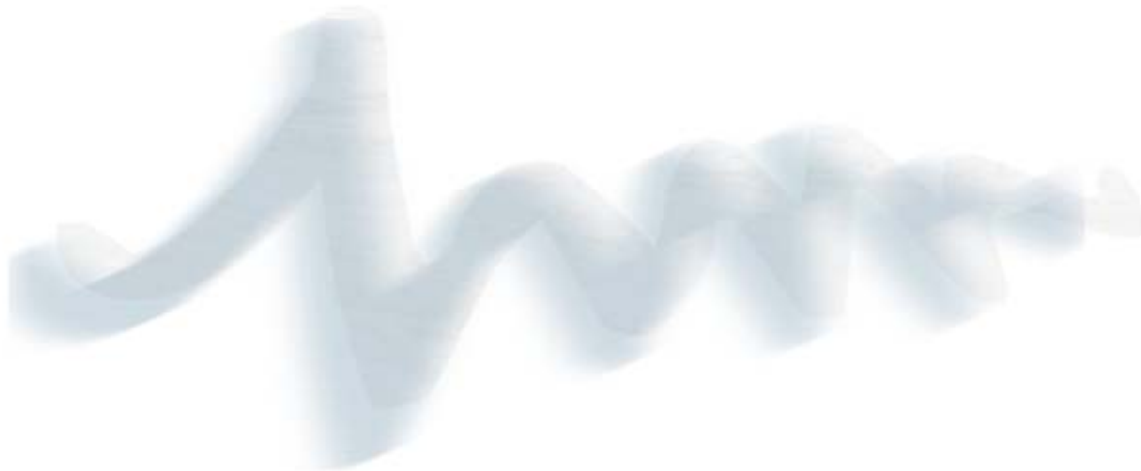


# Benefit Design for 2007



Christoff Raath

Consulting Actuary  
Health Monitor Company



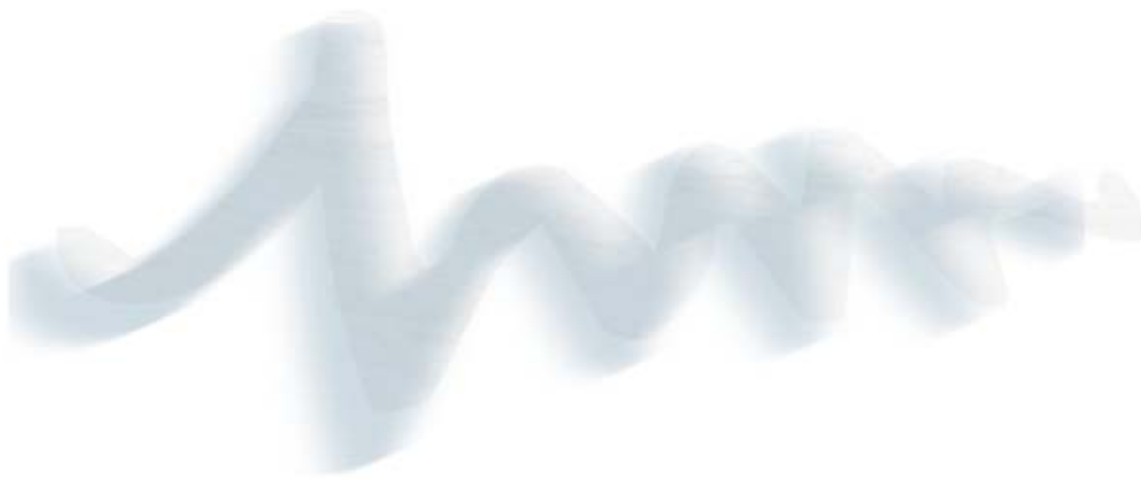
# Benefit Design

- Risk management theory
- The good old days
  - Benefit design as we know it
- Social Health Insurance
- The future
- Strategic considerations
  - LIMS
  - Circulars 8, 9
  - REF

# Insurability

- Large number of homogenous exposure units (risk pool)
- Loss definite and measurable
- Fortuitous and outside of control
- Significant but not catastrophic
- Relatively infrequent events

