The Centre for Actuarial Research (CARE)

A Research Unit of the University of Cape Town

Low-Cost Options in Medical Schemes

The Need for Low-Cost Options and an Analysis of Benefit Designs Used in 2001

CARE Monograph Number 6

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1. Introduction

1.1 Background and Context

The Department of Health released a policy document in September 1997 dealing with the possibility of a Social Health Insurance (SHI) scheme for South Africa. The policy objectives for an SHI scheme were given as :

a) SHI will support the public health system, which is the health care system of ultimate resort.
b) SHI is to provide an effective mechanism for collecting public hospital fees, by ensuring that all formal sector employees and their dependants are insured for public hospital treatment.
c) SHI is to provide formal sector employees with state sponsored insurance cover for essential hospital care at low cost.

In effect, an SHI scheme would seek to increase the number with insurance cover for at least major healthcare costs from an existing 7 million people to approximately 14 million people.

SHI policy is closely linked to two other policies, namely the re-regulation of the private medical scheme industry and the decentralisation of public hospital management (combined with hospital revenue retention).

The re-regulation of the private medical scheme industry was achieved with the Medical Schemes Act, No. 131 of 1998. The major provisions of the Act and Regulations came into force with effect from 1 January 2000. A key goal of the legislation is to return to an environment of community-rating, as had existed until 1989. Included in the reforms is a minimum package of hospital benefits that all schemes must provide in at least one setting without financial restrictions.

During the latter part of the 1990s, medical schemes increasingly began to explore the development of healthcare packages for the emerging market of 7 million people who could become covered under an SHI scheme. This has become generally known as the "low-cost option market", reflecting the reality that earnings levels in this market are lower than for the group already covered by voluntary medical schemes.

In most cases, existing schemes included one or more options aimed at this target market. Restricted membership schemes, which are largely employer-based, typically included these options as they extended membership to all grades of employee. Open medical schemes, which must accept anyone who applies to become a member at standard rates, have in recent years increasingly included low-cost options in their benefit offerings.

1.2 Objectives

The overall objective of this report is to identify and analyse trends in the provision of low-cost options in open medical schemes. More specifically the objectives of this report are to identify low-cost medical scheme options that offer 'essential benefits', defining both what is meant by 'low-cost' and which benefits are considered 'essential'. The benefit design of these low-cost options is described and their distinguishing characteristics identified. The benefit designs are summarised with a particular focus on the use of capitation or risk-sharing agreements with healthcare providers.

The market for low-cost options is made up of two groups : those currently not covered by medical schemes who can afford the low-cost options, and those current members of medical schemes who can no longer afford the options they have been using and thus need a lower-cost solution. The main body of the report is supported by information on both these groups, obtained in the course of the 2001 research programme by the Centre for Actuarial Research. More in-depth work on the demographics of the potential membership of an SHI scheme is planned for 2002.

1.3 Data

Information on benefit designs and contributions was obtained for 32 open medical schemes, out of a total number of 51 in the market in January 2000. These schemes are associated with 23 separate administrators. The 32 schemes offer a total of 166 options. Appendix A contains a list of the administrators, schemes and options considered in the analysis.

Information on benefits and contributions was obtained primarily from marketing material, both printed and electronic. The analysis is done from the perspective of a consumer or corporate buyer of these products.

1.4 Acknowledgements

The authors would like to thank the Research and Monitoring Division of the Council for Medical Schemes for their assistance in obtaining material.

The authors gratefully acknowledge the assistance of Preeta Rama for the work on contribution increases and Keith Titley and Jenny Wolhuter for material on the Wooltru Healthcare Fund.

2. The Population Not Covered by Existing Medical Schemes

The documents outlining a possible SHI scheme have referred to the group of people in formal employment who are not currently members of medical schemes. While it is generally expected that this group has lower levels of income than those who have voluntarily joined medical schemes, little is known about the demographics of the group. The Centre for Actuarial Research has embarked on a multi-year study to obtain demographic and health status information on the group in formal employment who are not members of medical schemes. The first results, splitting those in medical schemes from those not in schemes, are presented below.

The October Household Survey (OHS) is an annual survey conducted by Statistics South Africa. It is based on a probability sample of a number of households, with the number depending on the availability of funding. The number has varied from 16 000 in 1996 to 30 000 in 1999. The OHS for 1999 has been used in this report.

The OHS 1999 was conducted on 30,000 households, covering approximately 106,000 people. From this data set, approximately 15,800 people indicated they were covered by a medical aid, medical benefit scheme, or private health insurance. This is approximately 15 % of the population that has some level of private medical cover. These people were found in approximately 4,800 households.

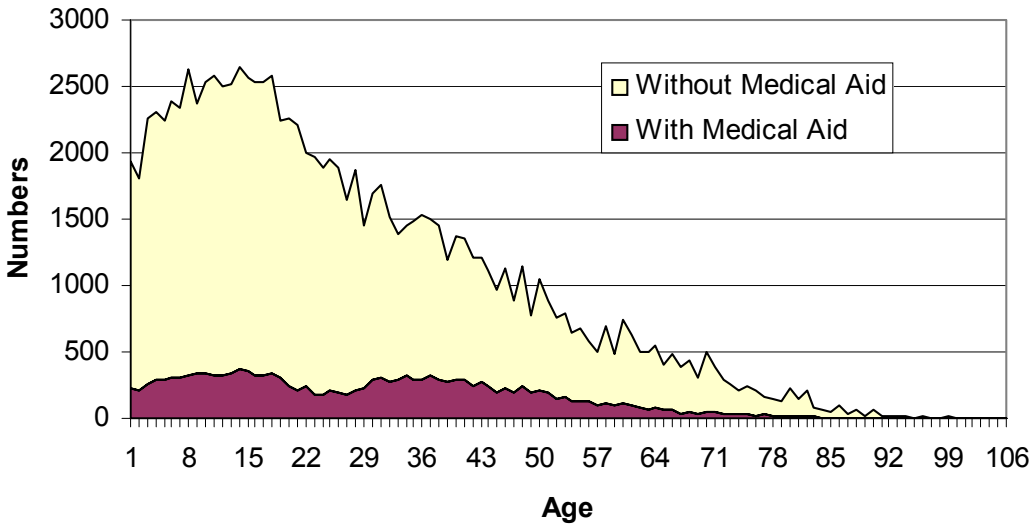
Respondents to the survey provided their age and income bracket. Further useful information was that each respondent was allocated a unique identity number and a unique household number, as well as indicating their relation to the head of the household. Their unique identity number was used to rank their position in the household. However where all the members of the household have medical cover, it is not possible to determine who the member of the medical scheme is, and who the dependants are.

A concern is that it is not possible to determine whether a person is a member of an open or restricted scheme. Proxies have been used in certain circumstances to obtain a useable estimate, using judgment and cross-checking information with data from the Council for Medical Schemes, particularly on income levels.

2.1 Age Profile

An age analysis was done of all the people surveyed in the OHS, separating out those who were beneficiaries of medical aids. The comparison of the two on the graph below shows the much younger age profile of those not covered by medical schemes.

Age Profile of South African Population from OHS 1999



It is apparent that a large percentage of South Africans are under the age of 18 years. Of interest is the decline in medical scheme membership in the age group 20 to 30 years old, compared to age groups before and after that segment. This typical bi-modal age structure is commonly seen in South African medical schemes and the phenomenon requires further investigation.

Further work needs to be done in 2002 to separate those not covered by medical schemes into those in employment and those not employed.

2.2 Family Size Profile

The determination of family profile for those not covered by medical schemes will be tackled in 2002. Early results on the family profile of those in medical schemes is useful for the determination of the benchmark family discussed in Section 4.2.

The initial focus was on the OHS data as the primary source of information. The member of the medical scheme was taken to be the head of the household. This assumption seems reasonable in light of the fact that it would normally be the head of the household who has the best remuneration package, and by proxy therefore the better medical scheme. The contribution rate to be paid by the family would typically be determined by the income of the head of household, where income bands are used by the scheme.

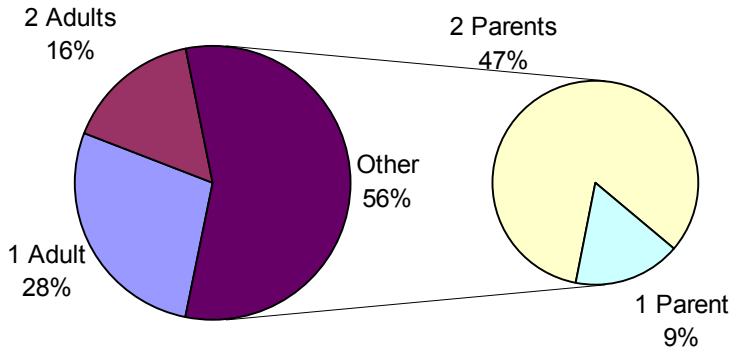
Approximately 4 800 heads of households were analysed. This figure was obtained by filtering the approximate 15 800 who had medical cover, for the key indication that they were rated as the head of the household. The rest of the analysis was based solely on the heads of the household, by proxy, the principal members.

The number of dependants was the most problematic data to extract from the OHS, as there was no additional evidence from the Council for Medical Schemes data. The first problem was that there was no specific question relating to how many dependants (adult or child) a person had. Also problematic, was the structure of a 'typical' South African household. It does certainly not follow the traditional Mother, Father and two children pattern. Households have a large number of children that are the children, grandchildren, nephews and nieces of the head of the household.

However, an attempt was made to construct a model of the 'typical' household. Firstly, the number of children per household was examined. The largest households were taken to be two parents and *at least* three children. The list of principal members was then filtered by the children who had medical cover. Starting where the first child was rated as the second member of the household this was used as a proxy for a single parent home, and in most cases was correct. A picture of single parent homes, with 1,2, and 3 children was then built up. A similar principle was applied to obtain the same results for two parent homes, obviously filtering out the single parents.

The next step was to look at the households without children, which was constructed by screening *all* the households with *all* the children. A profile of single people households was then obtained, by screening this preceding list, with a list of spouses/partners. The households consisting of couples without children were then the complement of single households. The diagram below summarises the results.

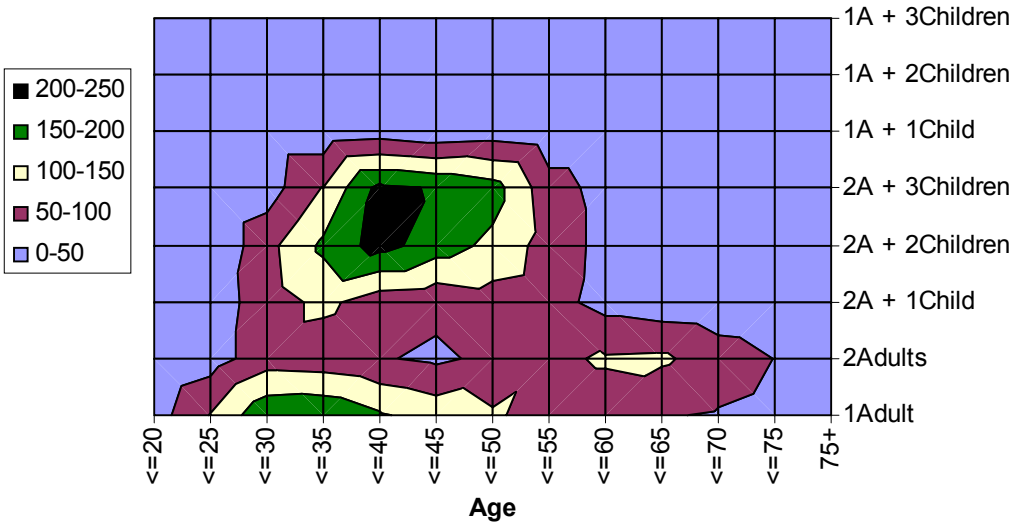
Household Structure for Medical Schemes from OHS 1999



As illustrated above, 56 % of households had children, with the majority having two parents. Single parent households made up approximately 9 % of all households.

The contour chart below shows the age and family profiles together. The areas of greatest concentration are shown by higher contours. The greatest concentration occurs at just above age 40, with a family size of between (2 adults and 2 children) and (2 adults and 3 children).

Age and Family Size of Medical Scheme Members in OHS 1999



2.3 Income Profile

2.3.1 Council for Medical Schemes Interim Survey, September 2000

No data regarding income of members of medical schemes was obtainable from the Council for Medical Schemes data for 1999. However, preliminary results were released from an Interim Membership Survey the Council conducted amongst open scheme members for the first nine months of 2000, i.e. up to September 2000. These are tabulated overleaf.

The data shows that approximately 54 % of open medical scheme members earn less than R4 000 per month. It would appear to indicate that R 4000 per month could possibly be used as a type of benchmark, representing the average middle-income salary.

41% of members in medical schemes earn less than R3 000 per month and this would include many of the pensioners.

