

EXAMINATION

September 2006

Subject SA1RSA — Health and Care Specialist Applications

EXAMINERS' REPORT

Introduction

The attached subject report has been written by the Principal Examiner with the aim of helping candidates. The questions and comments are based around Core Reading as the interpretation of the syllabus to which the examiners are working. They have however given credit for any alternative approach or interpretation which they consider to be reasonable.

M Stocker
Chairman of the Board of Examiners

November 2006

Comments

Individual comments are shown within each question.

- 1 (i) *Note: Candidates did not perform well in this question due to failure to focus on the employer's requirements, as the question specified.*

Types of medical cover that will meet employer's requirements:

Employer's requirements can be classified under the headings of financial consideration and employment considerations.

Financial Considerations:

- The employer wants to contain costs and provide value for money
 - Medical scheme cover:
 - Has become expensive and the environment complex.
 - Most employers would not regard medical schemes as offering value for money.
 - There are no real low cost products available in the market.
 - Insurance cover:
 - This cannot be on an indemnity basis.
 - Costs of insurance may be lower.
 - But does not meet the needs of the employer as it does not lead to improved health amongst employees, or better treatment, and hence overall cost of absenteeism and lower productivity may be higher (but hard to quantify).
 - Cover via occupational health facilities:
 - This would typically successfully contain costs.
 - But is not attractive to high income individuals who want freedom of choice in respect of service providers, and hence can only be offered to lower income individuals.
- Employer contributions need to be tax-efficient.
 - Medical scheme cover:
 - Totally tax deductible.
 - Insurance cover:
 - Where taken out on behalf of employees, and as long as it can be justified that premiums were expenses incurred in the production of income, premiums should be entirely tax deductible in the hands of the employer.

- Cover via occupational health facilities:
 - Off-site treatment was problematic until 1 March 2006 as it attracted fringe benefit tax in the hands of the employee.
 - Now tax situation much improved and both employer expenses and employee benefits arising from occupational health facilities, whether on-site or off-site, are tax deductible up to first R500 for individual, subject to a number of rules.

Employment Considerations:

- Need to ensure that the members value the benefit as a means of attracting and retaining employees.
- Need to ensure that members receive coverage that will assist in ensuring that the employees remain healthy and productive members of the workforce.
- Seeking broad employee coverage which requires the scheme to provide a low-income type product to make it affordable for the poorer employees — a PMB type package might be suitable for low-income earners while a more comprehensive package would be desirable for the more affluent workers. The employer is however restricted to offering only one option on a closed medical aid due to the relatively low potential principal members, as prescribed in the requirements for registering options. Most likely to opt for low-income product as this meets the need of the majority of employees; however this may conflict with the needs of higher earning members for whom membership is compulsory.
- To the extent that the employees are not already covered for medical expenses related to the work injuries they will require major medical and day-to-day coverage.
- Employee wellness benefits including psychology would be important to the employer to ensure employees remain healthy.
- Accessibility to medical services by mineworkers is critical and may wish to contract with doctors and hospitals in the Northern Free State and Gauteng, possibly providing services on site.
- HIV/AIDS benefits critical to manage disease to keep healthy so as to minimise sick days; maximise productivity and minimise the loss of skilled labour.
- Likely to try and achieve some income cross-subsidy in the contribution rates.

- A critical element of the medical aid is that it must be simple to explain and understand by the members.
- There will need to be a level of education provided e.g. on HIV/AIDS etc.

The above needs will be met by medical scheme cover, rather than non-indemnity insurance cover. Hence, medical scheme cover best meets the needs of an employer from an employment / wellness point of view, but is expensive, whereas insurance cover does not meet the needs of the employer from a wellness / employment perspective, but premiums tend to be more affordable.

Nevertheless, low premiums of insurance products do not help lower income individuals if they end up with high out-of-pocket expenditure in the event of illness, and hence insurance cover has only limited application in practice.

Health-related insurance cover meets real needs where it is structured to be a form of income replacement in the event of illness or disability, and hence almost every employer has to offer this form of cover (either via a pension fund or via insurance products) in order to attract staff.

Cover via occupational health facilities, given new tax rules, seem to be a good compromise for low income individuals, but may still lead to labour relations difficulties because of the unequal treatment of employees that this necessitates (as medical scheme cover would have to be offered to higher income individuals).

(ii) Challenges in offering cover for low-income earners:

- Minimum level of benefits provided is PMB which implies a minimum cost of benefit provision that must be incurred.
- Scheme would have to have a single benefit option due to the membership restrictions — they would not be in a position to register multiple options due to a low overall membership — focus on low-income product; however this may be insufficient for more affluent members for whom membership is compulsory.
- Low-income members not likely to become members unless the scheme is at no or very little cost to the member i.e. the employers subsidy will need to cover a significant portion of the contribution.
- Mine workers are likely to receive weekly wages making monthly contributions and contribution collections tricky.
- Mine workers are likely to have disrupted membership as changing needs require alternative uses of disposable income.
- Scheme is likely to face significant anti-selection as members who do elect cover perceive it to offer value for money.