# Benefit Design Theory...



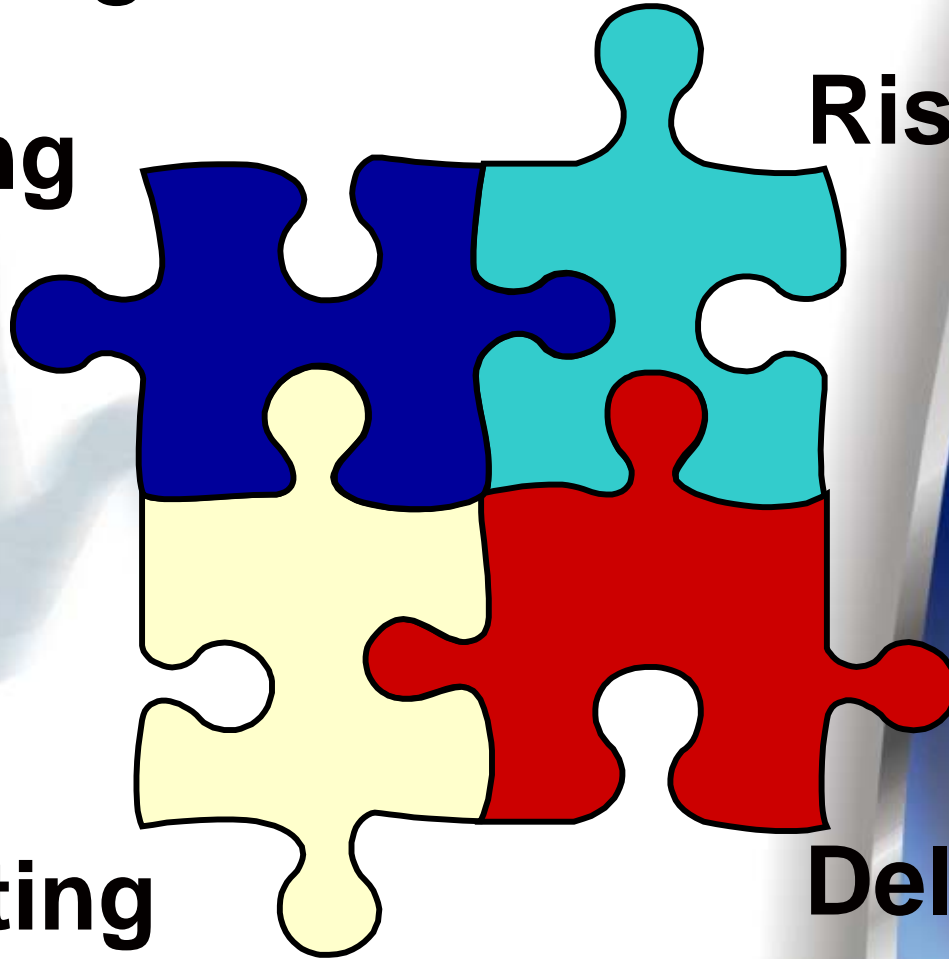
# Design Overview

**Rationing**

**Risk-sharing**

**Contracting**

**Delivery**

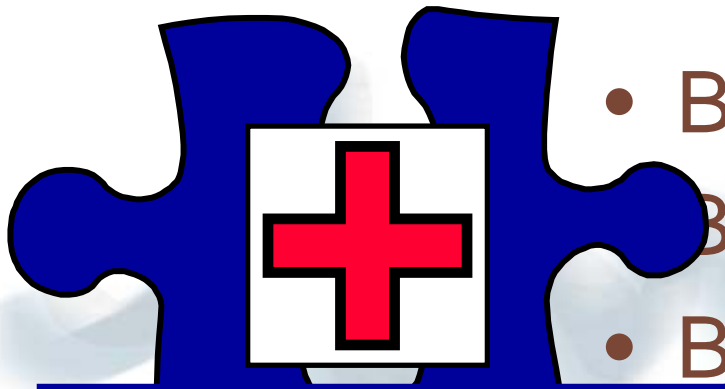


# The Rationing of Care



- By budget
- By hassle
- By queue
- By income
- By protocols
- By law

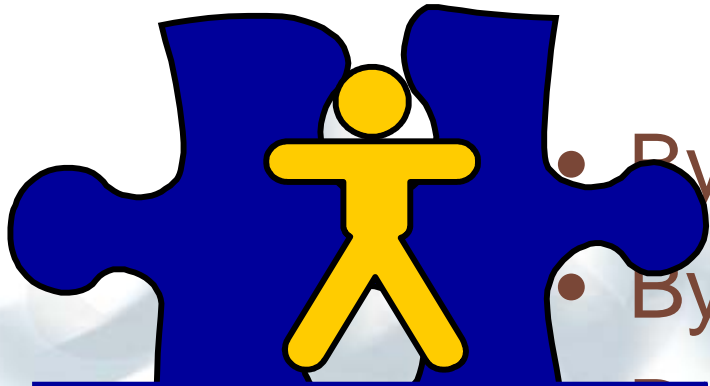
# The Rationing of Care



Healthcare Providers

- By age
- By scarcity
- By prognosis
- By ability to pay
- By scheme membership
- By protocols and

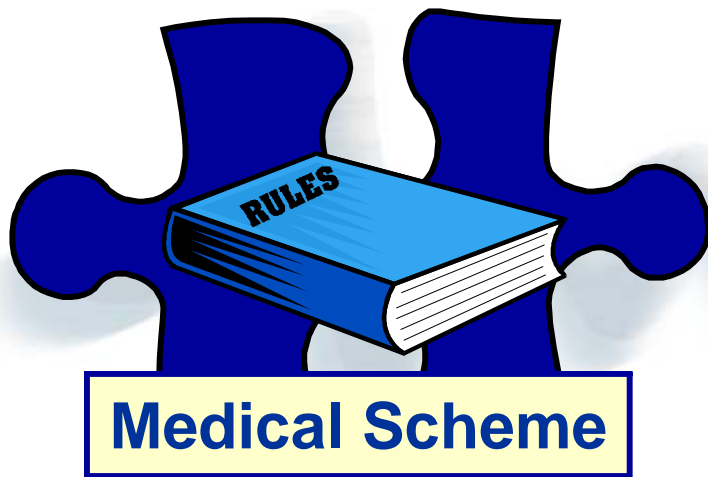
# The Rationing of Care



**Individuals, Families**

- By ignorance
- By affordability
- / conscious choice

# The Rationing of Care



- By price
- By rules
- By quantity limits
- By financial limits
- By pre-authorisation
- By member ignorance
- By benefit complexity