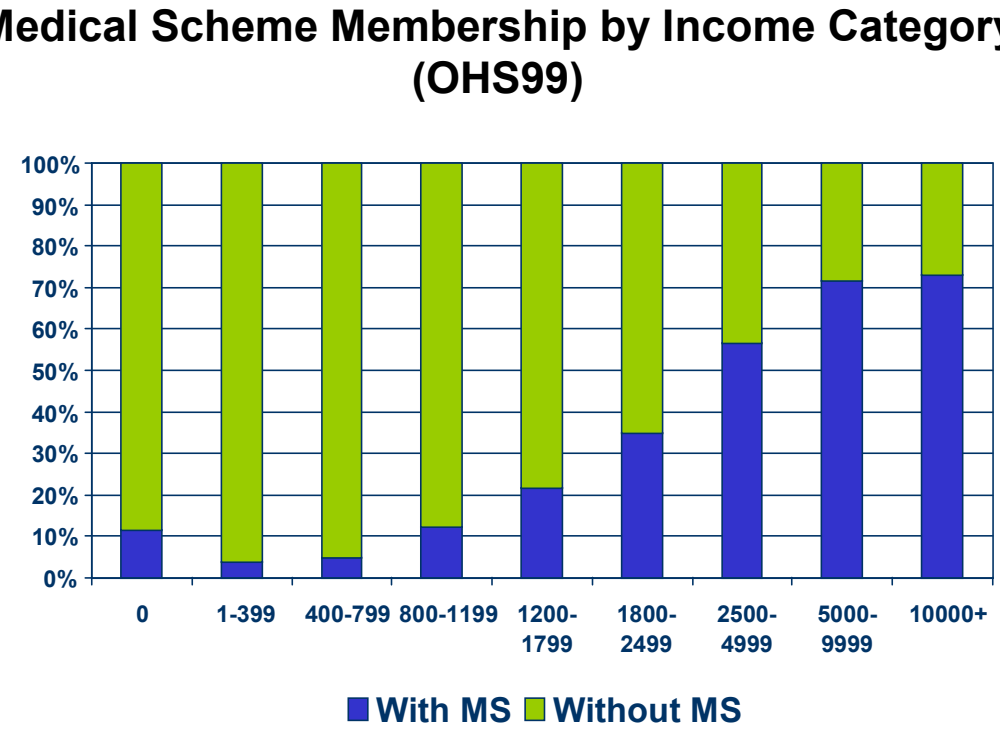
Income of Open Medical Scheme Members from CMS Interim Survey, 2001

Income	Percentage	Cumulative %
<2000	12.44	12.44
2000-3000	28.90	41.34
3001-4000	12.32	53.66
4001-5000	14.65	68.31
>=5001	31.68	100
Total	100	

The data were compared to the income data in the OHS 1999 for those with medical cover. Although the income brackets used for the two studies differ, an attempt was made to calibrate the two studies. The proportion of members of medical schemes with income over R5 000 is approximately 30% in both studies.

2.3.2 October Household Survey 1999

When the income distribution for the entire OHS 1999 is compared with those in the data set who have medical cover, the degree of coverage by income band is of significant interest, as shown below.



At the upper end of the scale, for those earning over R 5000 per month, over 70% have medical cover. It could be expected that an even higher percentage than 70 %, have medical cover in the R 10000+ per month income bracket.

A possible explanation is that the people who refused to give income information contains a proportion of high income individuals. In fact, just under 60 % of all those that refused to provide income information had medical cover. If these are taken to be higher income individuals, then the coverage for the group earning over R10 000 per month is substantially higher than 72%.

The picture is quite the reverse at the other end of the spectrum. For people earning less than R 2500 per month, the proportion with private medical cover tails off sharply.

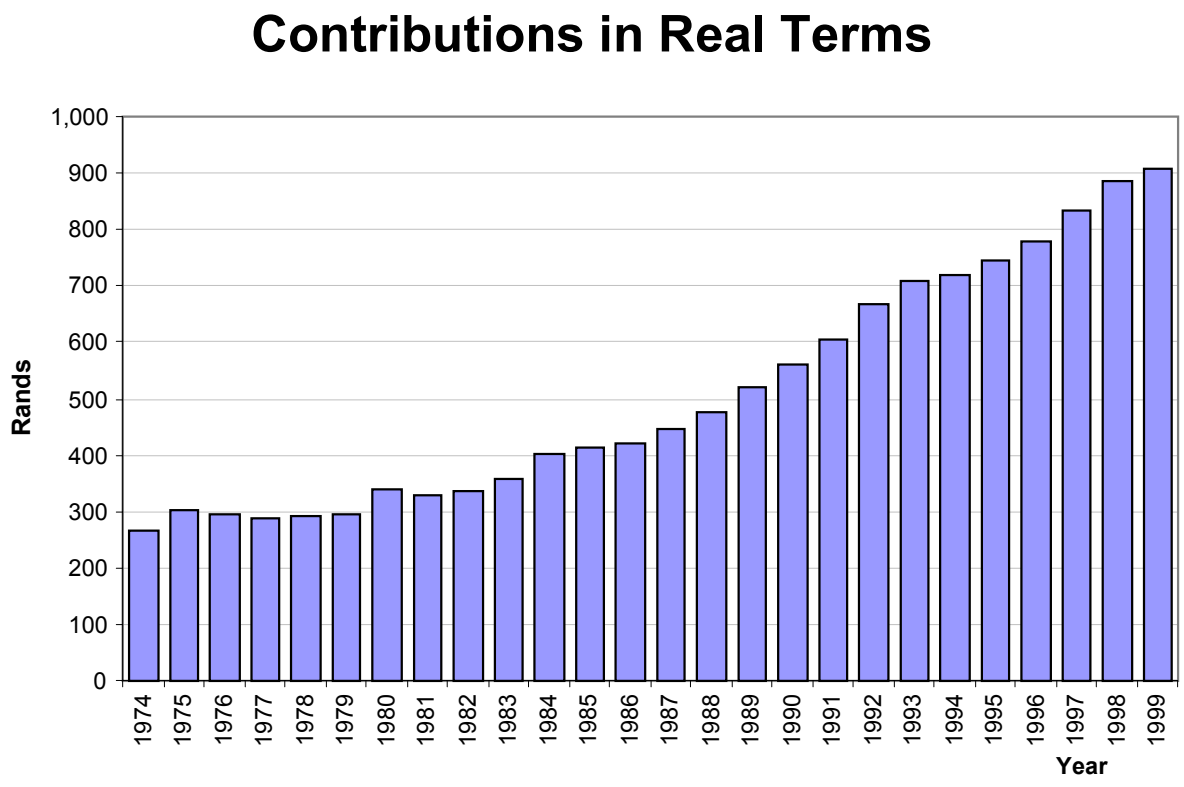
Note also that 63 % of the surveyed population stated that they had received zero income in the previous month.

3. The Pressure for Low-Cost Alternatives for Existing Members

A second source of potential members for low-cost options is those who are members of schemes but can no longer afford the contributions of their existing packages. During the course of research work in other areas, a number of new items of information were uncovered which bear on this group.

3.1 Contribution Increases Exceed Inflation

The major force driving members to seek lower cost alternatives is the increase in real contribution rates. The graph below is taken from a long-term study by Rama and McLeod, in which data from the Council for Medical Schemes were considered over the full period since records have been kept.



From 1974 to 1999, average contributions per member have increased in real terms by a factor of three times, from some R300 per month to R900 per month (in 2000 Rand terms).

This pressure on affordability has serious consequences for existing members of schemes. Given the income distributions in Section 2.3, the opportunity to attract new members with lower income levels is also seriously jeopardised.

3.2 Change in Employer Subsidy for Workers

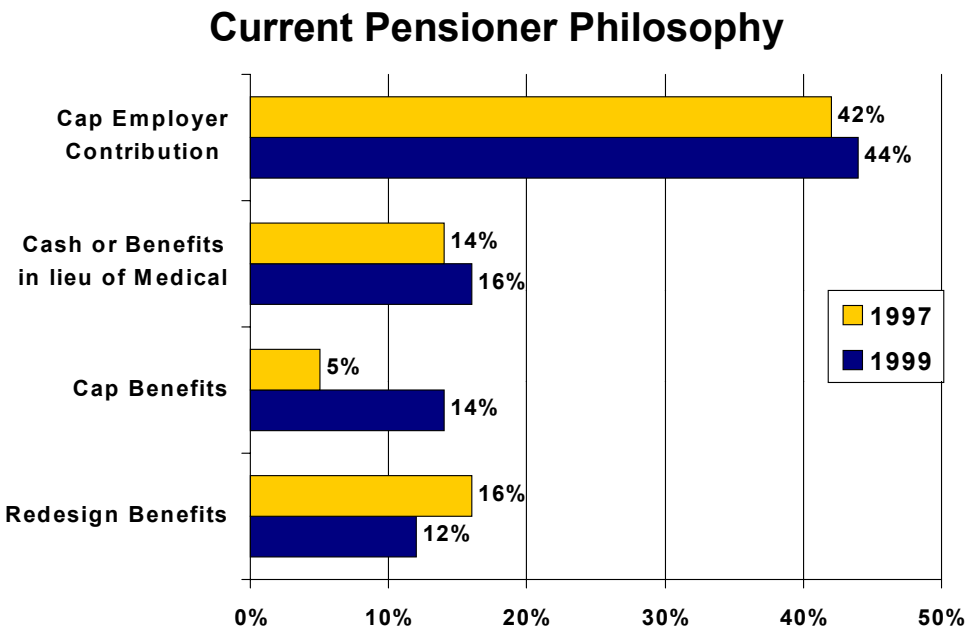
At the beginning of the 1990s it was common practice for employers to offer a 50% or even 66% subsidy of the medical scheme contributions. This is no longer the case and employers increasingly seek to limit the subsidy in some way.

While not an exhaustive list, the following factors have impacted on the subsidy policy of employers :

- Medical benefits are now a larger proportion of employment costs. In the 1970s medical benefits were of the order of 3% of payroll, rising to 8-11% by the 1990s.
- As more options were made available in schemes, it became increasingly unfair to subsidise all options at 50%. Employers now set the subsidy in relation to a particular basic option, with the member being responsible for the cost of choosing a more expensive option.
- The increased focus on employment equity principles has ensured more attention is given to the impact of subsidies.
- In the 1970s, remuneration packages were typically described as cash plus benefits, including medical scheme benefits and retirement benefits. The concept of total remuneration has become widespread, under which the total package is quoted, with employees having flexibility in their choice of benefits.
- It is now increasingly unlikely that a person would join a single company for their entire working life. The question of length of employment as a factor in subsidy decisions is increasingly under scrutiny.
- The accounting standard AC116 requires that companies account for the promises made to subsidise post-retirement medical scheme benefits. Any promise is expected to be accounted for in full during the working lifetime of the employee. AC116 is now mandatory for South African companies.
- In the 1990s there was a substantial shift from defined benefit to defined contribution retirement schemes. This increasingly focused attention on the nature of the subsidy for medical benefits.

3.3 Reduction in Employer Subsidy for Pensioners

The Old Mutual Healthcare Surveys have tracked the thinking of employers on the question of medical scheme subsidies over a number of years. The graphs below illustrate the impact on current pensioners.

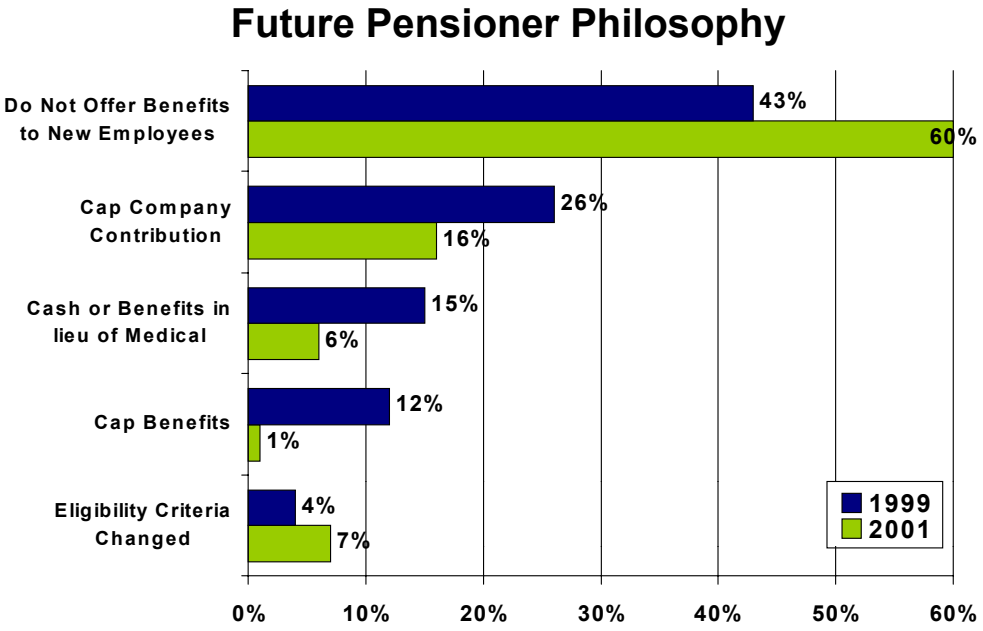


Source : OMAC Health Survey 1999

The major response is to put a cap on the employer contribution towards the medical scheme. In some cases, employers have changed from a percentage subsidy to a fixed Rand subsidy that may escalate with ordinary inflation. Given the inflationary pressures on medical scheme contributions shown in Section 3.1, the pensioner member is likely to feel substantial financial pressure within a few years of the employer changing the subsidy structure. This comes at a time when healthcare needs are greatest.

These pensioners will need to seek more affordable levels of healthcare. Whereas the choice of their own doctor may have been important, the financial pressure leads them to consider restrictions on the choice of provider and to accept capitated models of care.

The impact of changes in subsidy policy is seen to greatest extent in the subsidy offered to new employees. The graph below shows the measures taken on subsidies for future pensioners.



Source : OMAC Health Survey 1999, 2001

In 1999, 43% of employers reported no longer offering subsides in retirement to new employees. This increased to an alarming 60% of employers in the 2001 survey.

People seeking employment are often in no position to seek alterations to the terms of their employment at the time of accepting a position. Thus there appears to be no reaction to this decision by employers.

The problem engendered for medical schemes will remain hidden for some time. It is only as people reach retirement that the full impact of this employer policy will be felt. It is likely to exacerbate the affordability problem for those in retirement, leading to a crisis in healthcare cover for the elderly.

4. Criteria for Low-Cost Medical Scheme Options

In order for options to be included in the analysis they had to meet certain criteria. The cost of the option for a benchmark family was used as the primary basis for selection, with the benchmark family defined in Section 4.2. Each option was scrutinised to ensure that it covered at least an "essential" package of benefits, as described in Section 4.3. The treatment of optional additional benefits and medical savings accounts is given in Section 4.4.

The process of isolating low-cost options is demonstrated in Sections 4.5 and 4.6. A complete list of the low-cost options meeting the criteria is given in Appendix B.

4.1 Terminology and definitions for this Report

Traditional – A traditional benefit is one that is paid from pooled funds

New generation – New generation schemes allow members to combine traditional benefits with medical savings accounts. These are tax- free individual accounts from which members can draw to pay medical bills not covered by the insured benefits.

Managed care – Arrangements that monitor utilisation of health care and that ensure the member receives care that is medically necessary, high quality, cost-effective and in the appropriate setting.

Capitation – Usually refers to a pre-determined Rand amount, per covered person, paid directly to a medical provider. The provider is then responsible for the provision of health services for each of these covered persons for an agreed time period.