- Ensuring the cost-effectiveness of the benefit to members is difficult if not provided on-site at the mines, and this would not appeal to higher income individuals.
- But membership of medical scheme may result in members assuming the right to access private facilities etc. driving costs for lower income members.
- Must maintain simplicity of benefit structure, and cannot have large number of options.
- Managing inflation over time may be difficult meaning that affordable contributions initially may become unaffordable over time.
- Need to take a decision on the application of waiting period and condition specific exclusions may make the scheme unattractive but without it the scheme is exposed to significant anti-selection.

(iii) Impact of HIV/AIDS on mine:

- If untreated, significant number of deaths following deterioration in health.
- Poor health will result in low productivity and high absenteeism.
- Also high absenteeism due to attendance of funerals.
- Deaths lead to loss in skills and shortage of labour — not such a problem for work where unskilled labour is required and there are large labour markets, but mines have a significant proportion of skilled and semi-skilled workers.
- However there is a social responsibility and would be introducing new workers into a high HIV/AIDS prevalent environment.
- Infected members are likely to have infected spouses — disability benefit cost impact and higher death benefits; pensions will however cost less due to shortened lifespan.
- May be significant staff turnover; staff assistance.
- Additional costs & time of recruiting, resettlement and training.
- High prevalence of opportunistic diseases such as TB, which can be cured with appropriate treatment, would otherwise result in deaths.
- Cohesion of work teams might be affected, which has a knock-on effect on productivity.

- HIV negative individuals may be concerned about HIV positive co-workers.
- The safety record of the mine might be negatively affected due to less experienced workers having to take on more responsibility.

Impact on low-income members:

- May lack education around disease.
 - May lack access to drugs and medical management due to cost in private sector and lack of facilities in public sector.
 - Risk that without proper management incomplete use of ART may result in viral resistance and poor health outcomes.
 - Being unaware of their status could lead to spread of HIV.
 - Without proper management contraction of the virus could result in premature deaths.
 - Likely to be breadwinners — early deaths likely to have significant social and economic impact on families.
 - There may be psychological impact on workers becoming aware of positive status and stigmatisation of AIDS/HIV individuals.
 - Likely to suffer from opportunistic diseases that could otherwise have been treated or prevented — TB in particular.
 - Significant deterioration in quality of life where proper management could improve both longevity and quality.
- (iv) The Occupational Diseases in Mines and Works Act provides the following cover:
- Limited to those performing “risk work” in mines and works (i.e. organisations associated with the mining industry, such as quarries).
 - Only provides compensation for those occupational diseases attributable to risk work.
 - Which is restricted to cardio-respiratory diseases.
 - Such as pneumoconiosis, tuberculosis, chronic airways obstruction, occupational asthma and progressive systemic sclerosis.

- Provided that the Certification Committee of the Medical Bureau for Occupational Diseases certify that the condition is attributable to the performance of risk work at a controlled mine or works.
- No person is entitled to compensation under this Act if he / she has received or is still receiving compensation under the Compensation for Occupational Injuries and Diseases Act.
- No person who is entitled to benefits under the ODMWA is entitled to compensation from COIDA.

(v) Impact of REF and recent Government Healthcare Reforms:

Risk Equalisation Fund

- REF seeks to equalise risk profile based on risk factors relating to age, chronic profile, gender and maternities.
 - May be compensated for high chronic and age profile reducing the cost of delivery.
 - This however depends on whether the profile of the workers would result in a payment out of (resulting in reduced contributions) or a payment into (increased contributions) the REF Fund.
 - The extent to which the REF makes cover more affordable depends on the extent to which basic cover now does not need to be priced for an adverse underlying risk profile of the scheme as a whole.
- The REF will have cash flow implications on the scheme depending on the REF modality adopted.
- Open enrolment means that the scheme cannot decline membership to eligible employees, which might drive up costs if there is a significant degree of anti-selection given a lack of compulsory membership for those earning less than R5000.
- Low-income earners are unlikely to afford medical scheme cover unless the majority of the cost is covered by the employer's subsidy.
- Additional reporting requirements of the REF is likely to push up the administration costs of the scheme in delivering healthcare.
- Given that this scheme is unlikely to obtain approval from the Registrar for introducing more than one option, it means that typically lower claiming low income individuals would not be able to join an option where they can benefit from their lower claiming profile in terms of pricing of that option. However, even if more than one option

were allowed, the introduction of the REF will remove this advantage at least in respect of PMBs, as this now has to be risk equalised for the scheme as a whole.