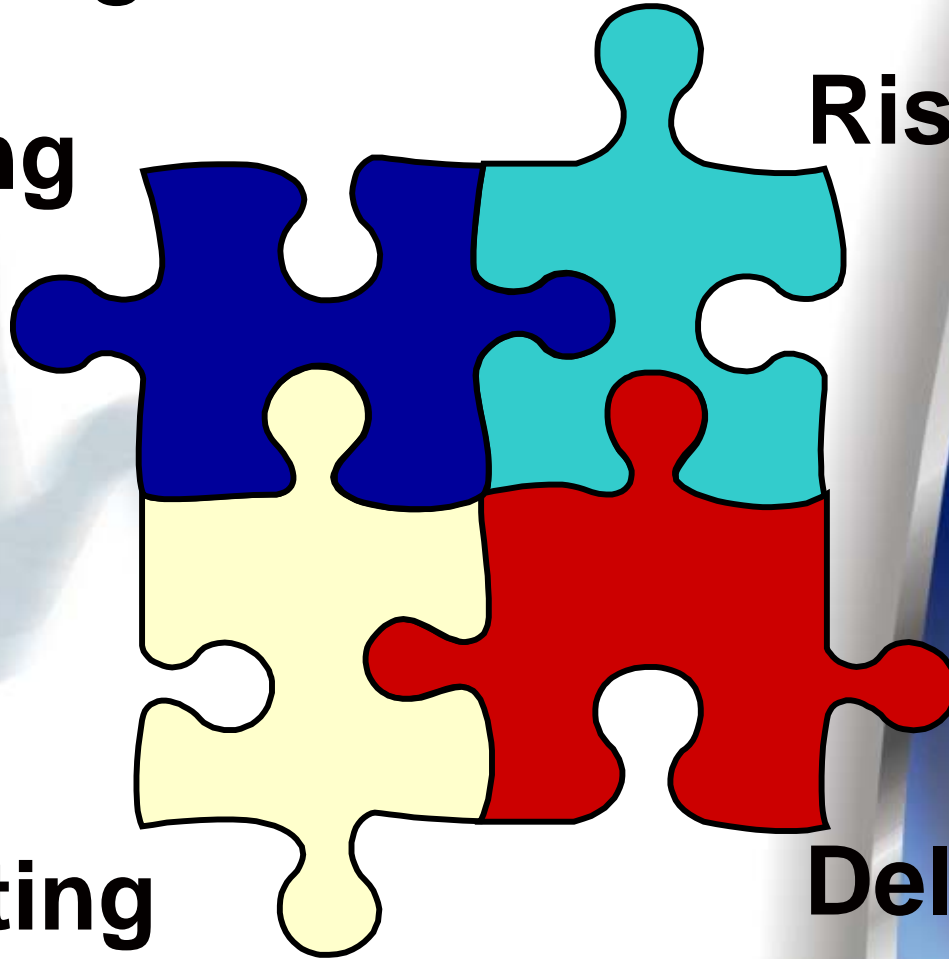
# Design Overview

**Rationing**

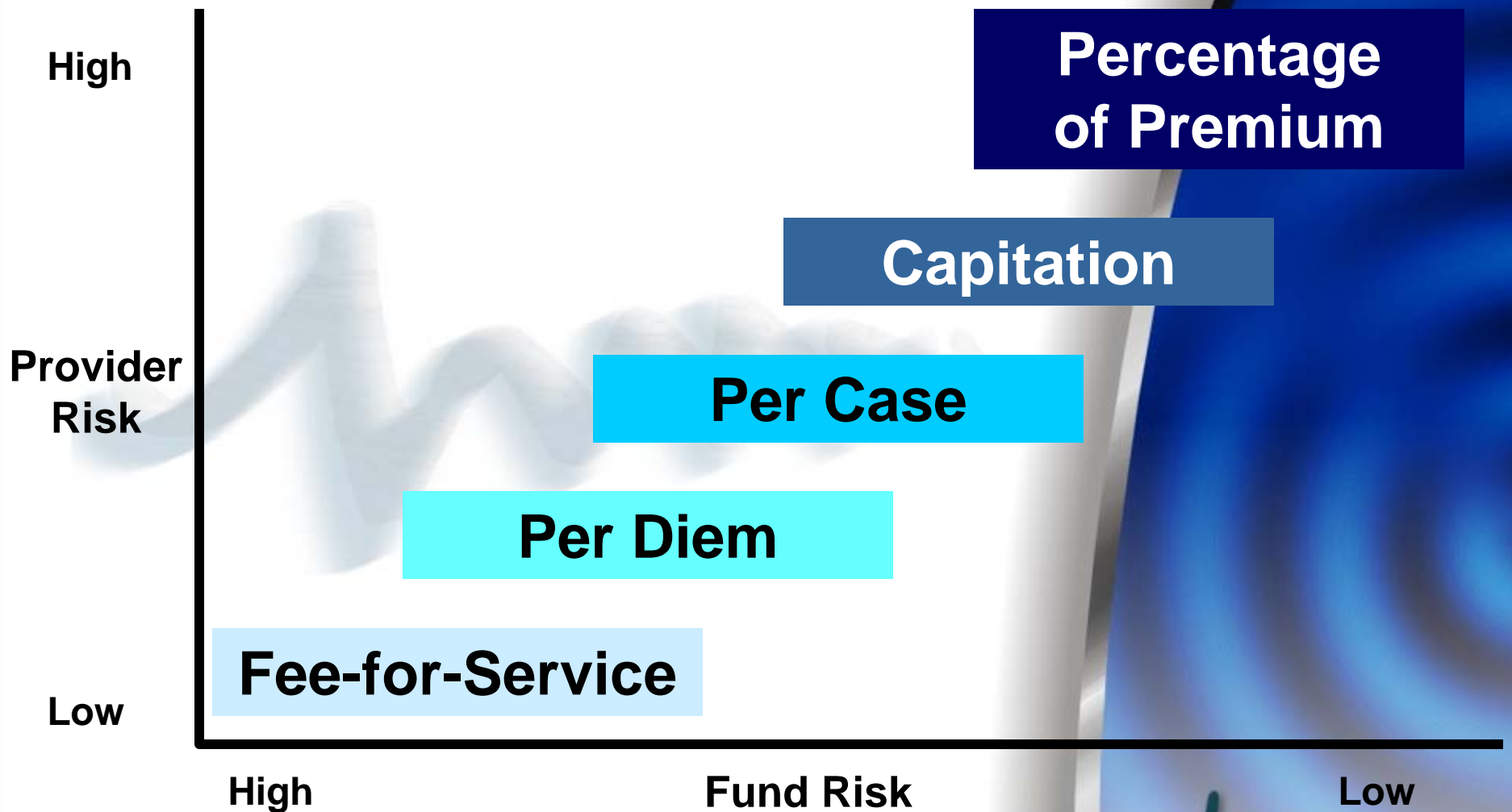
**Risk-sharing**

**Contracting**

**Delivery**



# Risk Transfer



Source : Garofalo et al, *Managed Care Contracting*, 1999

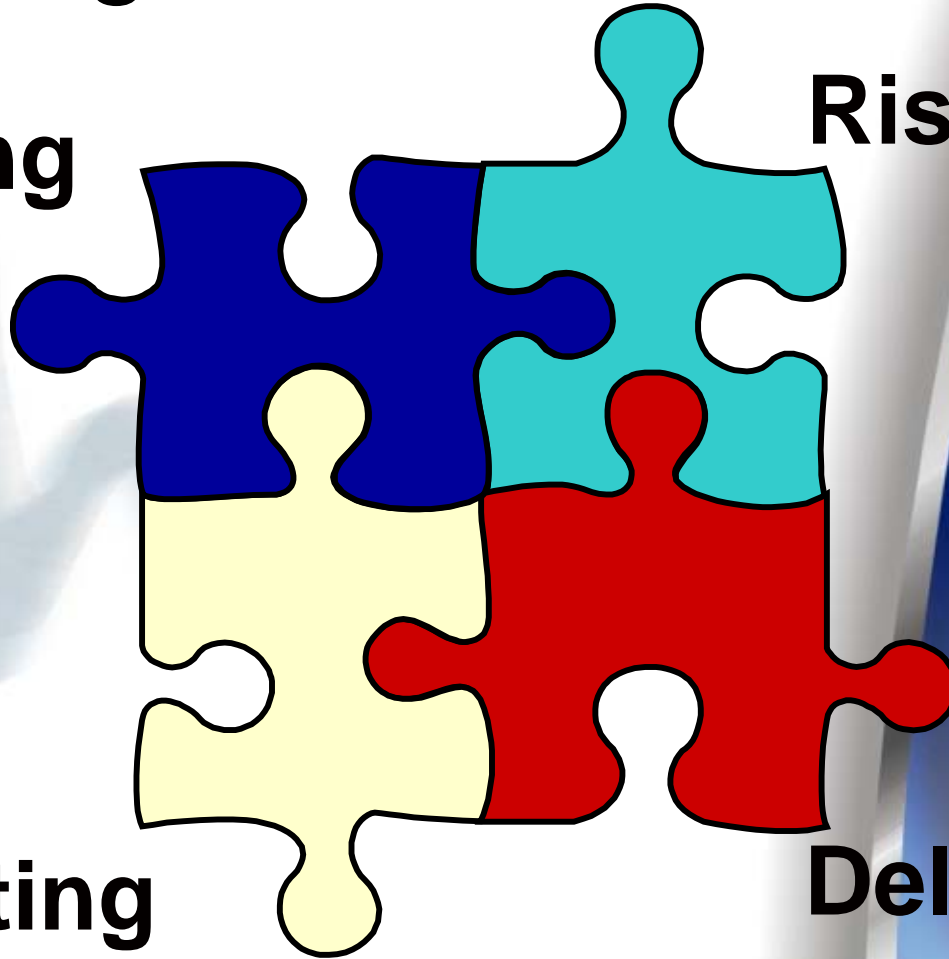
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**Rationing**

