Why CMS is stopping low-cost benefit options - Fin24 26 January 2020

The enrolment of membership to schemes has been stagnant, and the proportion of the population that enjoys medical scheme cover has decreased during past decade.

So why is the regulator discontinuing the Low-Cost Benefit Option (LCBO) intended to increase the affordability of medical schemes?

Having seen a modest growth of 6.7% - from 8.32 million to 8.8 million - between 2010 and 2017, with the proportion of the population that enjoys medical scheme cover having decreased from 16% to 15.9% over the same period, it has now become clear that we need change.

Has the Council for Medical Schemes gone rogue? No.

The truth is: health care delivered within a well organised, team-oriented, universal access national systems will improve outcomes, sustain national economies and provide greater synergy of health, wealth and social well-being than when fragmented aspects of health care are provided in a highly commercialised environment.

Increasing affordability

The concept of a LCBO is intended to increase the affordability of medical schemes and membership through the development of a product targeted to a specific group of the population - mainly low-income the households - so that they would be able to afford medical scheme cover.

Generally, these households cannot afford high medical scheme premiums – the premiums paid determine the quality of benefits medical scheme members can receive.

While higher premiums covered richer benefits, there was an opportunity to offer lower-income earners inferior benefits.

Mainly, such products potentially use the state as a designated service provider without entering into the necessary agreements with the state and lack prescribed minimum benefits.

Prescribed Minimum Benefits

However, the South African economy has come under a lot of strain, and higher levels of unemployment suggest that a low-cost benefit option for low-income earners could be difficult to realise.

We have been working with the prescribed minimum benefits committee – and developed a prescribed minimum benefits package with a specific focus on primary healthcare.

- **READ**: Fix low-cost benefit options, don't ban them, say medical insurers

Prescribed Minimum Benefits or PMBs are a set of defined benefits that ensure all medical scheme members have access to certain minimum health services, regardless of their benefit option.

In addition, we consider the proposed PHC package as a basis for the discussions that will lead to the development of an affordable and quality healthcare financing package to citizens of South Africa.

However, as we move towards the National Health Insurance (NHI) to address the ever-widening disparities in access to health care that threaten the security of all, the health-care system should not aggravate unfairness.

The NHI would introduce other new dimensions to the South African health financing system, notably the possibility of using public resources through strategic purchasing of services for the population.

Stakeholders on the benefits of LCBO
Also, earlier this year we received the following inputs from industry stakeholders on the benefits of LCBO.

· In order to prevent the adverse events that may be caused by the introduction of the LCBO, this should be permitted only to individuals who are earning below the income tax threshold. This contradicts the tax exemption for these individuals, whose main purpose is to ensure that their disposable income remains as high as possible; and not to pay for health cover;

· The low income-earning, targeted group may actually need a tax subsidy for them to afford some of these products;

· Targeting low income earners for these products also negates the income cross-subsidisation that is necessary to ensure sustainability of these risk pools. This is accompanied by the risk of cherry picking and anti-selection, placing their long term sustainability at risk;

· Experience in middle income countries show that extensions for health cover succeed better when they are targeted to wealthier population members;

· In the absence of mandatory cover, the targeted group may choose not to take-up this offering on the basis of non-affordability. Those that take up this cover may mainly be responding to the marketing initiatives rather than addressing real needs. The extent of the uptake of this cover will need to be significant for this to redirect service users away from the over-burdened public facilities;

· The administrative cost and burden to the schemes regulator of ensuring through regulation that only tax exempt individuals are allowed to enjoy this cover is significantly high, and needs to be guaranteed to ensure effectiveness and efficiency, and -

· Stagnant economy does not support the successful introduction of these products, whilst ensuring that there is effective regulation to protect these members.

An analysis report has further made the following key findings:

· The claims ratios of medical schemes and the exempted products are 94.3% and 45.5%, respectively. This indicates that medical schemes pay claims at a higher rate than the exempted insurers. The non-payment of these claims often results in members settling these claims out-of-pocket, leading to their impoverishment;

· The non-health expenditures in medical schemes sit at 8.4% of the contributions on average, compared to the 48.4% of the exempted insurers. This clearly indicates that there is a higher proportion of the member's contributions funding administration costs than in a medical scheme;

· Another key finding was that whilst medical schemes are non-profit making, the exempted insures were found to generate up to 8.3% on average;

· Medical schemes are subjected to a statutory 25% solvency requirement and the some of the exempted insurer products, had solvency rate as lower than 10%. This places the long term sustainability of these products at risk;

· Exempted insurer products carry high brokerage fees compared to medical schemes, and
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· On average, there is great variation between premiums paid for the various exempted product, with some clear costing far higher than what would be affordable by tax exempt low income earners.

Protecting medical scheme members

As a statutory regulator, the Council for Medical Schemes' mandate is to exercise oversight over medical schemes, medical scheme administrators and brokers. Our job is to ensure that medical scheme members are protected at all times.

Based on the above findings and discussions, it is difficult for us to support the introduction of the LCBO and demarcation products as they are currently structured and operated.

Indeed, no LCBOs will be allowed for low-income market segments going forward, to align such products with the broader health policy discussion that seeks to ensure adequate access to care, irrespective of the economic status of the population.

We believe that they do not guarantee value for money, and they fail to protect the interests of their members and are likely to drive them to access health care from public facilities due to their limited inferior benefits.

We instead prefer to promote a discussion that will lead to the implementation of a single comprehensive basic option that should be implemented across all schemes as recommended by the Health Market Inquiry. This we believe will reduce information asymmetry, promote competition, drive prices down and provide a sound basis for the introduction of Universal Health Coverage.

Dr Sipho Kabane is Registrar and Chief Executive officer of the medical schemes regulator, the Council for Medical Schemes.

Views expressed are his own and do not necessarily reflect those of Fin24.