Prescribed Minimum Benefits

- PMBs place a requirement on the minimum level of benefits (and hence cost) that must be provided by a medical scheme. Assuming only offering PMB package then the full benefits will be equalised by the REF. The scheme would benefit from delivering benefits at a lower cost to those published in the REF grids.
- There are additional costs to delivering these benefits as the scheme is not permitted to implement co-payments and deductibles etc. on these benefits.
- And given that cover must include diagnosis, treatment and care in respect of specified chronic conditions and other conditions typically requiring hospitalisation.

Single Exit Pricing

- The regulation of medicine prices and mark-up is hoped to reduce the cost of medication. It should then reduce the cost of delivering medication to low income members.
- New proposals means that reduction, if any, would not be as high as initially anticipated.

Tax Reforms

- The introduction of flat-rate tax thresholds which have replaced previous 2/3 relief on contribution income means that low-income members who can obtain cover at a cost below R500 will not be liable for tax on any subsidy exceeding 2/3rds of the contribution which would previously have been the case.
- This will reduce the cost of cover to individuals and encourage entry into the medical scheme market, provided employers provide the subsidy to low income individuals.

National Health Reference Price List

- For a small scheme such as this, the rate at which NHRPL is published has a major impact on affordability, as this scheme would not have the bargaining power to negotiate lower rates with doctors, given its geographical spread.
- To the extent that NHRPL is higher than inflation, it will make a low cost product increasingly unaffordable.

Note: credit was also given for other new legislation not discussed above, as appropriate.

- 2** (i) Total hospital costs have increased by 58.3% from 2005 to 2006. Breaking down costs into number of lives, admission rates, length of stay and cost per day:
- Total number of lives increased from 212,500 to 287,500 which is a 35.3% increase.
 - Admission rates (admissions/lives) increased from 24.2% to 25.2% which is a 4% increase.
 - Length of stay > 2.2 to 2.1 which is a reduction of 4.5%.
 - Average cost per day (total cost/(admissions*length of stay)) increased from R7099.92 to R8367.83 which is a 17.9% increase.

From the above analysis the major drivers of the increased absolute cost is increased membership and cost per day of admission.

The increase in average cost per day may relate to:

- Hospital tariff and specialists/anaesthetists inflation — generally increase above CPIX; however this is unlikely to fully account for the hike in costs.
- Shift in mix towards more expensive procedures arising due to random variation or deterioration in risk profile. However average age has remained fairly stable suggesting younger average age of new joiners compensate for aging of existing profile. Young new joiners less likely to suffer from chronic conditions and hence it is difficult to attribute higher cost to demographic shift.
- Average length of stay disguises the level of care facility e.g. General ward, Hicare or ICU — the higher daily cost potentially driven by change in mix due to abuse or insufficient case management of high cost cases, or due to underlying change in risk profile.

- Without case management patients may have remained in hospital where lower cost step-down facilities may be more appropriate (note this is independent from the reduction in length of stay).
- A change in benefit design such as an increase in hospitalisation limits and other sub limits exposes the Fund to higher claims.
- Change in tariffs at which the medical scheme pays — e.g. a shift from paying at NHRPL to paying at cost due to PMB legislation.
- Improvements in technology and pharmaceuticals drive up costs.
- Increased utilisation due to member discernment and choice — move towards higher cost institutions.
- Over-servicing by hospitals or specialists.

The increase in admissions may relate to:

- Switch from procedures previously performed in-hospital to hospital admissions due to reduced/depleted day-to-day coverage from member end.
 - Or perverse incentives from service providers.
- (ii) Methods of managing costs can be categorised as changes in benefit design, changes/introduction of managed care initiatives & administration and switching procedures performed in-hospital to out-of-hospital environment where appropriate.

Benefit changes to limit cost and influence member behaviour:

- Introduction of co-payments and deductibles — reduces member and service provider incentive to abuse benefits and reduces costs, but can only be done for non-PMBs if members make use of designated service provider network.
- May further introduce / enforce co-payments strictly where members receive treatment outside restricted DSP.
- Introducing limits on hospital accounts and procedures (again only for non-PMBs).
- Reduction in the tariff rates paid by the medical schemes e.g. from cost to NHRPL — but this can only be done in the context of DSP agreement.

Case Management and Claims Administration

- Introducing pre-certification of hospital benefits as a means of checking member eligibility including the application of waiting periods, availability of benefits and benefit coverage.
 - Where applicable may be able to perform assessment of clinical appropriateness.
 - Placing limits on days accommodation before further length of stay pre-certified e.g. restricting stay in ICU to 1 day before re-assessment. Includes management of the incidence of ICU vs High Care vs General Ward stays.
 - Introducing Hospital Benefit Management where manager negotiates costs e.g. of appliances and implants etc. with provider; monitors high cost patients and discharge planning — includes movement to lower cost step-down facilities.
 - Enrol members on lifestyle (disease management) programs to manage diseases and institute protocols to intervene prior to health event leading to hospitalisation.
 - Scheme may nominate a particular low cost hospital group as designated service provider.
 - The scheme may provide nurse advice lines to again prevent unnecessary hospitalisation.
 - The scheme may decide to tighten the application of waiting periods, within the limits of the Act.
- (iii) Opportunities include negotiating fees through alternative reimbursement models or entering into preferred provider arrangements.