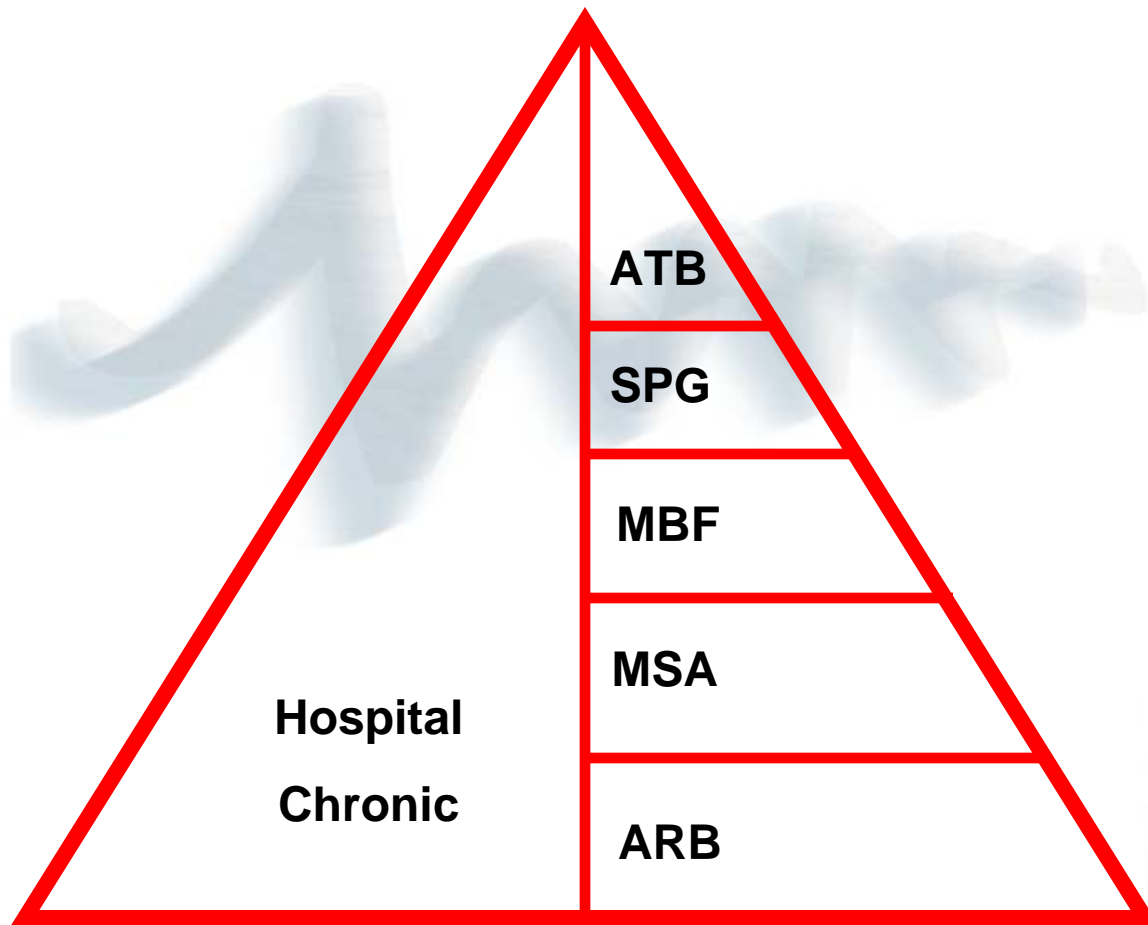
**Risk-sharing**

**Contracting**

**Delivery**



# Benefit Design As We Know It



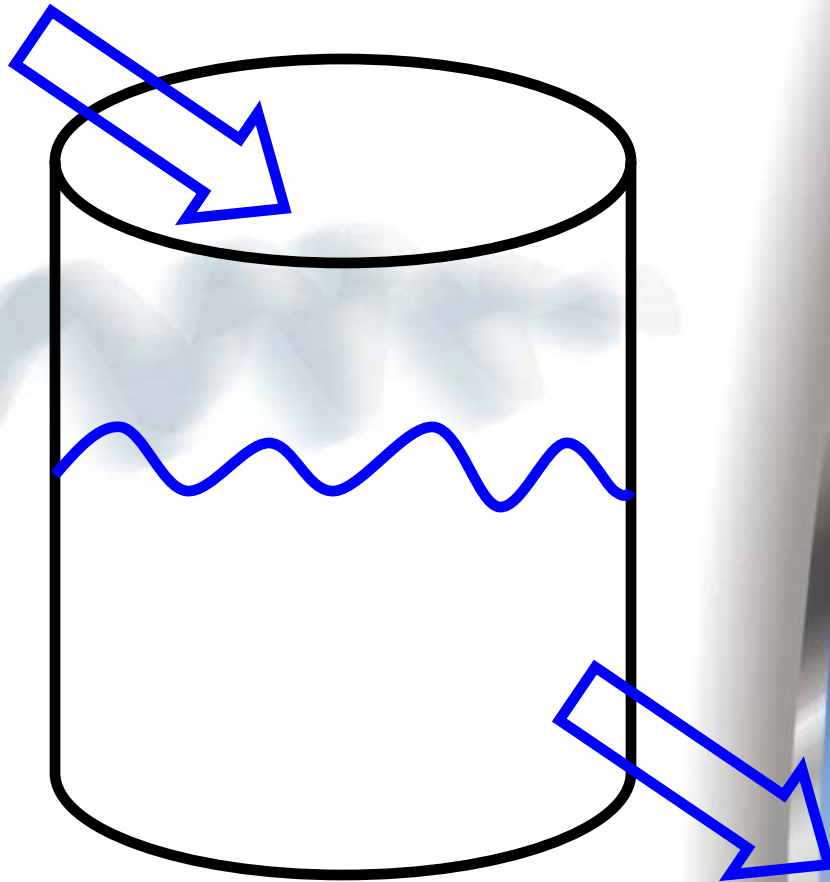
# Medical Inflation

- CPI x 2
- Utilisation escalation
  - Ageing
  - HIV/AIDS
- Price escalation
  - Balance in bargaining power?
- New treatments and technologies

***“How shall we cut benefits this time?”***

# “Money in, Money out”

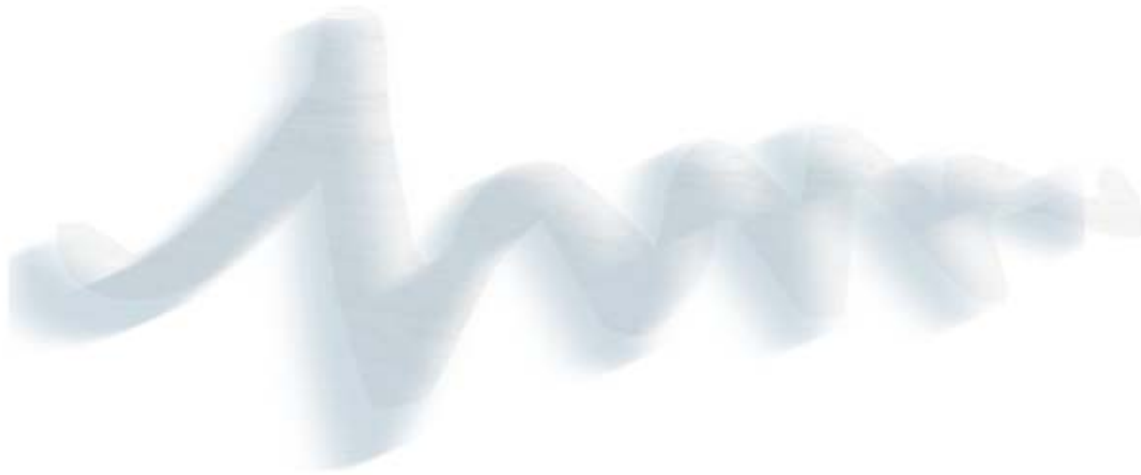
Contributions



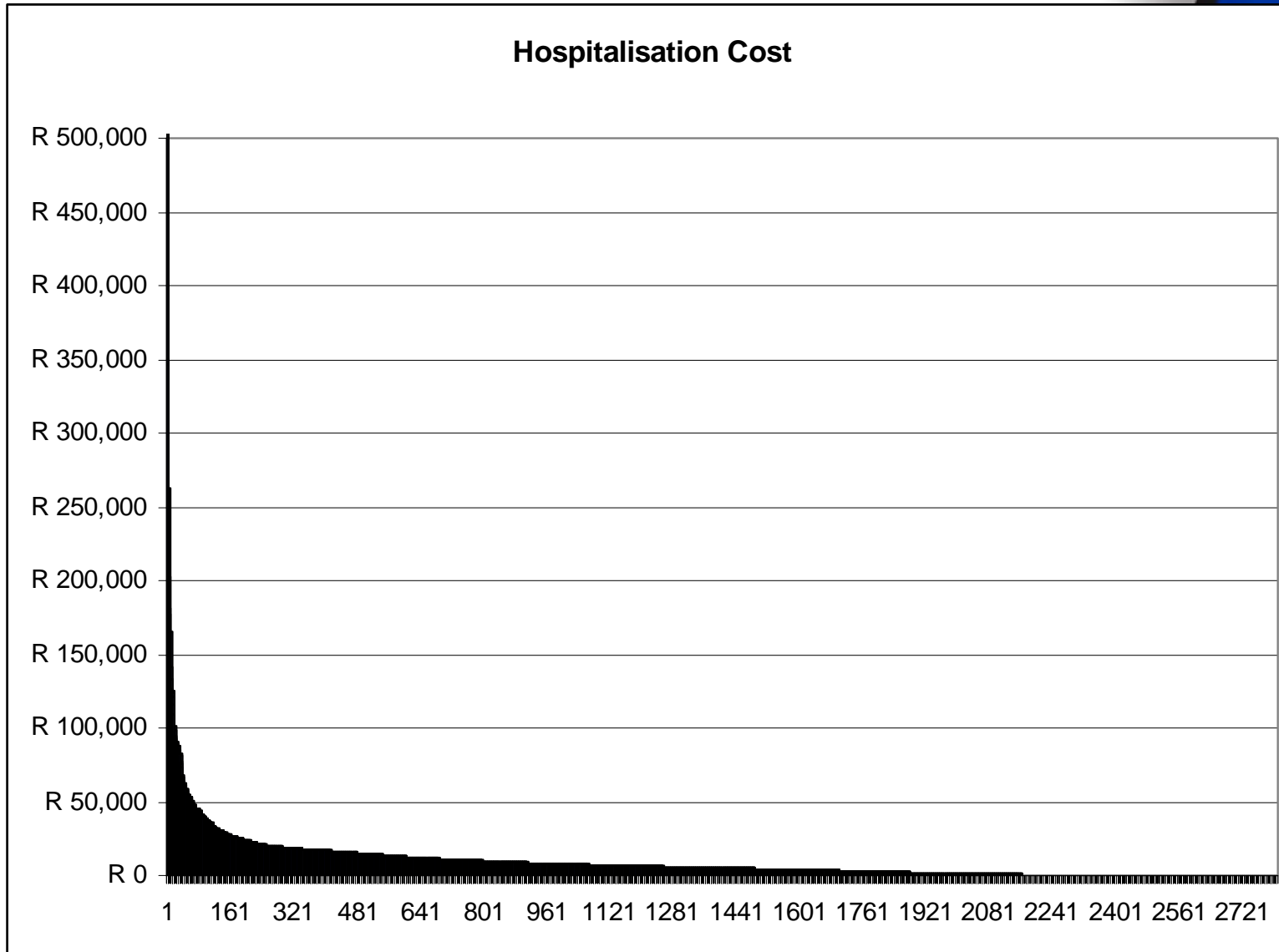
Benefits  
Expenses  
The Health Monitor Company