Major medical – Generally refers to expenses incurred if a member develops a major illness or requires major surgery.

Day-to-day – Refers to those medical expenses incurred by members that are not related to major illness or major surgery. These expenses tend to be incurred more frequently and are of a less catastrophic nature than major medical expenses.

BHF – Refers to the Board of Healthcare Funders who annually negotiate a tariff structure that is used for payments from a number of medical schemes.

4.2 The Benchmark Family

It was decided to utilise a family consisting of two adults and two children as the benchmark for comparison. This decision was based upon data obtained from the Registrar of Medical Schemes and the work described in Section 2.

The Registrar's data for 1999 suggests that the ratio of beneficiaries to members across all schemes (open, restricted and exempt) is 2.61:1.

Section 2.2 shows how the medical scheme membership is made up of concentrations of single people and families. The highest concentration of members, between the ages of 35 and 50, lies between the categories of 'two adults, two children' and 'two adults, three children'. However, the increases in contributions by including a third child are marginal and for it was considered sufficient to include two children in this study.

The use of two children and two adults gives a sense of the different contribution rates usually charged by schemes – those for principal members, adult dependants and child dependants.

For those schemes that use income rating it was decided to look only at contribution rates for income bands lying below R4 000 a month. Section 2.3 showed that 54 % of those in the medical scheme environment earn less than R4 000 a month. R4 000 is thus close to the average income for those in the medical schemes environment.

The benchmark family used in this study is thus two adults and two children, with family earnings of R4 000 per month.

4.3 The 'Essential' Benefit Package

The question of what benefits constitute an "essential" benefit package for the low-cost market is not an easy one.

During the 1990s, many schemes chose to offer "hospital only" packages which provided access to private sector hospitalisation. The packages were attractive to younger, healthy members without families. They were more suited to the higher end of the income spectrum where members would have sufficient savings or access to credit to be able to pay for day-to-day care from their own pockets. The same target group was also offered health insurance products known as "hospital plans" until the demarcation between medical schemes and health insurance was clarified in 2000. These "hospital plans" were considered by the Registrar of Medical Schemes as doing the business of a medical scheme, as defined in the Medical Schemes Act of 1998, and they may no longer be marketed.

From 1 January 2000, all medical schemes have been required to provide members with prescribed minimum benefits as listed in the Regulations of the Medical Schemes Act. The minimum benefits cover a spectrum of hospital benefits according to public sector hospital treatment protocols. Schemes must provide access to these benefits in at least one environment. This could be the public sector or other private networks could be contracted to supply these benefits. Schemes may not impose financial limits on members in respect of these benefits.

While public hospitals continue to have difficulty in identifying medical scheme members and seldom charge medical schemes for services rendered to their members, there is a perception that hospital benefits are supplied "free" by the public sector. Members and potential members of schemes would be reluctant to pay for public sector hospital benefits unless they perceived a qualitative difference in access to services. This will require the public sector to institute some form of differential access to services.

The attraction of a medical scheme to those not covered, is that it can provide improved access to healthcare services. The focus of the lowest cost benefit design attempted in the last few years has been to provide private sector day-to-day benefits. As contracting with the public sector for hospital services is not well-established in all provinces, some access to private sector hospital benefits has typically been included.

The market understanding of "low-cost options" is thus to include day-to-day benefits, together with hospital benefits. This is contrasted with the Department of Health position in 1997 where a low cost SHI package was seen to cover only hospital benefits.

The authors have not attempted to enter into the philosophical discussion of what should constitute an essential package of healthcare benefits. This issue is however crucial in the development of more detailed proposals for Social Health Insurance.

For the purposes of this report, the authors have chosen to consider only those options that include, as a minimum, a private sector day-to-day or primary care component, in addition to the prescribed minimum benefits. We have thus excluded options that provide only hospital benefits, even if these did meet the criterion of cost discussed in section 4.5 below.

4.4 Optional Benefits and Medical Savings Accounts

Other than as discussed below, optional benefits were excluded from the analysis. The reasoning behind this approach is that the analysis is concerned with low-cost options, and it is thus appropriate to focus on the most basic options available.

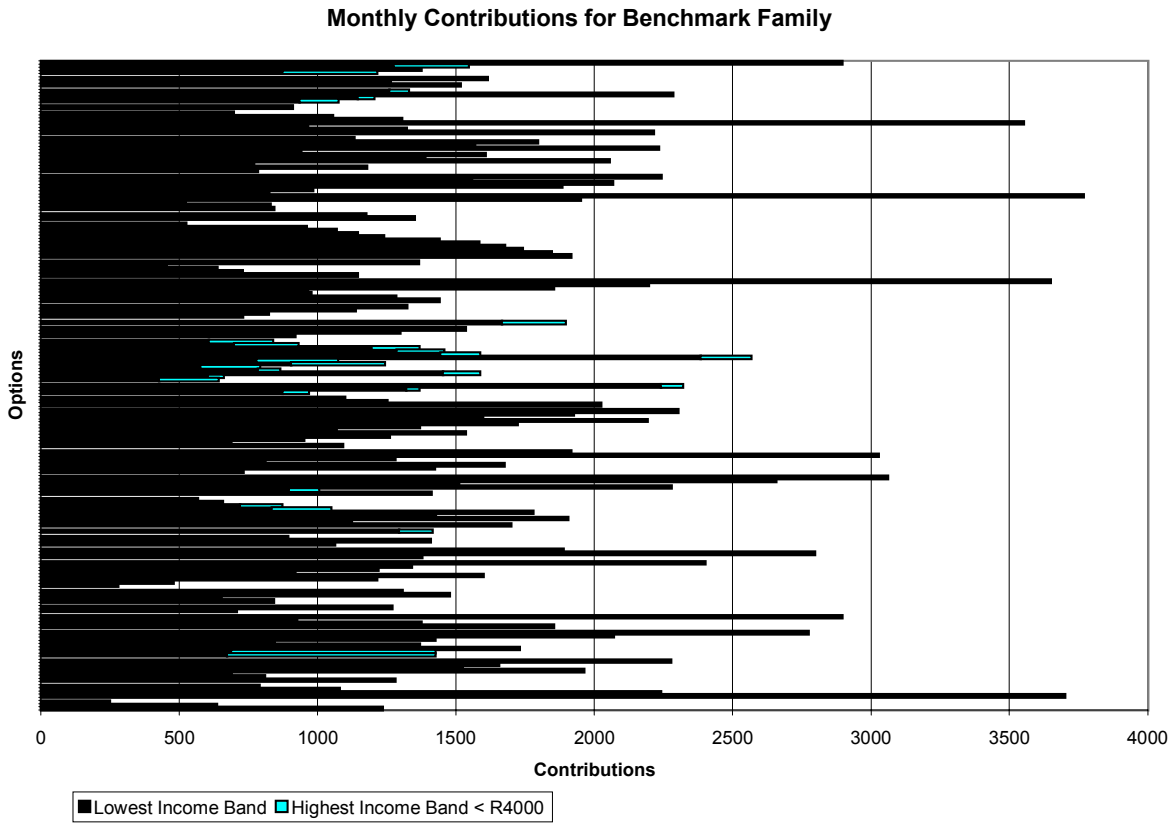
The exception is the inclusion of optional day-to-day benefits and medical savings accounts in some cases. The inclusion of these benefits has to do with the "essential" benefits package as discussed in Section 4.3. It was decided to include optional day-to-day benefits or medical savings accounts contributions for those options that offered no

other day-to-day or primary care benefits. In cases where optional levels of medical savings account contributions could be chosen, they were included at a level of 25% of the total contribution. This is in accordance with the maximum for savings account contributions laid down by the Medical Schemes Act.

4.5 Exclusion of High-Cost Schemes

Contributions were determined on each option for the benchmark family (two adults and two children with family income of less than R4 000 per month). Contributions were calculated excluding optional benefits and medical savings accounts. The resultant 166 contributions ranged from R250 per month to R3 768 per month. The range is illustrated in the graph below, without the ability to identify specific options.

It can be observed from the graph that the majority of the 166 options are priced at more than R1 000 per month. The problem of affordability of these options on a family income of R4 000 per month is immediately apparent.



At this point, all options where the contributions in the lowest income band exceeded R1 000 were eliminated. R1 000 was chosen as an upper limit because contributions of R1 000 a month imply at least 12.5% of income (with a 50% employer subsidy) being spent on medical scheme contributions for those earning R4 000 a month. The authors do have a serious reservation that at a monthly cost of R1 000, many families at low income levels would still find the payments unaffordable.

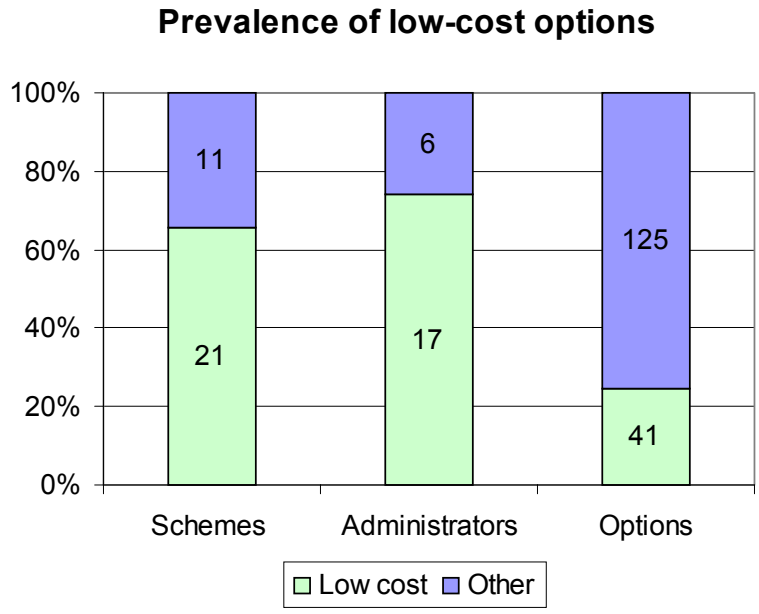
It was also noted, for those options where contributions in the lowest income band lay below R1 000 a month, whether contributions in the highest income band under R4000 exceeded R1400. If so, the options were eliminated.

Contributions were initially calculated excluding any optional benefits or contributions to medical savings accounts. A number of new generation options were priced at less than R1000 per month, but contained no day-to-day benefits. For those options that only contained 'essential' benefits if optional benefits were included, contribution rates were recalculated taking into account the optional portions. Options were eliminated if contribution rates including optional portions exceeded R1 000 a month.

Those options that still did not contain 'essential' benefits were also eliminated. In all, 125 of the 166 options were eliminated from further analysis.

4.6 Options meeting the Low-Cost Criteria

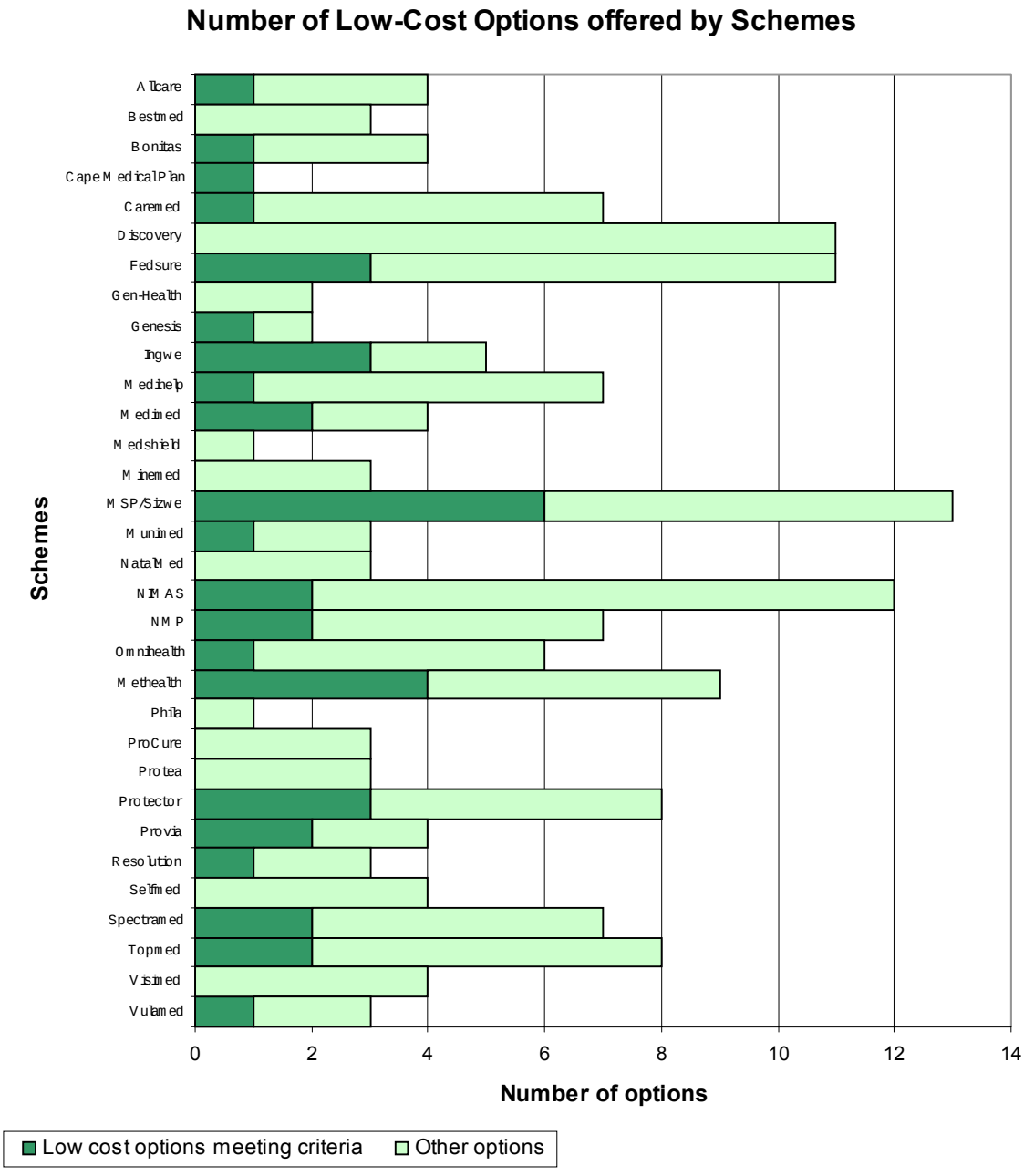
A complete list of the 41 options that met all the low-cost criteria is given in Appendix B. The prevalence of low-cost options is illustrated below, by considering the proportion of schemes, administrators and options included in the further analysis.