Fees include:

- Per Diem Models
 - A set rate is agreed per hospital day.
 - Reduces hospital incentive to over-service patient, particularly in respect of length of stay, and encourages cost efficiencies.

- Fixed Fees
 - A fixed rate is set to cover the costs of a particular procedure or diagnosis.
 - Suitable where there is little variance in the length of stay.
 - And hence may not easily apply to all types of treatment.
 - Global Fees
 - Similar to fixed fees but includes professional services in relation to a particular service or diagnosis.
 - Requires system of diagnostic grouping.
 - In addition the scheme can enter into preferred provider arrangements facilitating a further reduction in tariff amounts and volume discounts derived by channelling larger volumes through the preferred hospital network at the expense of hospitals outside of the network.
 - Further savings can be generated from early payment discounts.
- (iv) Possible explanations for the increase in chronic medication:
1. The total chronic spend increased 58.6%.
 2. The average proportion of lives claiming increased from 3.9% to 4.5% i.e. total increase of 15%.
 3. The average cost per claimant increased from R4944 to R5040 (1.9% increase).
 4. Number of lives increased 35%.

On the basis that chronic cost = proportion claiming * average cost per claimant * lives, the main driver of the escalated chronic costs is the increase in the total proportion of lives claiming. As observed in (ii) the risk profile of the population does not appear to have deteriorated. This implies that the increased cost is not a result of increased chronic prevalence but an increase in claiming patterns (i.e. number of lives claiming).

Further, increased chronic claims may arise due to a change in the benefit structure, formularies and protocols.

- There may have been an increase in the chronic medication limit.
- There may be an extension of the existing medicine formularies to include additional drugs.

- Which might be driven in part by new chronic condition protocols introduced by Council under PMB legislation.
- There may be an extension of the chronic conditions covered by the scheme.
- Relaxation of clinical entry criteria, particularly given the prospect of receiving payment from the REF, or paying less into the REF.

Changes driven by demographic profile:

- Increase in chronic profile not likely due to relatively stable age profile and due to new joiners with average age below that of the existing profile reducing the likelihood of increased chronic prevalence which is closely linked to age.
- However HIV/AIDS is a chronic disease distributed across all age bands which might imply increased prevalence.
- Increased awareness of members around chronic diseases due to REF chronic member registrations resulting in more people diagnosed and claiming.
- Switch of member preference from generics to more expensive proprietary brands.

Technology and Environment:

- Improved technology bringing new expensive drugs onto the market.
 - Extension of PMB protocols to include drugs not previously covered.
- (v) Chronic medication costs can be managed through changes in the benefit design or through implementation of protocols and formularies.
- Introduce limits on the chronic medication (non-PMBs).
 - Introduce formularies restricting the drugs offered by the scheme.
 - Require the use of generics as opposed to patented drugs.
 - Limit the chronic conditions covered (but the scheme must cover at least PMBs).
 - Introduction of strict entry criteria for registration on chronic programs and eligibility, but the ability to do this might be restricted by the REF.
 - Performing a Drug Utilisation Review will allow an analysis of the drugs used and the clinical appropriateness, this allows interventions

and application of protocols, by suggesting alternatives when appropriate.

- Managed care programs assist members with lifestyle and diet planning etc. to manage patient wellness.
- Introduce co-payments on certain drugs to manage down cost and disincentive to members to abuse benefits.

(vi) Channelling members to pharmacies:

- Introduction of Single Exit Price means that medicine prices are fixed and should be dispensed at fixed price.
- Not permitted to negotiate volume discounts with the manufacturers.
- The benefit of channelling members to specific pharmacies is not derived from medicine price but where specific retailers limit mark-ups and waiver charging of administration fees.
- The other potential benefit is to contract with specific pharmacies to apply the schemes formularies at the point of sale.
- The savings generated from these measures need to be evaluated against restricting the pharmacies from which members are able to obtain benefits.
- Depending on the width of the network, some members may struggle to find pharmacies operating in their area.
- Or where a member has access to a pharmacy within the network, the pharmacy may not stock the medication required by the member.
- Which may introduce the complexity of involuntary use of non-designated service providers, which in turn negates the benefits of a restricted network.
- The small savings due to SEP is unlikely to justify the limitations on members.
- But nominating a DSP will allow the Scheme to levy co-payments on medication other than PMB obtained outside of the DSP network.

END OF EXAMINERS' REPORT