# “Tools” to Cut Benefits

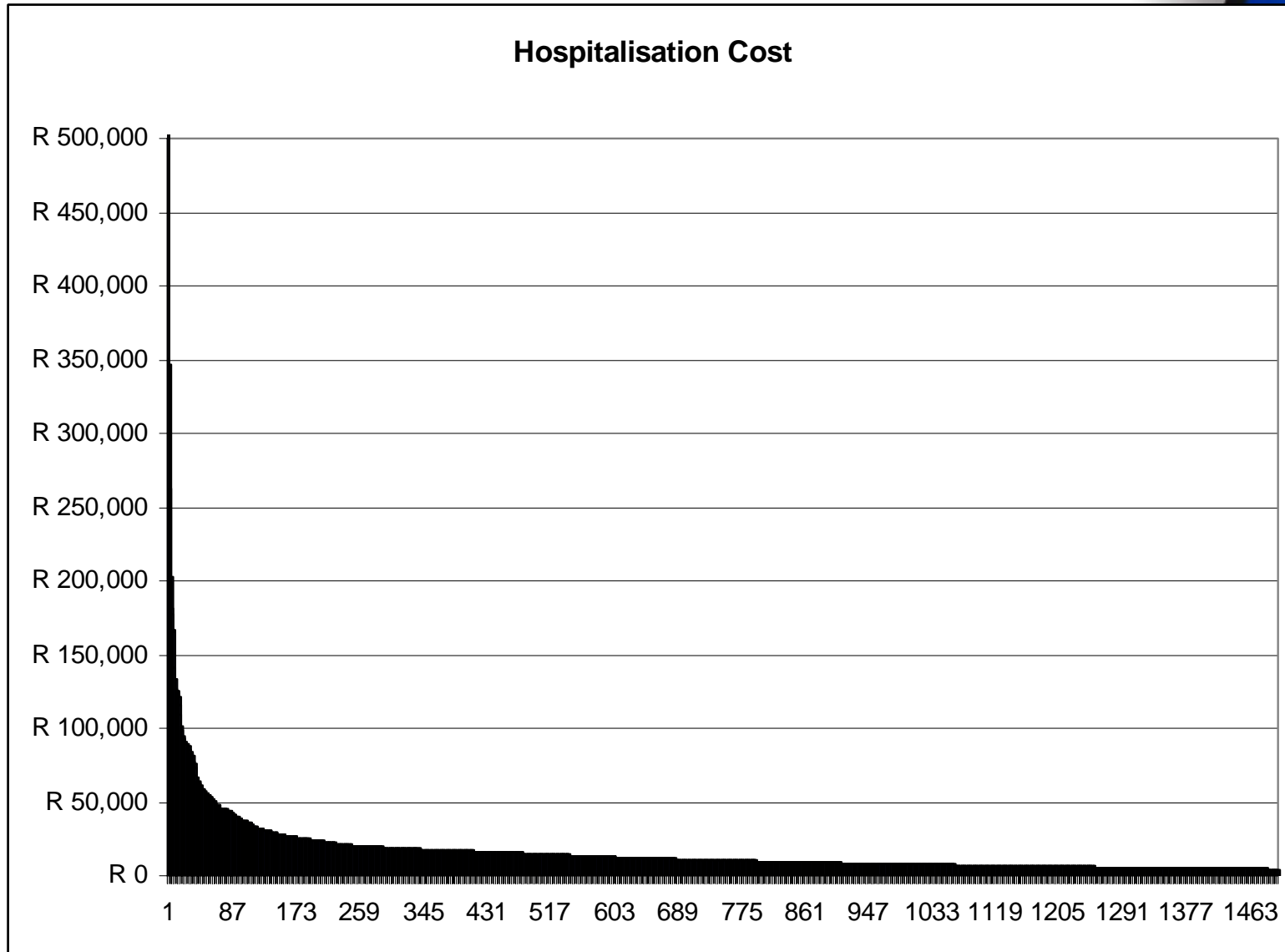
- The LIMIT



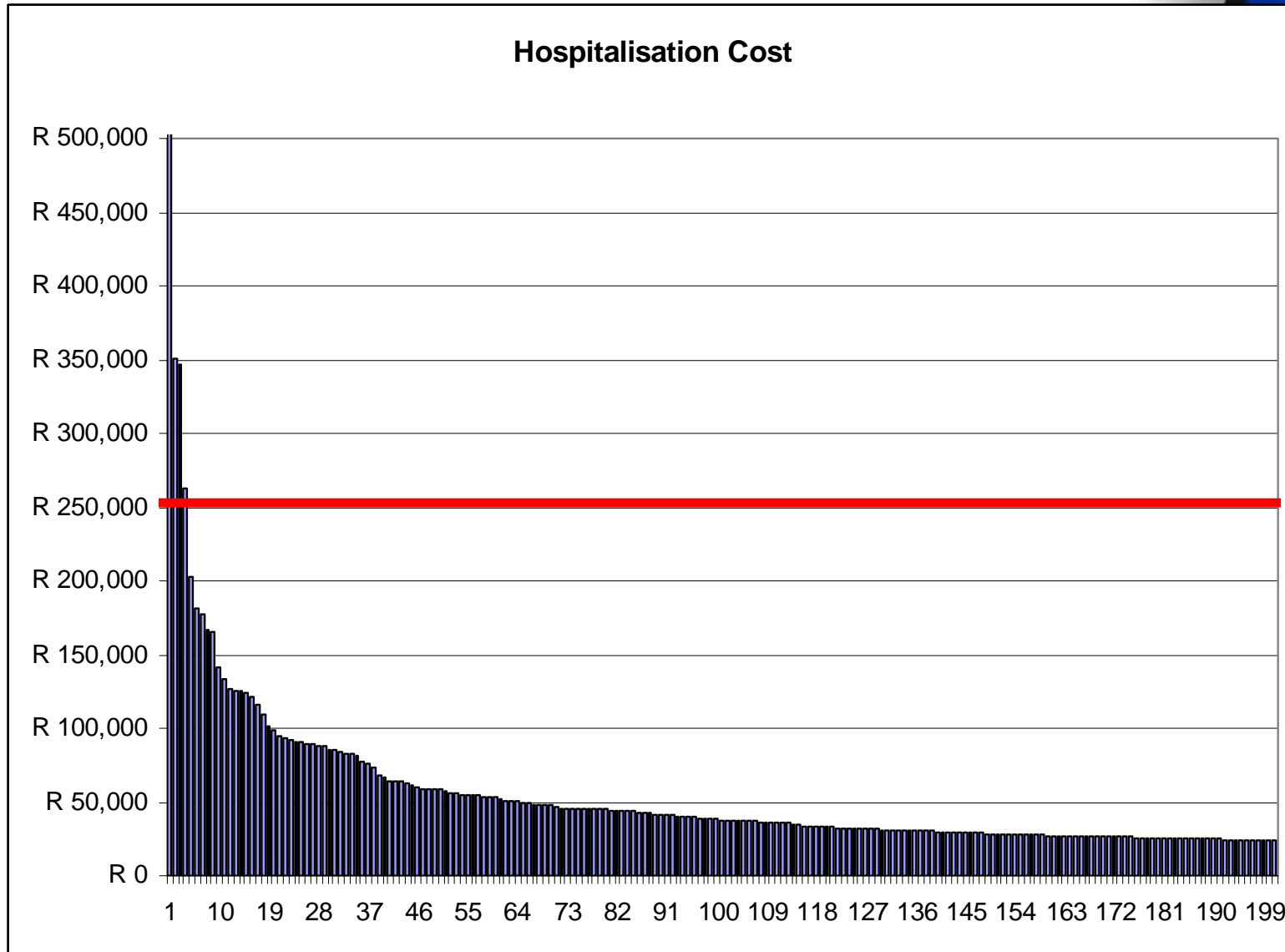
# Limits



# Limits



# Limits



# “Tools” to Cut Benefits

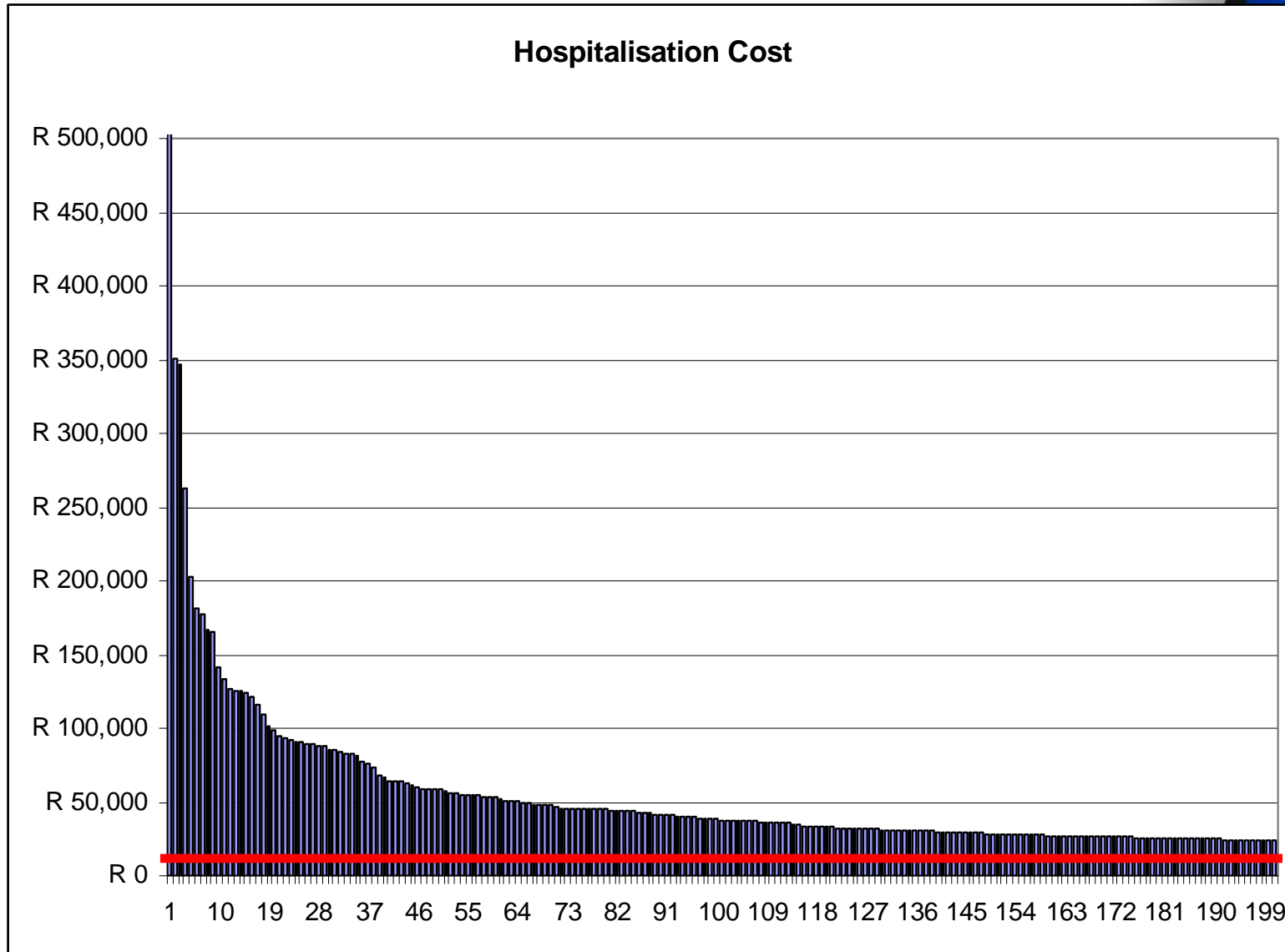
- The LIMIT
  - Prevents cover against catastrophes
  - Member’s “perceived value for money” unfavourable
  - Use it or loose it (target)
  - Minor saving to scheme (especially for high risk events)
  - Pseudo-savings account (especially for frequent/low risk events)

# “Tools” to Cut Benefits

- The LIMIT
- The COPAYMENT



# Copayment



# “Tools” to Cut Benefits

- The LIMIT
- The COPAYMENT
  - Percentage or R-amount or implicit (e.g. in-hospital gaps)
  - Discourage utilisation
  - Hassle factor
  - Significant scheme savings for high-volume claims
  - Probably better perceived value-for-money for member

# “Tools” to Cut Benefits

- The LIMIT
- The COPAYMENT
- The SAFETY NET / ATB

# Profile vs Benefits



# Profile vs Benefits

- PMB's form a large part of benefits
- Section 33(2)(b)
- Pareto's principle
  - 20% of your members incur 80% of your cost