It is interesting to note that whilst only 25% of the options analysed meet the low-cost criteria, 66% of the open schemes in the survey offer low-cost options and 75% of the administrators under consideration have a low-cost offering.

It was not possible to obtain data on membership numbers by option while the report was being prepared. This data was collected from schemes in 2000 in the revised annual statutory returns to the Registrar and the database was not available at the time of writing.

The number of low-cost options offered by each scheme is illustrated below.



5. Open Schemes with No Low-Cost Options

Of the 32 medical schemes included in the complete analysis, 11 did not offer any low-cost options in 2001.

5.1 Bestmed Medical Scheme

Bestmed offers three options, all of which make use of a hospital network. All three options cost more than R1 000 for a benchmark family even if optional day-to-day benefits are excluded.

5.2 Discovery Health Medical Scheme

Of the eleven options offered by Discovery Health, three cost less than R1 000 for a benchmark family, but only if contributions to the optional medical savings account are excluded. When the medical savings account contributions are included, none of the Discovery Health options meets the criteria for low-cost options.

5.3 Gen-Health Medical Scheme

Gen-Health offers two options – the High option and the Low option. Both benefits have an insured benefit covering both day-to-day and major medical expenses. There is an annual excess payable on out-of-hospital benefits which is provided for with a compulsory savings account.

5.4 Medshield Medical Scheme

Medshield only offers one option called Maxigold. This option is made up of an insured component and a compulsory savings account.

5.5 Minemed Medical Scheme

Of the three options offered by Minemed, one does cost less than R1 000 for a benchmark family, namely the Hospital and Chronic Medicines option. However, this option does not provide primary care or day-to-day benefits. The other two options, Doctor Network and Medical Centre, provide an insured benefit covering both major medical and day-to-day benefit. All three options make use of preferred providers.

5.6 Natalmed

All three options offered by Natalmed provide an insured benefit covering both major medical and day-to-day benefits. Two of the options, Gold and Platinum, also have an additional insured day-to-day benefit used primarily to meet co-payments.

5.7 Phila Medical Scheme

Phila, administered by Medscheme, offers only one option. This traditional option did not meet the low-cost criteria.

5.8 ProCure Medical Scheme

ProCure, a Liberty Healthcare scheme, was launched in March 2001. Benefit design for this scheme is similar to that of the other Liberty Healthcare open-enrolment scheme Provia. The major difference is that Provia is aimed at employer groups and ProCure is aimed at individuals. The differentiation is done on the basis that for Provia there is a scheme fee of R500 levied on each participating employer. This means that an individual would have to pay an additional R500 per month to join Provia.

ProCure has three options, two of which are new generation options and one of which is a managed care option. The cost of all these options exceeded R1 000 per month for the benchmark family.

5.9 Protea Medical Aid Society

Protea is a traditional scheme with all three of its options providing insured major medical and day-to-day benefits.

5.10 Selfmed Medical Scheme

Selfmed is the Sanlam Health scheme targeted at individuals. There are four Selfmed options, three of which are new generation options and one of which is a traditional option. None of these options meet the low-cost criteria.

5.11 Visimed Medical Scheme

Three of the Visimed options provide insured major medical and day-to-day benefits as well as an optional savings account. The fourth option is a pure new generation option providing only for major medical expenses.

6. Open Schemes with One Low-Cost Option

Of the 32 schemes analysed, ten offer one low-cost option. Seven of the ten are traditional options, one is a new generation option and two are managed care options. Both the managed care options make use of the Prime Cure network of clinics.

Appendix C gives details of the benefit and contribution structures in graphic form for each option discussed below.

6.1 Allcare Medical Aid Scheme

Allcare, a self-administered scheme, offers four options. Only the Chamber Budget option meets the low-cost criteria.

6.1.1 The traditional option: Chamber Budget

The Chamber Budget option is a traditional option. It offers an insured benefit covering both major medical and day-to-day expenses. Although there is no overall limit on the benefits there are a series of sub-limits. For example hospitalisation is limited to R50 000. Chronic medicine is limited to R3500 for a benchmark family. Benefits are paid at BHF rates.

Chamber Budget makes use of hospital pre-authorisation, some disease management and preferred providers for chronic medicines and emergency transport.

6.2 Bonitas Medical Fund

Bonitas, a large Medscheme scheme, offers four options. Of the four, only the Primary option meets the low-cost criteria.

6.2.1 The traditional option: Primary

The Primary option is a traditional product offering an insured benefit covering both major medical and day-to-day expenses. The overall limit of this benefit is R150 000 and benefits are paid at BHF tariffs. Significantly, there are no chronic medicine benefits.

Bonitas Primary makes use of hospital pre-authorisation and a number of benefit management programmes including an HIV programme.

6.3 Cape Medical Plan

6.3.1 The new generation option: Mediflex

Cape Medical Plan only offers one option called Mediflex that consists primarily of an insured benefit covering major medical expenses. The overall limit on this benefit is R500 000 but can be upgraded to R1 million. Certain benefits including hospitalisation are paid at private rates. There is also an optional insured day-to-day benefit and an optional medical savings account. The overall limit on the day-to-day benefit increases in multiples of R600 from R600 to R9 000. Chronic medicine is paid from the day-to-day benefit. In order to keep the contribution for a benchmark family under R1 000 a day-to-day benefit of only R600 can be selected. This means that there is no significant chronic medicine benefit.

Mediflex makes use of hospital pre-authorisation.

6.4 Caremed Medical Scheme

Caremed is an Old Mutual administered scheme offering seven options. Of these only the Essential option met the low-cost criteria. The Select option could also be purchased for less than a R1 000 a month by the benchmark family, but only if the medical savings account was not utilised. Without the medical savings account the Select option offers no day-to-day benefits and was thus excluded from the analysis.

6.4.1 The traditional option: Essential

The Essential option consists of an insured major medical benefit, an insured day-to-day benefit and an optional savings account. The overall limit for the major medical benefit is R50 000. The limit for the day-to-day benefit would be R2 650 for a benchmark family. Both benefits are paid at BHF tariffs. Chronic medicine can only be paid from the day-to-day benefit meaning that there is no significant chronic medicine benefit. An interesting feature of the day-to-day benefit is that if there is an unused portion at the end of a year it rolls over to the next year.

The Essential option costs less than a R1 000 for a benchmark family even if a contribution of 25% of the total contribution is made to the savings account. It is interesting to note that the medical savings account is not made available annually in advance, as it is with most other medical savings accounts. This limits the extent to which the member carries the responsibility for benefit management to some degree.

6.5 Genesis Medical Scheme

Genesis offers two options called Plan A and Plan B. Both of these plans cost less than R1 000 for a benchmark family. However Plan A does not include any day-to-day benefits.

6.5.1 The traditional option: Plan B

Plan B offers an insured major medical benefit with no overall limit, a R1 million vehicle accident benefit and a R1 million overseas travel benefit. There is no sub-limit for hospitalisation. Whilst all other benefits are paid at BHF rates, emergency hospitalisation is paid at private rates. Chronic medicine forms part of a chronic disease management benefit which has an overall limit of R500 000. Day-to-day benefits are provided for with an optional combination of medical savings account and insured benefit. There is a choice of ten overall limits for this benefit. There is also an above threshold benefit.

Genesis makes use of hospital pre-authorisation and a medical advice line.

6.6 Medihelp

Medihelp offers seven options. Of the seven only the Nucleus option meets the low-cost criteria. The Medihelp Dimension Core option costs less than a R1 000 for a benchmark family if the optional day-to-day benefits and medical savings account are excluded.

6.6.1 The managed care option: Nucleus

The Nucleus option is made up of an insured major medical benefit and a capitated primary care benefit. The insured major medical benefit provides for public hospitalisation. Private hospitalisation is only on approval. Major medical benefits are paid at BHF. The primary care benefit makes use of the Prime Cure network of clinics. Chronic medicine is available through the clinics.

6.7 Munimed

The Munimed scheme, which is self-administered, has three options. Only the Omega option is included in this analysis.

6.7.1 The traditional option: Omega

The Omega option is a traditional option. It offers an insured benefit covering both major medical and day-to-day benefits. The overall limit is R100 000 and benefits are paid at BHF tariffs. There is a R4 000 chronic medicine benefit for a benchmark family. The chronic medicine benefit requires a 20% co-payment.

Hospitalisation requires pre-authorisation and Munimed also make use of an HIV/AIDS management programme.

6.8 Omnihealth Medical Scheme

Omnihealth, an amalgamation of a number of schemes, was launched for 2001. Omnihealth is administered by Medscheme. There are six Omnihealth options, of which the Omnisave option is included in this analysis.

6.8.1 The traditional option: Omnisave

Omnisave is made up of an insured major medical benefit, an insured day-to-day benefit and an optional medical savings account. However, Omnisave only costs less than R1 000 a month if the medical savings account contributions are excluded.

The major medical benefit has no overall limit and the hospital benefit has no sub-limit. Benefits are paid at BHF tariffs, except surgical procedures, which are covered up to private rates. The day-to-day benefit limit is R3 600. Some day-to-day benefits are paid at private rates. Chronic medicine benefits are paid either from day-to-day benefits or from savings, subject to approval and benefit management.

Omnihealth uses pre-authorisation and a number of management programmes, such as an HIV programme and a lifestyle management programme. There are also programmes for hospital benefit management and maternity.

6.9 Resolution Health Medical Scheme

Resolution Health, administered by Health Systems Management Trust, has three options. Of the three, the Fundamental option costs less than R1 000 per month for the benchmark family.

6.9.1 The traditional option: Fundamental

The Fundamental option is a traditional option. It is made up of a hospital benefit, an auxiliary services benefit (major medical benefit), a chronic medicine benefit, a day-to-day benefit and an optional medical savings account.

The hospital benefit has a R50 000 limit. The major medical benefit has no overall limit but does have a series of sub-limits. The chronic medicine benefit has a limit of R3 000 and makes use of a preferred provider network. The day-to-day benefit has a limit of R1 700 (for a benchmark family). These benefits are paid at BHF rates.

Even with the maximum (25% of total) contribution to the medical savings account the Fundamental option still costs less the R1 000.

6.10 Vulamed

Vulamed, a scheme administered by Sovereign Health, offers three options: Basic, Standard and Advanced. The Basic and Standard options meet the low-cost criteria. However, the Basic option was not analysed because it only provides primary care and does not provide prescribed minimum benefits.

6.10.1 The managed care option: Standard

The Standard option is a managed care option comprising an insured major medical benefit, a capitated primary care benefit and an optional medical savings account. The major medical benefit covers hospitalisation and specialist care. It is an interesting feature of this product is that it specifies that where clinically appropriate patients are admitted to public hospitals as a first resort for treatment of organ failure, cancer, infertility, mental health, substance abuse and AIDS.

The primary care benefit utilises the Prime Cure network of clinics. Chronic medicine is unlimited if provided by the clinic, subject to a fixed formulary. An additional R10 000 benefit is available for medicine, both acute and chronic, not on the medication list.

Vulamed makes use of hospital pre-authorisation and an HIV/AIDS disease management programme.

7. Open Schemes Offering a Range of Low-Cost Options

Of the 32 schemes analysed, 11 offer a range of low cost options. These 11 schemes together provide 31 of the 41 low-cost options studied. 15 of the 31 options could be classified as managed care options, with nine as traditional options and seven as new generation options. Appendix C gives details of the benefit and contribution structures in graphic form for each option discussed below.

7.1 Fedsure Health

Fedsure offers 11 options divided into three ranges: Ultima, Prima and Larona.

The Ultima range consists of six new generation options. Two of these options were priced at less than R1 000 for the benchmark family, but only if both the optional medical savings account and optional day-to-day benefit were excluded. These options were excluded from the analysis.

The entire Larona range met the low-cost criteria. The marketing material indicates that this "product range has been specifically designed for the needs of lower income members". The Larona range is made up of a traditional option, a new generation option and a managed care option (Prime Cure).

7.1.1 The new generation option: Larona New Generation

Larona New Generation consists of an insured major medical benefit, an extended medicine benefit, an optional day-to-day benefit and an optional medical savings account. The major medical benefit has an overall limit of R100 000. Benefits are paid at BHF tariffs. The extended medicine benefit, from which chronic medicine is paid, has a limit of R4 500 (for a benchmark family). The chronic medicine benefit requires separate application and is subject to a list of medicines. The day-to-day benefit has a limit of R1 080 (for a benchmark family). Including both the optional day-to-day benefit and contributions to the savings account (at 25% of total contributions) this option is still priced at less than R1 000 and is the cheapest of the Fedsure offerings.

7.1.2 The managed care option: Larona Prime Cure

Larona Prime Cure has a R100 000 insured major medical benefit and optional savings account like Larona New Generation. However, the extended medicine benefit and optional day-to-day benefit are replaced by a capitated primary care benefit. This benefit makes use of the Prime Cure network of primary care clinics, as the name of the option suggests. Chronic medicine is unlimited if provided by the clinic and is subject to a fixed formulary. This option is the most expensive of the three.

7.1.3 The traditional option: Larona Traditional

Larona Traditional consists of a R100 000 insured benefit covering both major medical and day-to-day benefits. It also includes an extended medicine benefit and an optional savings account, which are the same as those for Larona New Generation.

If contributions of 25% of total contributions are made to the savings account for either the Traditional or Prime Cure options they do cost more than R1 000. However, both these options do contain a day-to-day benefit component and were thus still included in the analysis.

All Fedsure options make use of hospital pre-authorisation and various disease management programmes.

7.2 Ingwe Health Plan

Ingwe offers five options. Of these five, three were included in the analysis. These are the Hospital option (either with or without primary care) and the Capitated options, using either Prime Cure or CareCross (and offering a choice between a preferred provider hospital network or an open hospital network).

