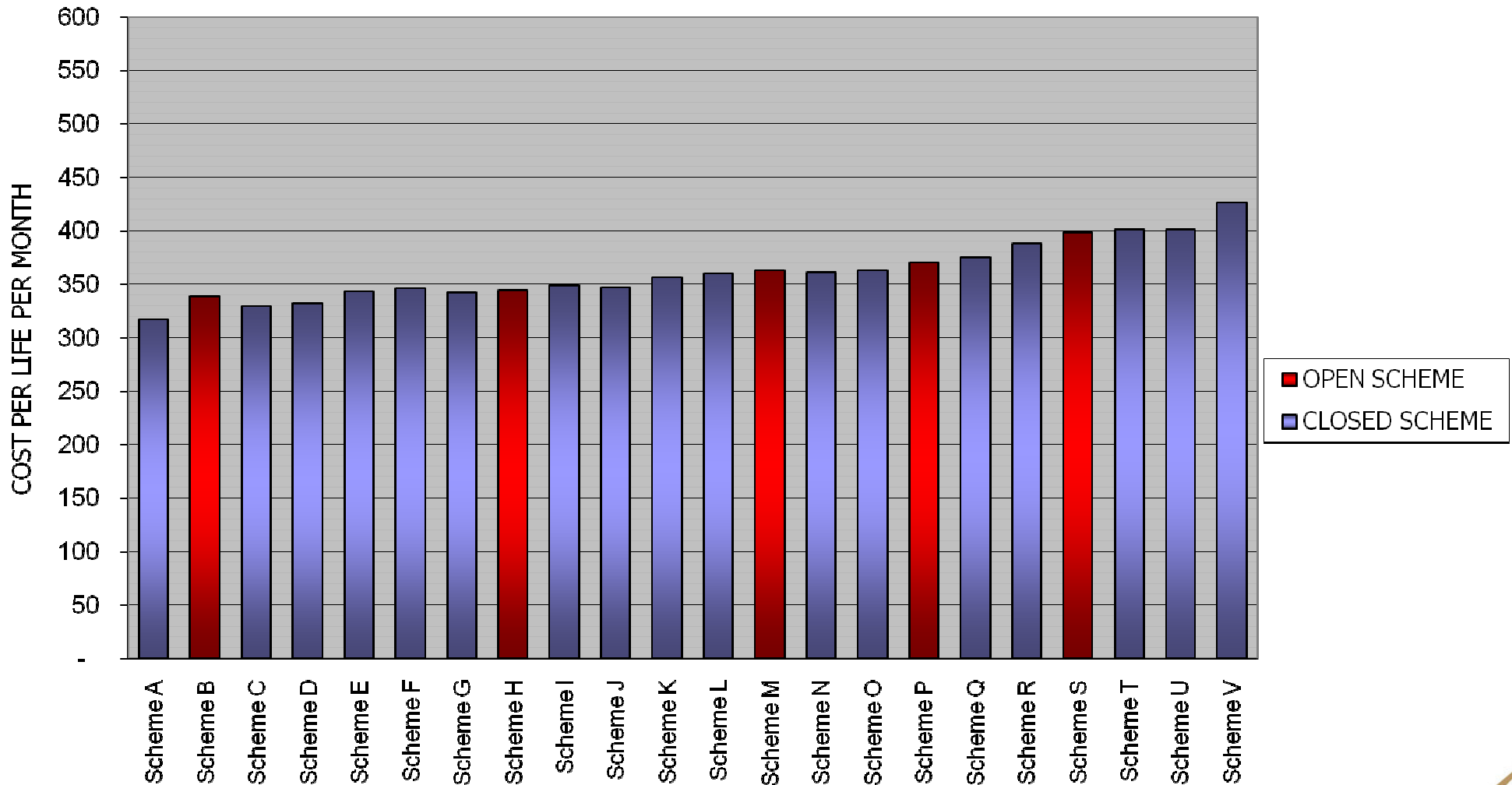


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# REF EQUALISES PMB'S AND NOT BBP'S