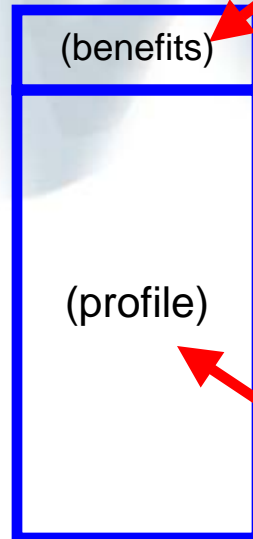
# Profile vs Benefits

R1000



Option 1

R500

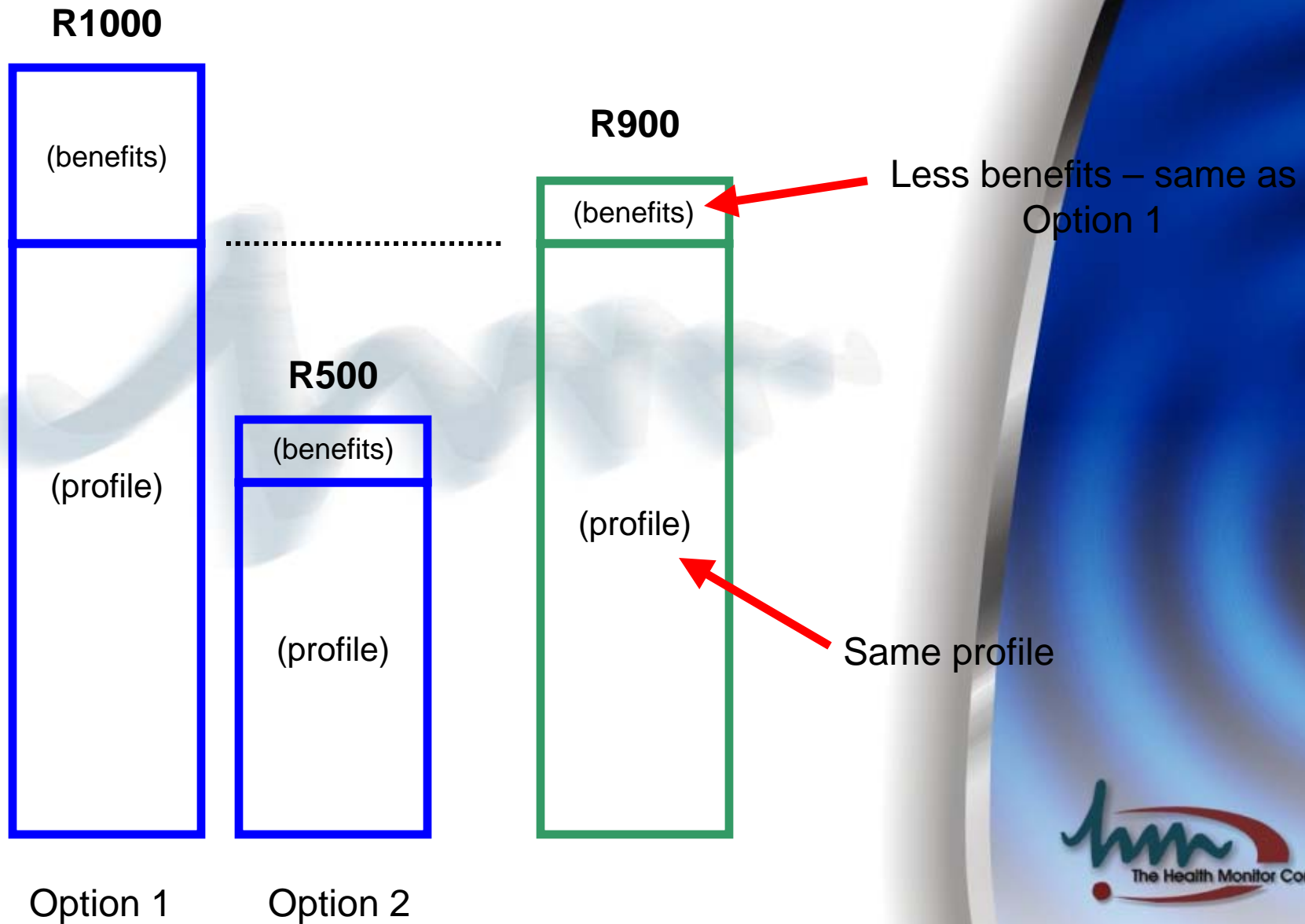


Option 2

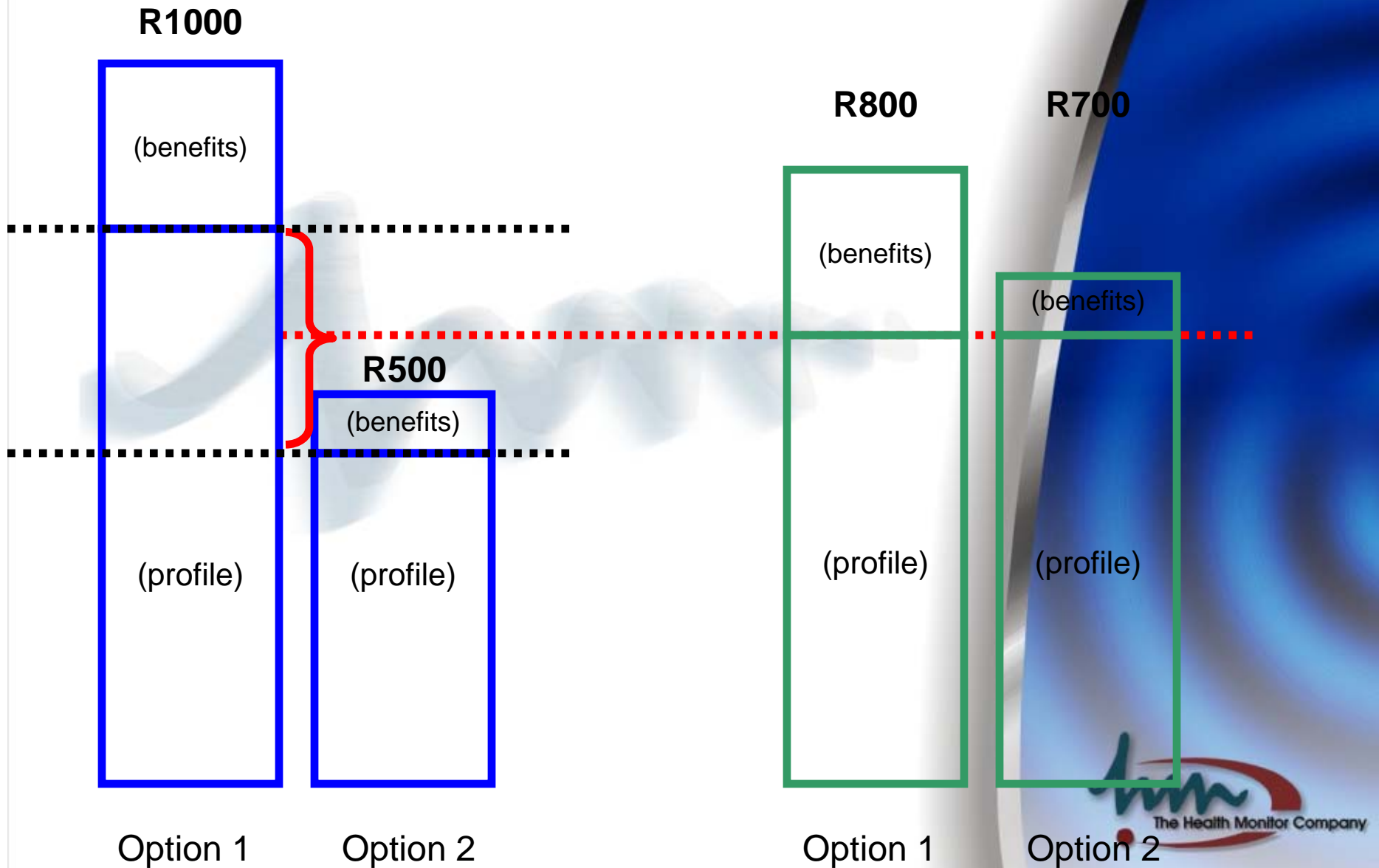
Less benefits

Healthier profile!

# Cut Benefits in Option 1



# “Circular 8-Type” Thinking



# Profile vs Benefits

- Benefit design's "secondary effect" on profile selection
- ... has become its primary effect

Consolidated Report



Transforming  
the Present -  
Protecting the Future  
Consolidated Report

Fo

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Report of the Committee of Inquiry  
into a Comprehensive System of Social  
Security for South Africa

March 2002

Transforming the Present - Protecting the Future iii



Source : DoH Social Security Report 2002

### Phase 1: Development of Enabling Environment

- Preparation of Public Sector Budget System
- Preparation of Public Sector Hospital System
- Consolidation of Medical Schemes Reforms
- Development of integrated subsidy system
- Implementation of measures to contain private sector cost increases

### Phase 2: Implement Preparatory Reforms

- Risk equalisation Fund for medical schemes
- Risk-adjusted subsidy to medical schemes
- State sponsored medical scheme
- Mandatory environment for civil servants

### Phase 3: Implement Statutory Mandates

- Mandate medical scheme membership for
  - Medium to large employers
  - High -income earners
- Voluntary contributory environment for low-income groups
  - State sponsored scheme
  - Public Sector Contributory Fund

### Phase 4: National Health Insurance Implemented

- Central Equity Fund
- Public Sector Contributory Fund

2002

2003

2004

2005

2006

2007

2008

Source : DoH Social Security Report 2002

# Phase 1 : Development of the enabling environment

# Phase 1 : Medical Schemes

- (b) Consolidation of medical scheme reforms to remove any residual risk selection and to increase coverage:
  - i. Expand prescribed minimum benefits to include chronic conditions and other essential services
  - ii. Phase out benefit options or, alternatively limit the degree to

Source : DoH Social Security Report 2002

# Phase 1 : Integrated Subsidy

- (d) Development of an integrated subsidy system:
- i. A process needs to focus on rectifying structural deficiencies within and between the existing risk-pooling mechanisms. These include:
  - 1. Inequity in the allocation of public health services
  - 2. The tax subsidy to medical schemes

Source : Social Security Committee Report 2002



# Phase 1 : Integrated Subsidy

- ii. The public sector budget system needs to be revised to ensure that the regional allocation of health services is equitable. Furthermore, the subsidy provided to the private sector must at no time exceed that provided to people covered through the public sector.