7.2.1 The new generation option: Ingwe Hospital

The Hospital option offers a R500 000 insured major medical benefit, an optional primary care benefit and an optional savings account. The major medical benefit makes use of a hospital network (Netcare) and benefits are paid at an agreed tariff. The optional primary care benefit has no overall limit only a series of fairly low sub-limits. It is important to note that there is no chronic medicine benefit.

This option is more expensive than either of the managed care options. Including the primary care benefit, it can only be considered low-cost for those earning less than R3 500 per month. This is because monthly contributions for those benchmark families earning between R3 500 and R4 000 per month exceed R1 400.

The option is low cost for all income groups below R4 000 per month if it taken without the primary care benefit, but with the medical savings account.

7.2.2 The managed care option: Ingwe Capitation

The Capitation option also offers a R500 000 insured major medical benefit like the Hospital option. This major medical benefit offers a choice between utilising a preferred provider hospital network (Netcare) or, for a higher premium, an open hospital network. The Capitation option also makes use of a capitation agreement for primary care benefits. The member has a choice between the Prime Cure and the CareCross clinic network. Use of the CareCross clinic is more expensive than that of the Prime Cure network.

In both cases chronic medicine is unlimited if provided by the clinic and is subject to a fixed formulary. There is also a limited out-of-network day-to-day benefit and an optional medical savings account.

The Hospital option including the primary care benefit, and the Capitated option using CareCross clinics in conjunction with an open hospital network both cost more than R1 000 per month if the full 25% contribution to the savings account is made.

Both the Hospital and Capitation options make use of hospital pre-authorisation and an HIV management programme.

7.3 Medimed Medical Scheme

Medimed, a scheme administered by Medscheme, offers four options. Of the four two meet the low cost criteria. Both of these options are managed care options.

7.3.1 The managed care options: Managed Care Level 2 and Level 3

The two Medimed options are structured in exactly the same way but make use of different primary care clinic networks. Both options offer an insured major medical benefit with an overall limit of R100 000 and a capitated primary care benefit. Major medical benefits are paid at 100% of BHF. There is no sub-limit for hospitalisation and chronic medicine is provided by the clinics.

The Level 2 option makes use of the ECIPA and UDIPA networks whilst the Level 3 option makes use of the Prime Cure network. The Level 2 option is more expensive for a benchmark family.

Medimed makes use of preferred providers, pre-authorisation and management programmes.

7.4 MSP/Sizwe Medical Fund

MSP/Sizwe, administered by Sizwe Medical Services, has thirteen options. Eight of these meet the low-cost criteria. There are two traditional options – Primary Care and Primary Options. There are three managed care options – Ecipamed, Medicross and Prime Cure. There is one new generation option – Incentive – and two hospital options – Hospital and Netcare Essential. Since we are interested in options with a day-to-day or primary care component we eliminate the hospital options from the analysis, and focus on the other six options.

7.4.1 The traditional options: Primary Care and Primary Plus

These two options have essentially the same structure. They offer an insured benefit covering both major medical and day-to-day benefits. Neither has an overall limit, and benefits are paid at BHF tariffs. The sub-limits under the Primary Plus option are much higher. It offers R500 000 of hospital cover whilst the Primary Care option only offers R30 000 of hospital cover (for a benchmark family). The Primary Plus option costs R90 a month more, for a benchmark family, for significantly more cover.

Both options have a R2 000 chronic medicine benefit, which is subject to registration with and approval by a chronic medicine management programme.

7.4.2 The managed care options: Ecipamed, Medicross and Prime Cure

These three options all have an insured major medical benefit, a capitated primary care benefit and a limited out-of-area primary care benefit. Chronic medicine is unlimited if provided by the clinics but is subject to fixed formularies and conditions.

The difference between the options obviously exists in the choice of primary care clinic network – Ecipamed, Medicross or Prime Cure. There is also a difference in the sub-limits for the major medical benefit. Prime Cure has lower sub-limits than the other two options: it has R50 000 of hospital cover whilst they have R80 000.

In terms of cost Medicross is the most expensive, both of the managed care options and all the MSP/Sizwe low-cost options. Similarly Prime Cure is the cheapest of the managed care options and all the low-cost options. Prime Cure is less than two-thirds of the cost of Medicross for a benchmark family.

7.4.3 The new generation option: Incentive

The Incentive option has an insured benefit covering major medical expenses and a compulsory medical savings account. Major medical benefits are paid at BHF tariffs and there is no overall limit. There is no limit for hospital benefits either. Contributions to the savings account are fixed at 25% of total contributions. There is no chronic medicine benefit except from savings.

All MSP/Sizwe options use a hospital benefit management programme and an AIDS management programme. Hospitalisation is subject to pre-authorisation.

7.5 National Independent Medical Aid Society (NIMAS)

NIMAS, a self –administered scheme, offers twelve options. These option are combinations of three major medical benefits and four day-to-day benefits. Of the twelve only two meet the low cost criteria. Both of the options are traditional in nature.

7.5.1 The traditional options: Quantum Optimum and Quantum Quantum

Both options have an insured major medical benefit and an insured day-to-day benefit. The major medical benefit (Quantum Core) is the same for the two options. It has an overall limit of R600 000 for a benchmark family and benefits are paid at private rates. There is no sub-limit for hospitalisation. The sub-limit for chronic medicine is R300 in the first year of membership and thereafter R1 440. The day-to-day benefit for Quantum Optimum has an overall limit of R5 040 for a benchmark family, whilst the benefit for Quantum Quantum only has an overall limit of R2 160. Both benefits cover expenses at 100% of BHF. Both options also offer an optional medical savings account.

In addition to sub-limits NIMAS also makes use of condition limitations. Limits are imposed on various medical conditions. Limits are most stringent in the first year of membership.

7.6 National Medical Plan

Sovereign Health's National Medical Plan (NMP) has seven options. Both the Incentive and Prime Cure options meet the low-cost criteria.

7.6.1 The new generation option: Incentive

The NMP Incentive option is made up of a major medical benefits, an optional day-to-day benefit with three levels of cover, an optional savings account and an above threshold benefit.

The NMP Incentive option costs less than R1 000 for a benchmark family only if contributions to the optional medical savings account are excluded and if the lowest level of optional day-to-day cover (R1 800 p.a.) is selected.
It should be noted that the threshold for the above threshold benefit cannot be reached with this level of day-to-day benefits.

There is no overall limit on major medical benefits, although pre-authorisation is required for hospitalisation. There is also no sub-limit for chronic medicine benefits but members to have to apply for the benefit and benefits are subject to the ChroniCare network.

7.6.2 The managed care option: Prime Cure

NMP Prime Cure is a managed care option. It contains an insured major medical benefit, capitated primary care and an optional medical savings account. There is no overall limit on the major medical benefit and no sub-limit for the hospital benefit, but hospitalisation is subject to pre-authorisation. The major medical benefit is paid at BHF tariffs.

The primary care benefit makes use of the Prime Cure network of clinics. Chronic medicine is unlimited if provided by the clinic but is subject to the formulary determined by Prime Cure.

NMP makes use of a number of management programmes. Examples include programmes for members suffering from cancer, those needing heart transplants and those with substance abuse problems. There is also a programme for women and a maternity programme.

7.7 OpenPlan Medical Scheme

The Metropolitan Health scheme is called OpenPlan. There are nine OpenPlan options. Four of these options are included in this analysis. There are two traditional options and a new generation option and a managed care option.

7.7.1 New generation option: Essential

The Essential option has a R500 000 insured major medical benefit and an optional medical savings account. Benefits are paid at BHF tariffs. Chronic medicine benefits are paid at cost, limited to R2 000 per beneficiary, or R8 000 for the benchmark family.

7.7.2 Managed care option: Primary Plus

The Primary Plus option has a R30 000 insured major medical benefit component and a capitated primary care benefit and a R500 out-of-area primary care benefit. Chronic medicine is unlimited if provided by the clinic, subject to a fixed formulary. This is the cheapest of the OpenPlan options.

7.7.3 Traditional options: Principal Basic and Principal

Both these options consist entirely of an insured benefit covering both major medical and day-to-day expenses. Principal Basic has an overall limit of R40 000. Hospital benefits are limited to R30 000. Benefits are paid at BHF tariffs. Chronic medicine is limited to R2 500 and is paid at cost.

The Principal option is the most expensive of the OpenPlan options. The overall limit for the Principal option is R500 000. A 20% co-payment is required for day-to-day benefits. Benefits are paid at BHF tariffs. Chronic medicine is paid at cost, limited to R4 000 per beneficiary. This equates to R16 000 for the benchmark family.

7.8 Protector Health

Protector Health is a self-administered scheme. It provides eight options, of which three meet the low-cost criteria. Of the three one is a traditional option and the other two are managed care options. All three options limit the member to a hospital network.

7.8.1 The traditional option: Familycare

The Familycare option offers an insured benefit covering both major medical and day-to-day expenses. There is no overall limit on this benefit, just a series of sub-limits. There is no sub-limit for hospitalisation. Chronic medicine is paid from the acute medicine limit, which is R4 500 for a benchmark family. Major medical expenses are covered at 100% of BHF whilst day-to-day benefits require a 20% co-payment. The member also has the option of a medical savings account that can be used to meet co-payments.

7.8.2 The managed care options: Primary Plus and Primary

Both of these options, Primary Plus and Primary, have an insured major medical benefit that covers expenses at 100% of BHF. The overall limit for the Primary option is R30 000 and for the Primary Plus option is R100 000. There is no sub-limit for hospitalisation. Both options provide capitated primary care. At present the benefits are only available in five areas. Chronic medicine is unlimited and available from the clinics.

Protector Health makes use of management programmes, pre-authorisation and preferred providers to manage expenses.

7.9 Provia Medical Scheme

Provia is a Liberty Healthcare scheme aimed at employer groups. In March 2001 they launched two new options: Silver and SilverCure. Both these options meet the low cost criteria.

7.9.1 The new generation option: Silver

The Silver option is made up of major medical benefit, a trauma benefit and an optional medical savings account. Contributions are less than R1 000 per month, for a benchmark family, even if the maximum 25% contribution is made to the medical savings account.

The major medical benefit has an overall limit of R200 000 for a benchmark family. Hospitalisation is limited to 100 days per beneficiary and 300 days per family. This is an unusual feature as limits on hospitalisation, if any, are usual monetary in nature. Chronic medicine is paid from the major medical benefit and is limited to R4 000 per family. The additional in-hospital trauma benefit has a limit of R100 000.

7.9.2 The managed care option: SilverCure

The SilverCure option has the same major medical benefit, trauma benefit and optional medical savings account as the Silver option. It differs in that it also has a capitated primary care benefit. SilverCure makes use of the Prime Cure network of clinics. Chronic medicine is unlimited if provided by Prime Cure, subject to Prime Cure's fixed formulary.

For both Silver and SilverCure pre-authorisation is required for hospitalisation. Liberty Healthcare makes use of a number of benefit management programmes including an HIV benefit and Crime Trauma benefit.

7.10 Spectramed

Rowan & Angel administer a scheme called Spectramed. Spectramed offers seven options. Two of these options, Spectra Hospital and Spectra Alliance, meet the low-cost criteria.

7.10.1 The new generation option: Spectra Hospital

Spectra Hospital consists of an insured major medical benefit and an optional medical savings account. There is no overall limit for the major medical benefit and the sub-limit for the hospital benefit is R600 000. Benefits are paid at BHF tariffs. There is no chronic medicine benefit. Spectra Hospital is more expensive than Spectra Alliance.

7.10.2 The managed care benefit: Spectra Alliance

Spectra Alliance is made up of an insured major medical benefit and a capitated primary care benefit. The major medical benefit has no overall limit but the sub-limits are lower than those for Spectra Hospital. The sub-limit for the hospital benefit is R200 000. Benefits are also paid at BHF tariffs. The primary care benefit makes use of either the Prime Cure or CareCross network of clinics. Chronic medicine is unlimited from the clinics, although subject to a fixed formulary, and registration with and approval from a chronic medicine benefit management programme.

Spectramed makes use of hospital pre-authorisation and a HIV/AIDS disease management programme.

7.11 Topmed Medical Scheme

Topmed is a Sanlam Health scheme. There are eight Topmed options. Two of these meet the low-cost criteria. These are the Bophelo and Bophelo Network options. Both of these options are new additions to the Topmed range, having only been introduced for 2001.

The Incentive Savings option is a new generation option that meets the criteria only if the optional savings component is excluded.

7.11.1 The traditional option: Bophelo

The Bophelo option is made up of an insured major medical benefit, a day-to-day benefit and an optional medical savings account.

Both Bophelo and Bophelo Network make use of a preferred provider hospital network. A 25% co-payment is required if a hospital outside of the network is utilised. For both options there is no overall limit for the major medical benefit and no sub-limit for the hospital benefit.

The sub-limit for the Bophelo day-to-day benefit is R1 500 per beneficiary and R3 000 per family. All Bophelo benefits are paid at BHF tariffs. Chronic medicine is paid from the day-to-day benefit and is subject to the acute medicine sub-limit, which is R800 per beneficiary and R1 600 per family.

Contributions fall below R1 000 per month even if the maximum contribution to the medical savings account is made.

7.11.2 The managed care option: Bophelo Network

Bophelo Network comprises a major medical benefit, similar to that of the Bophelo option, a capitated primary care benefit, a limited out-of-network primary care benefit and an optional medical savings account. The primary care benefit makes use of the Prime Cure network of clinics. Chronic medicine is unlimited if obtained from the clinic, subject to a fixed formulary.
Bophelo Network is R17 cheaper than Bophelo.

Both options make use of pre-authorisation and a number of management programmes. It should be noted that both Bophelo and Bophelo Network could only be considered low-cost for those earning less than R3 500. For those earning between R3 500 and R4 000 the monthly contribution for a benchmark family exceeds R1 400.