## Model 2007 BBP Cost After Full REF Financial Transfers



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# REF EQUALISES PMB'S AND NOT BBP'S

## Results from theoretical age-only model

- BBP cost for highest cost scheme 232% of lowest cost scheme
- After REF highest cost scheme still 34% higher than lowest cost
  - Open schemes highest BBP cost 18% higher than lowest cost
- Adding other risk factors increases the gap

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# REF EQUALISES PMB'S AND NOT BBP'S

- After full REF, still large differences in cost of Basic Benefits
- Schemes with better risk profile will still have an advantage
- Basic Benefits effectively ring-fences this advantage
- Results in less efficient industry
- Caused by portion of BBP community rated but not risk equalised
- Two solutions available:
  1. All Basic Benefits to be risk-equalised
  2. Limited risk rating allowed on Non-PMB portion of BBP

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# OTHER ELEMENTS

- Supplementary Benefits community rated
  - Waiting periods not allowed?
  - Not sustainable if fully community rated
  - Limited risk rating or sufficient waiting periods are needed
- REF introduced, including severe penalties to ensure data
- LIMS environment enabled
- Governance issues
  - Risk of losing trustee knowledge and experience within 1 year
- Many issues will be clarified by the Regulations

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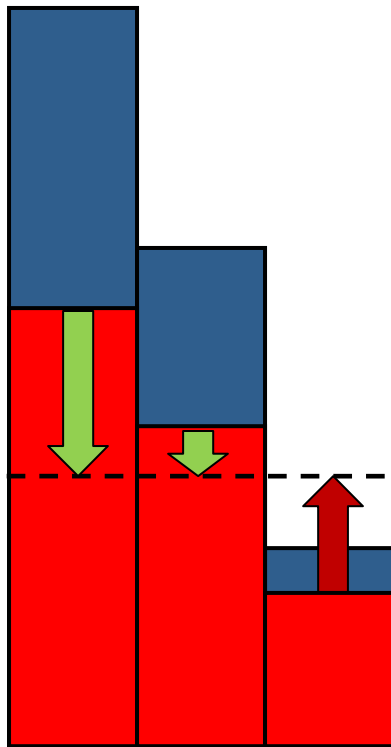


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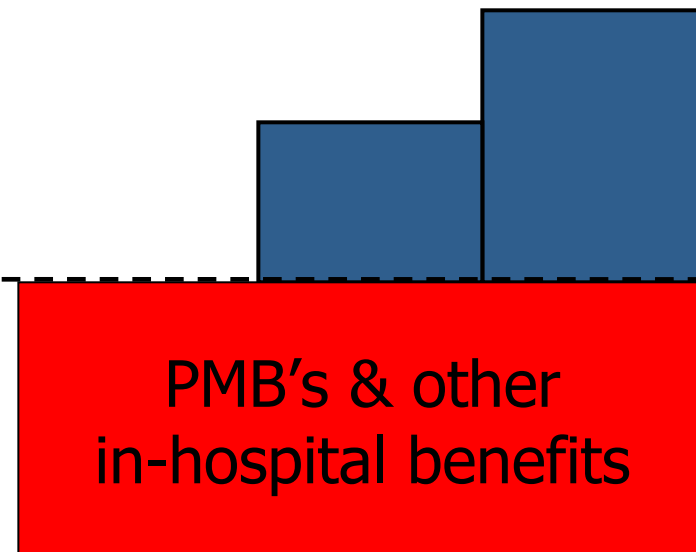


# IMPACT ON LOWER RISK MEMBERS

## Current Structure



## New Structure



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# IMPACT ON LOWER RISK MEMBERS

- Better risk profile generally results in lower cost for BBP's
- Allows schemes to charge less for options with lower risk profile
- Under new structure scheme charges the same for all BBP's
- Cost of providing BBP's increases strongly for many options
- REF may increase or reduce the cost of BBP
  - Depends on the overall scheme profile compared to industry
  - REF transfers at scheme level (vs. option level)