Source : DoH Social Security Report 2002



# Phase 2 : Implement preparatory reforms



# Phase 2 : Priorities

- Improve the quality and cost-effectiveness of cover within the voluntary contributory environment (medical schemes).
- Enhance the voluntary contributory environment to facilitate the establishment of the mandatory environment in phases 3 and 4.
- The greater the degree of cover, and the acceptability of the contributory environment, the less

Source : Social Security Committee Report 2002



# Phase 2 : Implementation

- Final implementation of:
  - The risk-equalisation fund (begun in phase 1)
  - The risk-adjusted subsidy to medical schemes (begun in phase 1)
  - The state-sponsored medical scheme
  - A mandatory environment for civil servants.

Source : DoH Social Security Report 2002



# The End-Game

	Common	Suppl A	Suppl B	Suppl C	Admin
<b>Scheme A</b>	750	100	150	200	150
<b>Scheme B</b>	650	110			140
<b>Scheme C</b>	800	90	100	150	155
<b>Scheme D</b>	780	120	140		160
<b>Scheme E</b>	700	130	150		110
...					
<b>Scheme Z</b>	680	130	150	190	160

- Provider / Network differentiation
- Mandatory contributions
- No broker commission paid by medical schemes

# How Will Schemes Differentiate?

- Brand
- Loyalty Programs
- Service Delivery
- Efficiency (price)
- Provider Networks
- Quality

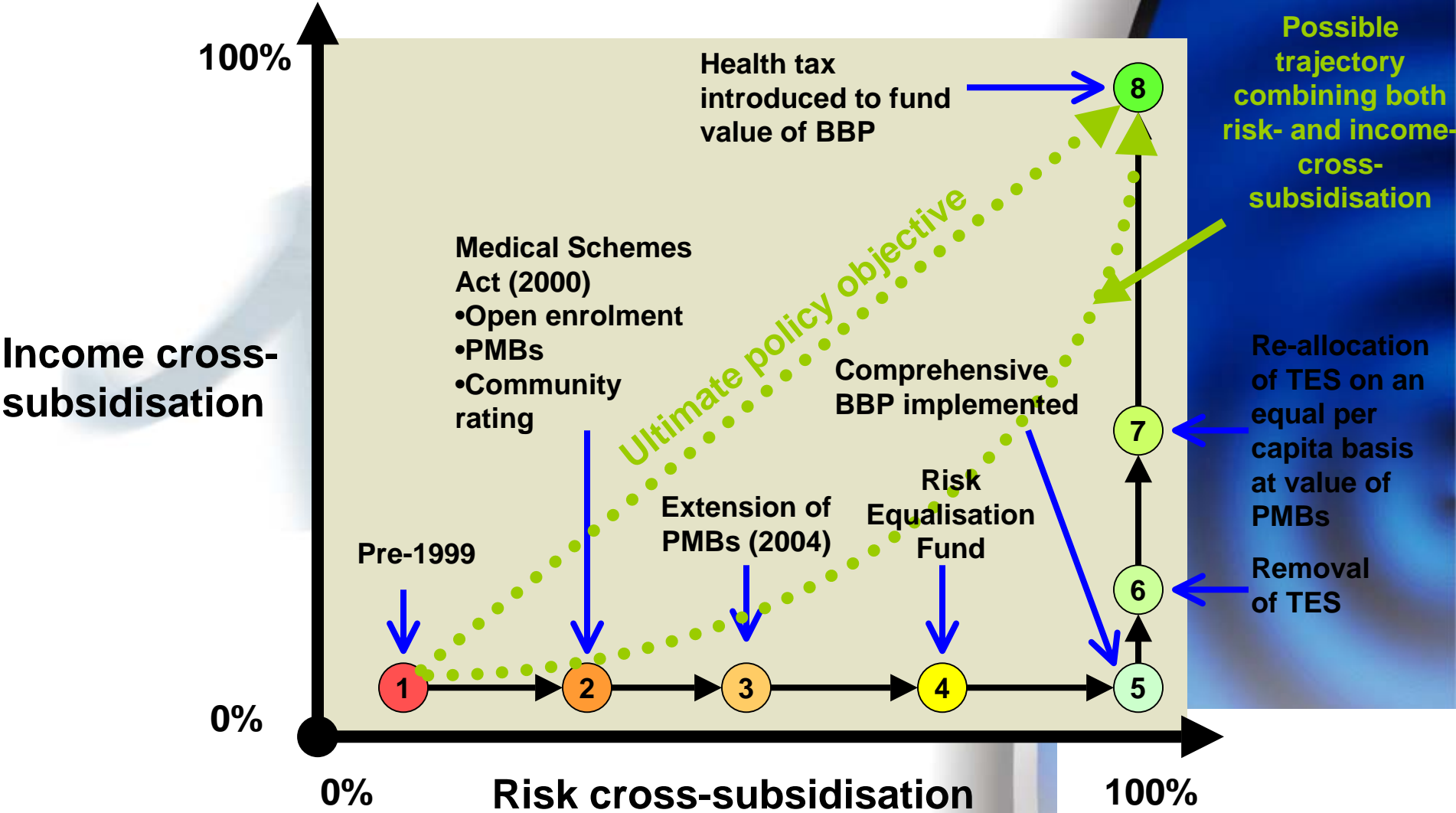
...not by benefit design...



# Regulatory Change

- Risk equalisation
- Benefit restructuring
  - Circular 8
  - Remove MSAs
- Tax reforms
- Expansion of PMB to BBP
- NHRPL (circular 9)
- LIMS
- Cost reduction
- Mandatory contributions

# Policy Objective and Trajectory



Source: MTT

# Risk Equalisation

- Should know by end of July
- “Age Only” or “Age & CDL”
- Net receivers: reduce?
- Net contributors: increase
- Cash flow implications
- Floating community rate
- “Efficient” cost
- Allocation to options

# RETAP Recommendation to CMS

## 1. Relax Section 33(2)(b)

1. We have serious concerns about the implementation of REF and the changes envisaged in Circular 8 of 2006 without income cross-subsidies and mandatory membership. Our concern is that options aimed at low income workers remain affordable in this interim period and that young and healthy workers do not leave the system due to excessive contribution increases. Accordingly, we strongly recommend that the provisions of Section 33 (2) (b) of the Medical Schemes Act making each option self-sufficient be relaxed in 2007 to ensure that the Board of Trustees of each medical scheme can use the REF financial adjustments in the way they best see fit to ensure affordable premium increases.

## 2. Exempt low-income schemes from REF entirely

## 3. Implement on age only if CDL conditions are problematic

Source: e-mail from RETAP to CMS dated 1 May 2006



# Circular 8

- “Not in 2007”
- Some parts may never be implemented
- Cross-subsidisation between options
- Common / supplementary
- Lower risk of anti-selection
- Keep “end-game” picture in mind

# REF / Circular 8

- Will have same effect
  - Low cost options will become more expensive
  - High cost options will become more affordable
- To be countered by
  - Tax reform
  - Income cross-subsidy

# Tax Reforms

- DoH aim to entirely remove Tax Expenditure Subsidy
- Replace with “universal grant”

# REF Implications on Benefit Design

- Uncertainty as to
  - Implementation
  - Pricing
  - Structure
  - Floating community rate
- More info at end of July
- Stress-testing of budget required

# Expansion of PMB to BBP

- Primary care
- Phase out hospital plans

# NHRPL

- Expect NHRPL >> inflation
- Pressure to negotiate
- May differ per option
- NHRPL published in September
- (after benefit submissions)

# LIMS

- LMP give a framework for benefit structuring
- LIMS household survey invaluable source of information

# Benefit Design

- Strategic positioning
- Don't reinvent the wheel (yet)
- Move away from
  - MSA
  - Hospital plans
  - Many options
- Relationships with providers
- Stress-test results
  - NHRPL → option selection → REF → contributions → option selection → .....
- Timelines