SOME COST-MANAGEMENT MEASURES ARE INCREASING COMPLEXITY

In an attempt to reduce the overall costs of healthcare, medical schemes are introducing various types of cost-management techniques, some of which directly increase the complexity for individuals.

These include, among others:

ALTERNATIVE REIMBURSEMENT MODELS

Alternative reimbursement models where the costs for certain procedures performed in hospital are negotiated upfront with the hospital group. For example, the fee for surgically removing an appendix may be agreed at a specific price.

So, regardless of the actual cost of the appendectomy, the medical scheme will only pay that price and the hospital will benefit if the actual cost was lower or face a loss if the actual cost is more. These alternative reimbursement arrangements help medical schemes to stabilise costs, but more importantly, incentivise hospitals to be more efficient when performing procedures.

A more efficient hospital would be able to reduce the actual cost of performing a procedure, thereby benefiting from the difference between the actual cost and the fee charged. Clearly, these types of arrangements would only work under tight monitoring and management of the quality and outcomes of care to avoid shortcuts being taken to reduce costs.

APPROVED MEDICATION LISTS

Many medical schemes have **approved medication lists** where they pay in full for medication on these lists. Sometimes the lists will be as simple as 'generic medication is paid in full', but at times the lists can become extremely complex and difficult to understand. The justification for these medication lists is to steer members towards medication that is not only cheaper, but also more effective in treating conditions and therefore keep follow-up costs to a minimum.

REIMBURSING SERVICE PROVIDERS

Reimbursing service providers more when they perform procedures in doctors' rooms and not in hospital. This should reduce the overall costs associated with certain procedures as the ward and theatre fees and the costs of anaesthetists and nurses are not incurred. To encourage this movement from in-hospital procedures to in-room procedures, some medical schemes impose **co-payments for treatment obtained in a hospital**. Members who are not aware of these conditions may choose to access care through hospitals without realising that they may incur a co-payment.

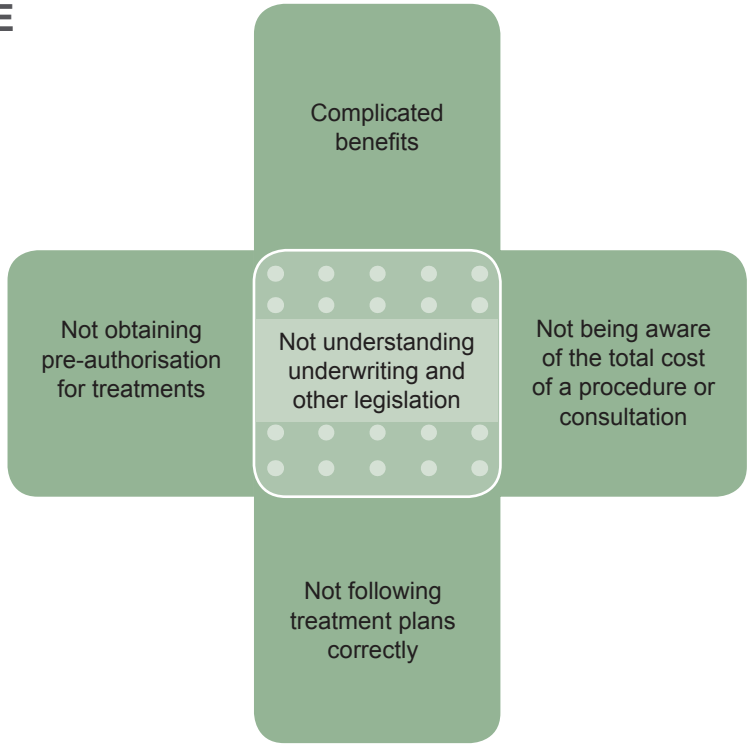
DISEASE MANAGEMENT PROGRAMMES

Disease management programmes specify treatment plans and medicines that individuals must use if registered for certain diseases, such as chronic conditions. The treatment plans are designed to provide more appropriate and efficient care to individuals, with the intention to reduce complications and overall costs in the long term. This again is an area where confusion may arise for individuals.

NETWORKS AND DESIGNATED SERVICE PROVIDERS

Introducing **networks** and **designated service providers (DSPs)** where members must access their healthcare services from specific, defined service providers for their claims to be paid in full. The justification for this is that medical schemes will negotiate reimbursement rates with these providers upfront, allowing for better management of overall costs as well as better control over negotiations. If members don't want to incur co-payments, they will visit providers who participate the network. Providers, wanting to ensure that their patient numbers do not decrease, may opt to join the network.

COMPLEXITY MAY BE INCREASING COSTS EVEN FURTHER



The intention of cost-management measures is to reduce overall healthcare costs, but these measures can sometimes be so complex that without effective communication and member education, individuals may actually face higher total costs through additional out-of-pocket payments.

When individuals don't follow the rules, either by choice or lack of understanding, it can result in out-of-pocket expenses. Situations in which out-of-pocket expenses can arise include:

- Going into hospital for a planned procedure without obtaining pre-authorisation from the medical scheme. This may also occur if an individual is admitted to hospital in an emergency and does not obtain the required pre-authorisation within the specified time period after admission.
- Certain benefits being extremely complicated (such as dentistry). Medical schemes will pay for a portion of treatments from day-to-day benefits, and another from hospital benefits, and sometimes may only cover check-ups.
- Not understanding underwriting and other legislation. Medical schemes can impose waiting periods, which means that, although a member is contributing towards a medical scheme, they are not entitled to the full set of benefits for a specified time period. One common waiting period is a 12-month waiting period for pre-existing conditions[6]. This often applies to members who move between medical schemes on a voluntary basis.
- Not being aware of the total cost of a procedure or consultation. Individuals should be able to discuss costs upfront with their doctors, but may feel intimidated to do so[7].
- Individuals who do not fully understand their condition or treatment plan may be embarrassed to ask for more detail[8], which could result in further costs if they don't follow treatment plans correctly and complications arise as a result.

The list above is not exhaustive but illustrates how individuals could easily break some of their scheme's rules. While these rules are designed to help manage costs and thereby benefit the member, their complexity sometimes makes it difficult for individuals to follow. It is therefore extremely important that members are well-informed and better guided to make the best decisions possible regarding their health.

6 Section 29A, Medical Schemes Act 131 of 1998
7 Mike et al (2005)
8 Ibid