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# IMPACT ON LOWER RISK MEMBERS

## Impact on contributions

- Low risk options generally provide for less benefits
  - BBP will make up the majority of benefits
  - Members on these options to receive large contribution increases
- Analysis of 2007 BBP cost – high increases for many options
  - Cost of BBP to increase by  $> 50\%$  for a number of options
  - BBP cost to increase by  $> 20\%$  for around 300 000 lives
  - After BBP + REF, increase  $> 20\%$  for around 280 000 lives

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# IMPACT ON LOWER RISK MEMBERS

## How will lower risk members react to high increases?

- Low risk options generally have younger members
- Generally lower earnings – may not be able to afford increases
- Due to good health they can most afford to opt out of system
  - Cross-subsidisation lost
  - Risk profile of whole industry deteriorates
- Similar problem if REF is introduced without Basic Benefits
  - Schemes with youngest members will pay in the most
  - Resulting high increases may drive young members out of system

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# IMPACT ON LOW INCOME MEMBERS

- Options / schemes aimed at blue collar workers
  - Generally have younger lower risk members
  - Members are very sensitive to cost
- Analysis on Medscheme options
  - Generally high increases from REF, especially if at option level
  - Basic Benefits + REF generally still results in high increases
- Affordability will force many of these members out of the system
- LIMS may help, if in place before REF or Basic Benefits
- Some mechanism is needed to keep good lives in the system

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The logo for "Cutting the Gordian Knot" features the text in a serif font, with "Cutting the" in a smaller size above "Gordian Knot". To the right of the text is a gold-colored geometric knot symbol, which is a complex, interlocking pattern.



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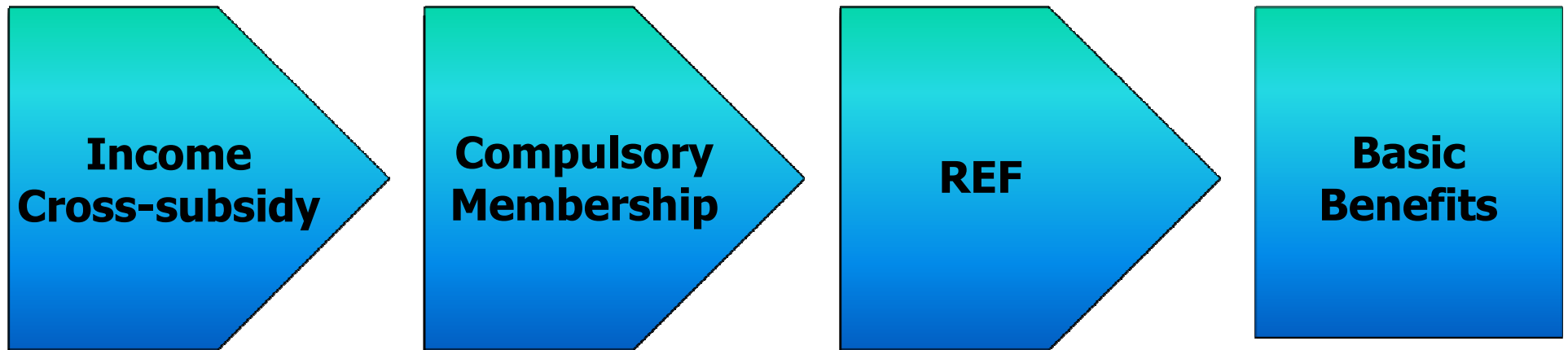
# ORDER OF IMPLEMENTATION

- Components of SHI can result in a stable Private Healthcare system
- If community rated non-equalised BBP's are minimised
- If SHI is introduced in the right order:
  - Introducing BBP before full REF risk transfers – system destabilised
  - Introducing REF or BBP without mechanism to retain good lives – system destabilised
  - Mechanism to retain good lives not practical without some form of income cross-subsidy

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# ORDER OF IMPLEMENTATION

Order resulting in highest level of stability



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# QUESTIONS / DISCUSSION



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