8. Examples of Low-Cost Product Design in Restricted Membership Schemes

8.1 Wooltru Healthcare Fund

The Wooltru Healthcare Fund was chosen as an example of low-cost product design in restricted membership schemes for a number of reasons :

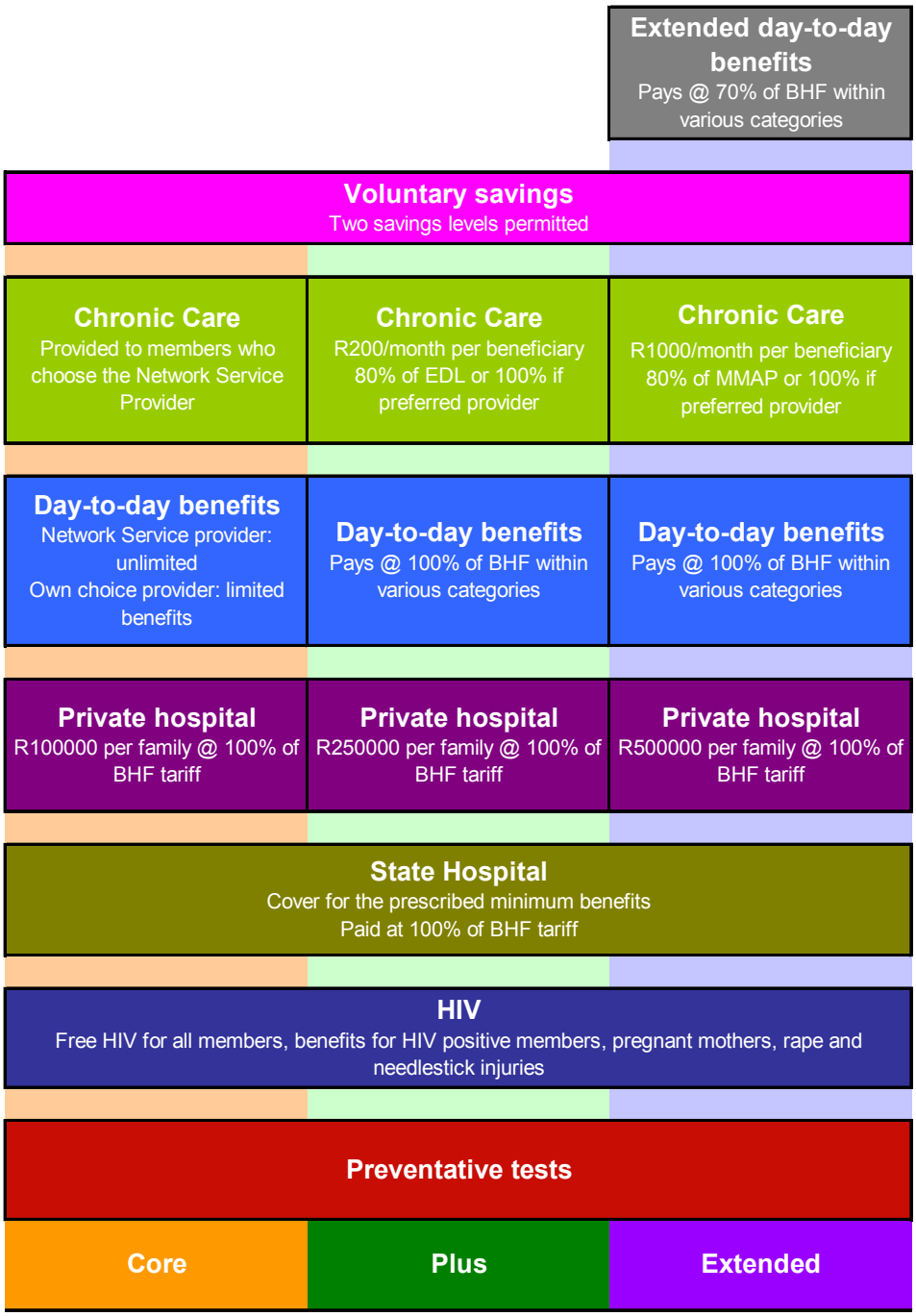
- It was completely redesigned for 2001 to meet the requirements of the Medical Schemes Act and to cope with challenges presented by the medical schemes environment.
- It attempts to meet the needs of lower income groups.
- It illustrates the shift from fee-for-service to capitation as a means to contain medical costs.
- It addresses the challenge presented by HIV/Aids and
- It is presented in an easy to understand and simple manner.

The Wooltru Healthcare Fund provides three options namely Core, Plus and Extended. The three options are distinct from each other in terms of their design and affordability. These are illustrated in the diagram overleaf.

The **Core option** is the cheapest of the three options. It is a managed care option that makes use of a capitation agreement with a network of primary care clinics to provide day-to-day benefits. It also provides the lowest level of hospital cover (R100 000). Chronic medicine is provided by the clinics and is subject to a fixed formulary. Members who do not live in the vicinity of any of the clinics have the option to use their own service providers. However sub-limits on benefits are low and there are no chronic medicine benefits. Members have the option of a medical savings account.

The **Plus option** is more expensive than Core, although substantially cheaper than the Extended option. It provides R250 000 of hospital cover and R200 per beneficiary per month for chronic medicine. The chronic medicine benefit is restricted to the Department of Health Essential Drug List (EDL) and a list of chronic conditions, and is subject to a 20% co-payment unless the preferred provider, Direct Medicines, is used. There is also a limited insured day-to-day benefit. Members have the option of a medical savings account.

The **Extended option** is the most expensive of the three. It provides the highest level of hospital cover (R500 000) and it includes a chronic medicine benefit of R1 000 per beneficiary per month. The chronic medication is limited to a list of chronic conditions and is subject to a 20% co-payment unless the preferred provider, Direct Medicines, is used. It provides the same insured day-to-day benefit as the Plus option but in addition it has an above-threshold benefit. The above-threshold benefit is subject to higher sub-limits but it has a 30% co-payment. Members also have the option of a medical savings account.



Wooltru Healthcare Fund Options in 2001

All three options have a preventative tests benefit and an HIV benefit. The HIV benefit provides an HIV test for all members, limited benefits for HIV positive members (excluding anti-retroviral drugs) and benefits for HIV positive pregnant mothers. It also covers rape victims and needle-stick injuries.

The Wooltru Healthcare Fund illustrates the following:

- The use of different overall product designs to meet different needs and affordability levels. It provides a managed care option (Core), a traditional option (Plus) and a new generation option (Extended).
- The use of capitation to contain costs as seen in the Core option
- The various types of chronic medicine benefits that can be provided. The Core option provides benefits through the clinic network. The Plus option makes use of a low monetary limit combined with the use of the EDL and a preferred provider. The Extended option has a high monetary limit.
- A preventative tests benefit which can help reduce costs in the longer run
- The use of hospital pre-authorisation
- That although not providing anti-retroviral drugs for all HIV positive members, drugs are provided for all pregnant mothers, rape victims and victims of needle-stick injuries.

As a restricted membership scheme, the employers in the group play a substantial role in making contributions affordable to the lower income workers. The employers deliberately socially-engineer the contribution scales to ensure affordability of the Core option to the lowest paid workers.

8.2 Transmed Medical Fund

In considering low-cost option design, of particular note is the pioneering work done by Dr Geetesh Solanki and Dr Jud Cornell on behalf of the Transmed Medical Fund in the mid 1990s.

The core benefit design for low-income workers and pensioners involved the contracted use of public sector hospital facilities. Benefit packages from mid-1996 onwards were thus differentiated on the basis of the provider of hospital care, with both private and public sector hospitalisation packages on offer.

The ground-breaking work of attempting contracts with the public sector in all nine provinces was the work of Dr Geetesh Solanki.

9. Analysis of Product Designs Used in Low-Cost Options

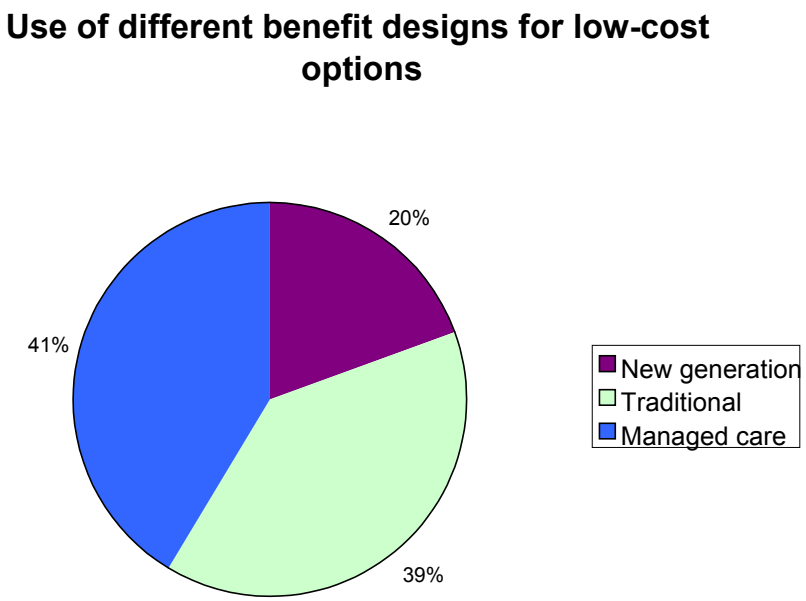
9.1 Fundamental Choice of Benefit Design

Conceptually, there are three major types of benefit design: traditional, new generation and managed care. In reality combinations of these do exist.

For this analysis, a **traditional option** was considered to be one offering both compulsory insured major medical benefits and insured day-to-day benefits. Some of the options categorised as traditional may offer an additional optional savings account.

A **new generation option** was considered to be one not containing a compulsory insured day-to-day benefit, but offering only a medical savings account to cover day-to-day benefits.

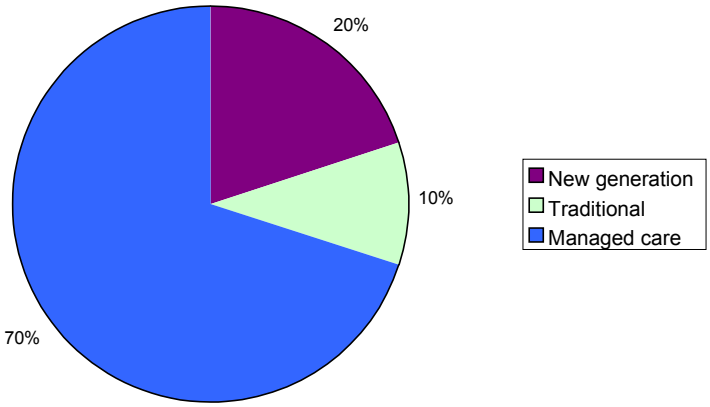
In this analysis, **managed care options** refer to options that offer a capitated primary care benefit, making use of a network of primary care clinics.



Of the 41 low-cost options in the study, 17 were categorised as managed care, 16 as traditional and eight as new generation options.

For the ten cheapest options, the breakdown of benefit designs differs as can be seen in the chart below. Managed care options are still in the majority amongst the ten cheapest options. There are 17 managed care options amongst all the low-cost options and seven of these fall within the cheapest ten.

Benefit designs of the 10 cheapest options



Conventional wisdom in the medical scheme industry holds that new generation options are cheaper than traditional options. Day-to-day expenditure is expected to decrease if the responsibility for benefit management is shifted to members. However this relationship does not seem to be reflected amongst low-cost options. One possible reason is that new generation options are being marketed to higher income groups who have a higher propensity to consume healthcare. New generation options may not be viewed as the most appropriate design for low-cost options.

New generation options often appear deceptively affordable in industry comparisons. If contributions to medical savings accounts are not included in contribution comparisons, new generation options appear to be cheaper than they actually are.

9.2 Medical savings accounts and above-threshold benefits

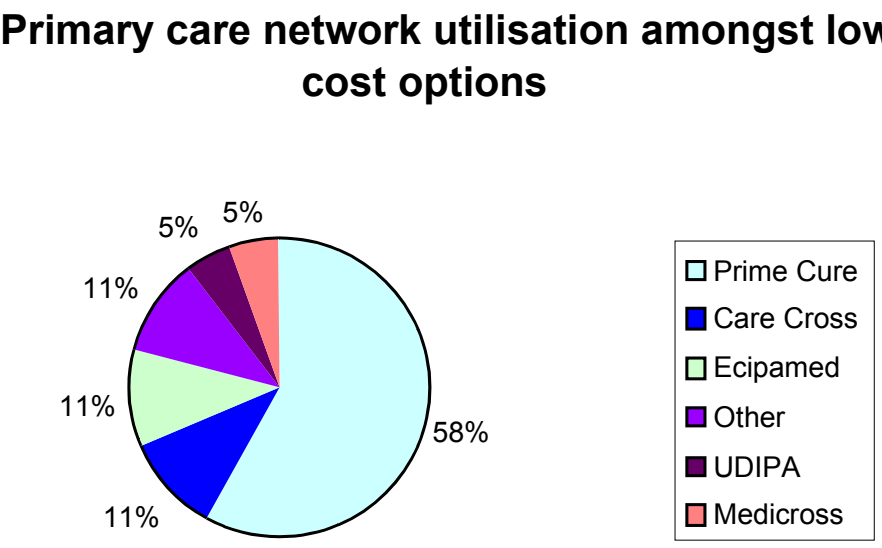
Medical savings accounts are offered in 23 of the 41 low-cost options. Medical savings accounts allow the scheme to share the risk of day-to-day benefits with members. However to keep contributions below R1 000 per month medical savings accounts could only be selected for 14 of the options.

Only the NMP Incentive and Genesis Plan B options use an above-threshold mechanism in their benefit design. However with contributions of less than R1 000 per month the threshold for the benefit cannot be reached. This particular benefit appears to be a feature of higher cost plans where the member can afford to spend more on day-to-day benefits in order to reach the threshold.

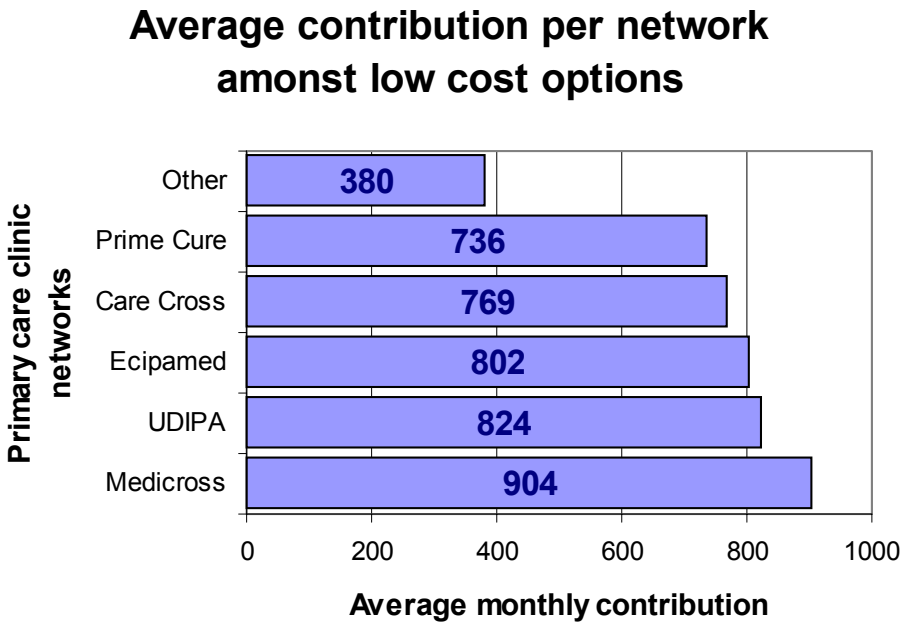
9.3 Use of Primary Care Clinic Networks

The use of capitated primary care benefits appears to be effective in reducing contribution rates. As was illustrated in Section 9.1, seven of the ten cheapest options make use of capitation agreements with primary care clinic networks.

The three networks utilised most often are Prime Cure, CareCross and Ecipamed. The Ecipamed network is found only in the Port Elizabeth region. Illustrated below is a breakdown of the network utilisation amongst low cost options.



The Prime Cure network is the network utilised most frequently for low-cost options. Of the 17 low-cost managed care options, 11 make use of the Prime Cure network. The chart below illustrates the average cost of the options utilising the various networks.



The two cheapest primary care network options are those provided by Protector Health, which do not make use of any of the established clinic networks. The network used has limited coverage, being available in only five areas. Other than those two options, the Prime Cure network of clinics provides the cheapest alternatives.

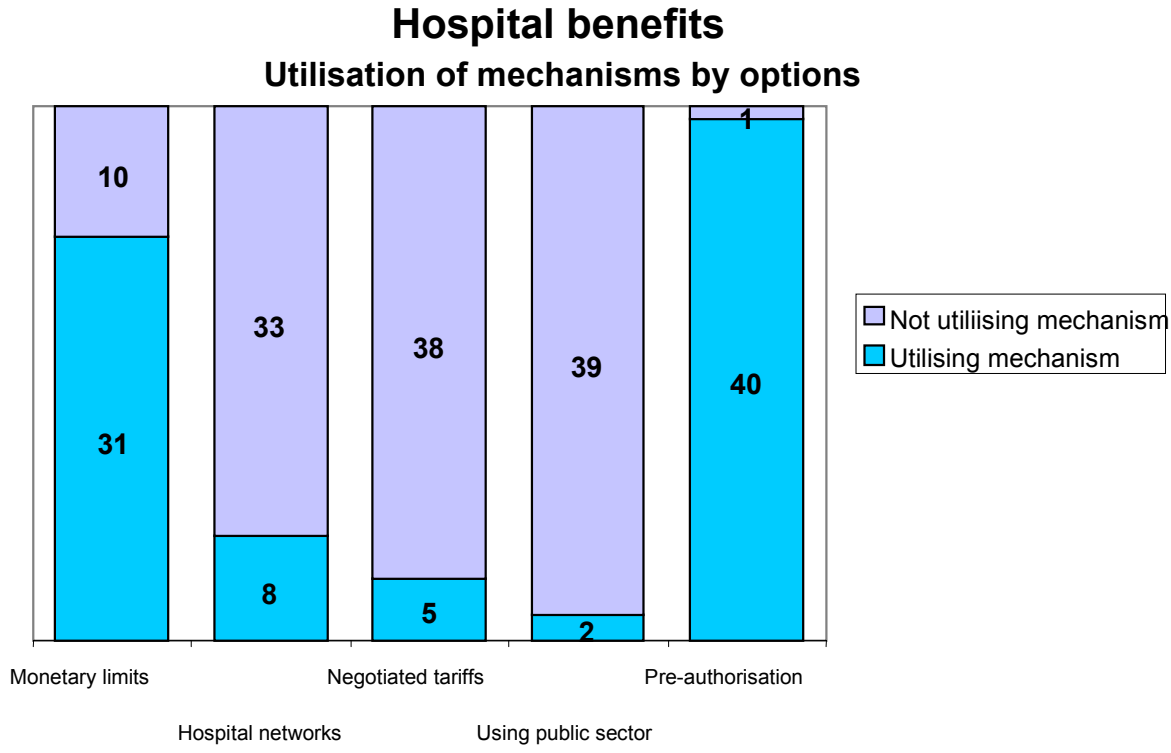
The Prime Cure network is associated with both the lowest average cost and the five cheapest managed care options after Protector Health. Medicross is associated with the highest average cost amongst the managed care options.

The three MSP/Sizwe plans offer similar benefits but use different networks. From there it can be seen that that Ecipamed is more expensive than Prime Cure and Medicross is more expensive than Ecipamed. The two Ingwe plans also offer similar benefits but use different networks and from there it can be seen that CareCross is more expensive than Prime Cure.

From this data it appears that the Prime Cure network is the most common and the cheapest network with national coverage for low-cost options. It also appears as if Medicross is the most expensive network.

9.4 Management of Hospital Benefits

Hospital benefits are provided in the private sector in 40 of the 41 options. The mechanisms used to control hospital expenditure are illustrated below.



9.4.1 Utilisation of the public sector

Only the Medihelp Nucleus and Vulamed Standard options make use of the public sector for the provision of in-hospital benefits. Medihelp Nucleus uses the public sector as a "preferred provider". Private sector care is only available on approval by the Board and on referral from the primary care clinic network.

Vulamed members are admitted to the public sector as a first resort for certain conditions, for example organ failure, infertility, cancer and HIV. The private sector will be used in these cases if it is deemed clinically appropriate. The placement decision lies with a case manager. The private sector is used to provide all other hospital benefits.

9.4.2 Monetary limits for hospital benefits

Monetary limits are imposed on hospital benefits in 31 of the 41 options. Eight have limits of R50 000 or less. Only two options combine monetary limits with a limit on the number of days that can be spent in hospital.

It is difficult to compare the limits on hospital benefits because limits may be for all benefits, for all major medical benefits or specifically for hospital benefits.

9.4.3 The use of a preferred provider network of hospitals

Eight of the 41 options (20%) make use of a preferred provider network of hospitals in the private sector. Three are Ingwe options, three are Protector Health options and two are Topmed options.

With the Ingwe options the member has the choice of using the Netcare hospital network for a lower premium. With Topmed, a 25% co-payment is necessary if the member uses an out-of-network hospital. For the Protector options, the member does not have choice of using hospitals outside of the network. This is not the case for all Protector Health options, only the low-cost options.

Five of the eight options using network hospital providers also make use of a capitated primary care benefit. Thus more than 10% of the low-cost options offer both capitated primary care and preferred provider hospital benefits.

9.4.4 Tariff structures

Only the three Ingwe options and two Topmed options, all of which use provide preferred provider hospital benefits, make use of negotiated tariffs.

Three options pay all hospital benefits at private rates. One option pays private rates for emergencies and another pays private rates for hospital claims over a certain amount. All the other options pay for hospital benefits at BHF tariffs.

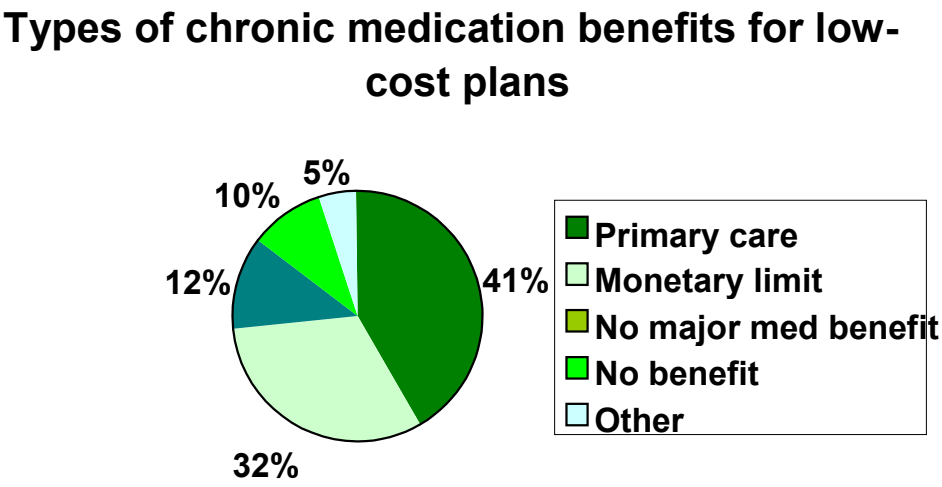
9.4.5 Hospital pre-authorisation

Wide use of hospital pre-authorisation is made, with 40 out of the 41 of the options insisting on pre-authorisation.

Only five options make mention of hospital benefit management programmes in their marketing material. Hospital benefit management builds on the information obtained during pre-authorisation. Features of hospital benefit management include discharge planning, concurrent and retrospective reviews, case management and hospital bill auditing.

9.5 Management of Chronic Medicine

The graph below illustrates the various types of chronic medicine benefits offered by low-cost schemes.



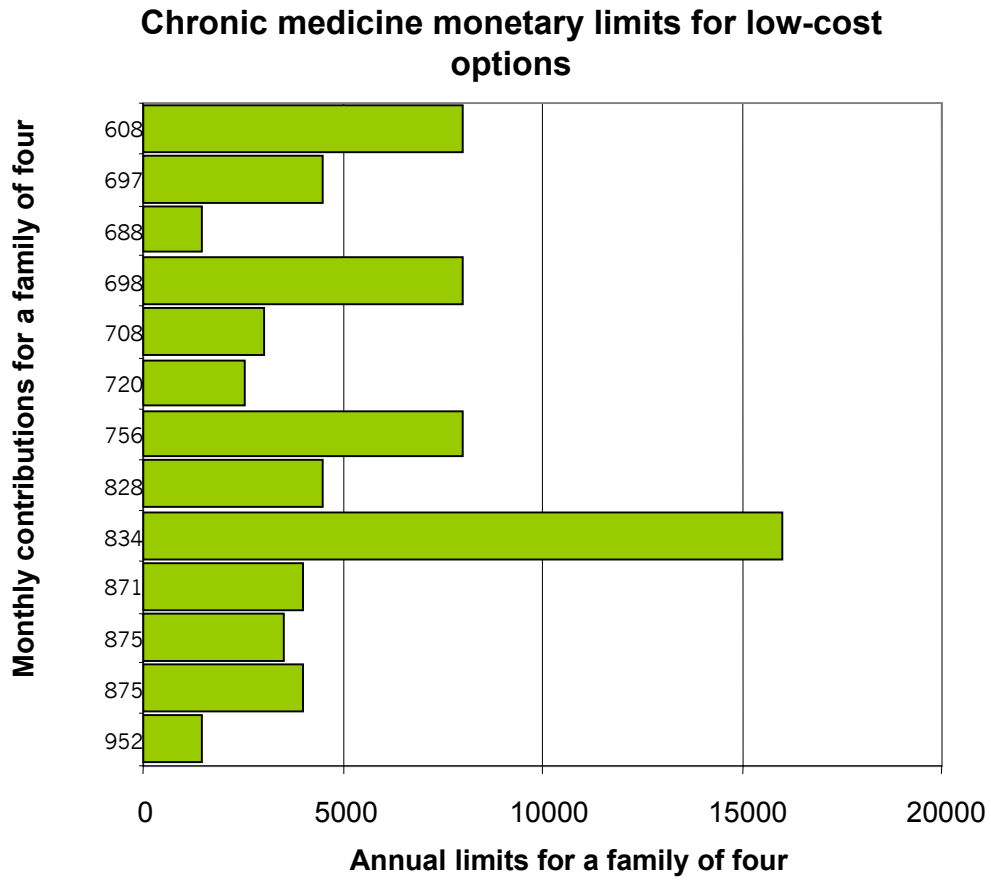
Four of the 41 low cost options offer no chronic medicine benefits. An additional five of the options do not provide major medical benefits for chronic medicine. Chronic medicine is covered either out of the acute medicine benefit, savings account or day-to-day benefit. Chronic medicine benefits do not make up part of the prescribed minimum benefits so they can be excluded entirely from packages.

The 17 options that make use of primary care clinics to provide chronic medicine benefits, are the 17 options that have capitation arrangements with the clinic networks. Chronic medicine provided by a primary care clinic is subject to a fixed formulary and is generally not limited in monetary terms.

Chronic medicine may only be available through preferred providers. For example, with Medicross clinics members are required to use the Pharmacross pharmacy affiliated with the clinic.

One option, namely NMP Incentive, makes use of neither monetary limits nor primary care clinics. In this case the benefit has to be registered for and is controlled through a chronic medicine benefit management programme. Another exception is the Genesis Plan B option. It provides for chronic medicine as part of a chronic disease benefit. The overall limit for this benefit is R500 000 with no sub-limit for medicine.

The majority of the options make use of monetary limits for chronic medicine benefits. The range of the limits relative to monthly contributions is illustrated below.



The minimum limit is R1 440, the maximum limit is R16 000 and the average is R5 298 per annum, which equates to less than R450 per month. There is no correlation between the level of contributions and the monetary limit on chronic medicine.

Chronic medicine benefit management programmes were mentioned in the marketing material of 14 of the schemes. The nature and scope of these programmes is not always available from the marketing material.

9.6 Benefit and Disease Management Programmes

There are a wide range of diseases, conditions and treatments covered by disease management programmes: asthma, high blood pressure, cancer, high cholesterol, diabetes, renal and haemo-dialysis, heart transplants, HIV/Aids, psychiatric conditions and substance abuse.

HIV/Aids programmes are the most prevalent of the disease management programmes. 31 of the 41 schemes analysed provide an HIV/Aids programme. What is uncertain is the level of cover provided by these programmes, and how many actually provide anti-retroviral drugs.

11 options offer an asthma management programme, 6 options offer a cancer management programme and 6 options offer a diabetes management programme.

Benefit management programmes are available for hospital benefits, chronic medicine benefits, maternity benefits, optometric benefits and dental benefits.

The two most common benefit management programmes are those for chronic medicine benefits (available in 34% of options) and those for optical benefits (available in 20% of options). Maternity benefit management programmes are found in 17% of options.

9.7 Use of Preferred Providers

The use of preferred provider hospital networks was discussed in Section 9.4. The use of preferred providers for chronic medicine usually occurs in conjunction with the provision of medicine by primary care clinics, as discussed in Section 9.5.

The use of preferred providers for emergency transport was found in 76% of the low-cost options, with Netcare 911 being the most common provider.

9.8 Risk-sharing and Capitation

The only forms of risk-sharing with providers that could be identified from the marketing material were the capitation agreements used in the provision of primary care benefits, as discussed in section 9.3 above and the limited evidence of negotiated tariffs for hospital benefits with preferred providers, as discussed in section 9.4.4.

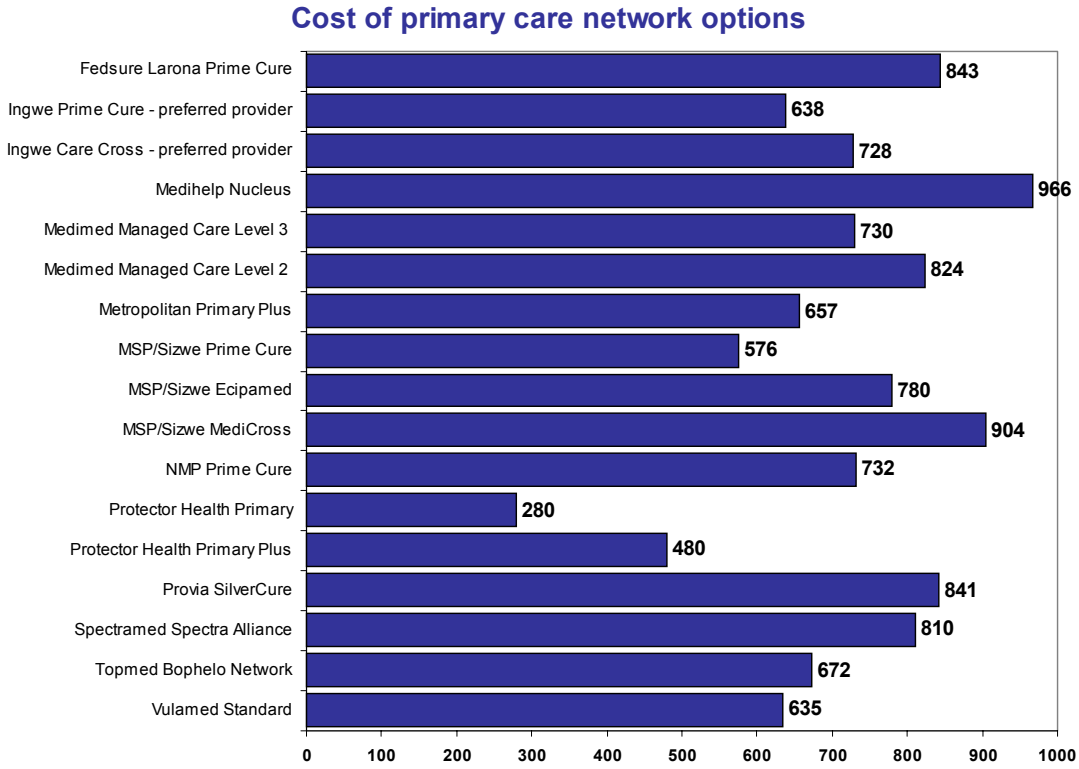
Whilst other mechanisms may be used, they are not apparent to consumers.

10. Thoughts on the Further Development of Low-Cost Options

Pressure on affordability remains a key issue for members and a barrier to potential members. This pressure will become more intense with contribution increases continuing at above inflationary levels and employer subsidies been reduced. The crisis of affordability for those in retirement is expected to become a major issue as those currently entering employment are no longer offered healthcare subsidies in retirement.

The income levels of the potential 7 million people who are employed but not covered by medical schemes is substantially lower than the group already covered. Saturation of the market at upper income levels is occurring, but the proportion covered drops off sharply as income levels reduce. It is important to remind product developers that 54% of all existing members earn less than R4 000 per month.

It is demonstrated that the offerings "available" to a family of four earning R4 000 a month are in many cases too expensive at present. Even restricting those offerings to a maximum level of R1 000 a month represents a level of affordability that few can aspire to. The graph below demonstrates the level of contributions for the 17 capitated primary care options.



The graph shows that most of the low-cost options are still costing R600 to R800 per month for the family of four. This is still not affordable at income levels of R3 000 and below. In our opinion the industry will need to break through the R500 per month barrier in product design in order to fully unlock the potential of the low-cost market.

Of interest is the pricing of the Protector Health Primary option at only R280 for the benchmark family. This option has an insured major medical benefit with an overall limit of R30 000, that covers expenses at 100% of BHF. There is no sub-limit for hospitalisation. Capitated primary care is provided and chronic medicine is unlimited when obtained from the clinics. At present the benefits are only available in five areas. The same structure with an overall limit of R100 000 costs R480 per month.

There are encouraging signs of a move towards risk-sharing with providers on day-to-day benefits. This trend should be nurtured and encouraged. However the reliance on financial limits to control spending on chronic medicine by many low-cost schemes is unfortunate. This implies that those who need cover most will use all the limit available to them. Involvement of the providers in the decisions to ration care is a preferred route and the use of strict formularies by primary care clinics is a preferred solution.

It is in the area of hospitalisation benefits that most work needs to be done in the development of low-cost options. In 2001 there was a disappointing lack of offerings that engage the public sector in the provision of care. The barriers to contracting are high, but not insurmountable. Those responsible for product development are encouraged to enter into dialogue with provincial health authorities on a way forward. In the process this should also stimulate the private sector hospital groups to create suitable offerings.

It is our opinion that a key element of contracting with either public or private sector hospitals will be to enter into risk-sharing arrangements, rather than traditional fee-for-service.

Our recommendation for the next generation of low-cost option design is to consider the following :

- Hospitalisation offered in differential amenities in a public hospital.
- Specialist services in a public hospital.
- Chronic medicine offered either in the public hospital or with a strict formulary by the primary care providers.
- Primary care offered in private sector capitated networks.

The contributions for a family of four, earning less than R4 000m per month will need to be of the order of R500 per month, or lower, in order to satisfy the goal of affordable healthcare.

11. References

Department of Health, **White Paper for the Transformation of the Health System in South Africa.** Notice 667 of 1997 in the Government Gazette no. 17910.

Department of Health, **A Social Health Insurance Scheme for South Africa: Policy Document**, September 1997.

Rama P. and McLeod H., **An Historical Study of Trends in Medical Schemes in South Africa: 1974 to 1999.** Centre for Actuarial Research, University of Cape Town, Monograph No. 1, July 2001.

Appendix A: Open Medical Scheme Information Obtained

Scheme	Administrator	Options covered
Allcare Medical Aid Scheme	Allcare	Allcare
		Chamber Optimum
		Chamber Nugen
		Chamber Budget
Bestmed Medical Scheme	Bestmed	Topcare
		Millennium Standard
		Millennium Comprehensive
Bonitas Medical Fund	Medscheme	Standard
		Elite
		Bonsave
		Primary
Cape Medical Plan	Cape Medical Plan	Mediflex
Caremed Medical Scheme	Old Mutual Healthcare	Essential
		Standard
		Advanced
		Classic
		Select
		Comprehensive
		Optimum
Discovery Health Medical Scheme	Discovery Health	Classic Core Standard
		Classic Core Max
		Classic Comprehensive Standard
		Classic Comprehensive Max
		Essential Core Standard
		Essential Core Max
		Essential Comprehensive Standard
		Essential Comprehensive Max
		Foundation Core
		Foundation Plus
		Coastal Core
Fedsure Health	Fedsure Health	Ultimax
		Ultima 300
		Ultima True Health
		Ultima Medicross
		Ultima 200
		Ultima 150
		Primax
		Prima 100
		Larona New Generation
		Larona Traditional
		Larona Prime Cure

Gen-Health Medical Scheme	Hall Administrators	Low Option
		High Option
Genesis Medical Scheme	Genesis	Plan A
		Plan B
Ingwe Health Plan	Ingwe	Classic
		Hospital
		Capitation Prime Cure
		Capitation CareCross
		Capitation Medicross
Medihelp	Medihelp	Sentinel 100
		Sentinel 80
		Sentinel Basic
		Nucleus
		Dimension Core
		Dimension Vital
		Dimension 100
Medimed Medical Scheme	Medscheme	Delta Plus
		Managed Care Level 1 (Medicross)
		Managed Care Level 2 (ECIPA, UDIPA)
		Managed Care Level 3 (Prime Cure)
Medshield Medical Scheme	Medscheme	MaxiGold
Minemed Medical Scheme	Providence	Doctor Network
		Medical Centre
		Hospital and Chronic Medicines
MSP/Sizwe Medical Fund	Sizwe Medical Services	Primary Care
		Primary Plus
		Affordable
		Affordable Plus
		Full Budget
		Super 100
		Ecipamed
		MediCross
		Prime Cure
		Incentive
		Elite Incentive
		Hospital
		Netcare Essential
Munimed	Munimed	Alpha
		Sigma
		Omega
NatalMed	NatalMed	Silver
		Gold
		Platinum
National Independent Medical Aid Society (NIMAS)	NIMAS	Premium Core, Premium Day-to-Day
		Premium Core, Optimum Day-to-Day
		Premium Core, Quantum Day-to-Day
		Premium Core, Medicross Day-to-Day

		Optimum Core, Premium Day-to-Day
		Optimum Core, Optimum Day-to-Day
		Optimum Core, Quantum Day-to-Day
		Optimum Core, Medicross Day-to-Day
		Quantum Core, Premium Day-to-Day
		Quantum Core, Optimum Day-to-Day
		Quantum Core, Quantum Day-to-Day
		Quantum Core, Medicross Day-to-Day
National Medical Plan	Sovereign Health	Comprehensive
		Gold
		Economy
		Incentive
		Incentive Plus
		Medicross Gold
		Prime Cure
Omnihealth Medical Scheme	Medscheme	OMNIcare
		OMNIplus
		OMNIcore
		OMNInew.gen
		OMNIsave
		OMNIcare
Methealth OpenPlan Medical Scheme	Metropolitan Health	Essential
		Primary Plus
		Principal Basic
		Principal
		Principal Plus
		Providential
		Providential Plus
		Medisaver
		Medisaver Select
Phila Medical Scheme	Medscheme	Phila
ProCure Medical Scheme	Liberty Healthcare	Essence
		Essence Network
		Elite
Protea Medical Aid Society	Status	Plan 1
		Plan 2
		Plan 5
Protector Health	Protector Group Administrators	Flexicare Plus
		Flexicare
		Familycare Plus
		Familycare
		HMO Plus
		HMO
		Primary Plus
		Primary

Provia Medical Scheme	Liberty Healthcare	Gold
		Platinum
		Silver
		SilverCure
Resolution Health Medical Scheme	Health Services Trust	Progressive
		Fundamental
		Prestige
Selfmed Medical Scheme	Metropolitan Health	80%
		MEDXXI
		MEDXXI Comprehensive
		MEDXXI Exec
Spectramed	Rowan & Angel	Spectra Plus
		Spectra Elite
		Select Gold
		Select Platinum
		Spectra Hospital
		Spectra Alliance
		Spectra Advanced
Topmed Medical Scheme	Metropolitan Health	100%
		80%
		Limited 100%
		Incentive Savings Plan
		Incentive Comprehensive Plan
		Exec
		Bophelo
		Bophelo Network
Visimed Medical Scheme	Old Mutual Healthcare	Mercury
		Venus
		Mars
		Jupiter
Vulamed	Sovereign Health	Basic
		Standard
		Advanced
32 schemes	**23 administrators**	**166 options**

Appendix B: Low-Cost Options

Scheme	Administrator	Options covered
Allcare Medical Aid Scheme	Allcare	Chamber Budget
Bonitas Medical Fund	Medscheme	Primary
Cape Medical Plan	Cape Medical Plan	Mediflex
Caremed Medical Scheme	Old Mutual Healthcare	Essential
Fedsure Health	Fedsure Health	Larona New Generation
		Larona Traditional
		Larona Prime Cure
Genesis Medical Scheme	Genesis	Plan B
Ingwe Health Plan	Ingwe	Hospital
		Capitation Prime Cure
		Capitation CareCross
Medihelp	Medihelp	Nucleus
Medimed Medical Scheme	Medscheme	Managed Care Level 2 (ECIPA, UDIPA)
		Managed Care Level 3 (Prime Cure)
MSP/Sizwe Medical Fund	Sizwe Medical Services	Primary Care
		Primary Plus
		Ecipamed
		MediCross
		Prime Cure
		Incentive
Munimed	Munimed	Omega
National Independent Medical Aid Society (NIMAS)	NIMAS	Quantum Core, Optimum Day-to-Day
		Quantum Core, Quantum Day-to-Day
National Medical Plan	Sovereign Health	Incentive
		Prime Cure
Omnihealth Medical Scheme	Medscheme	OMNIsave
Methealth OpenPlan Medical Scheme	Metropolitan Health	Essential
		Primary Plus
		Principal Basic
		Principal
Protector Health	Protector Group Administrators	Familycare
		Primary Plus
		Primary
Provia Medical Scheme	Liberty Healthcare	Silver
		SilverCure
Resolution Health Medical Scheme	Health Services Trust	Fundamental
Spectramed	Rowan & Angel	Spectra Hospital
		Spectra Alliance
Topmed Medical Scheme	Metropolitan Health	Bophelo
		Bophelo Network
Vulamed	Sovereign Health	Standard

Appendix C: Benefit Design and Contribution Structures of Low-Cost Options

The benefit design and contribution table structure of each of the low-cost options is illustrated.

Schemes with low cost options are shown alphabetically.