



## MEDICAL SAVINGS ACCOUNTS

The new Medical Schemes Bill published in September allows for medical savings accounts, but only after the medical industry put up a fierce fight over the prohibitions on this method of health funding in the first draft proposals of the Bill. Our guest editor, Anton Roux, Group Financial Director of Medscheme, explains the pros and the cons of medical savings accounts.

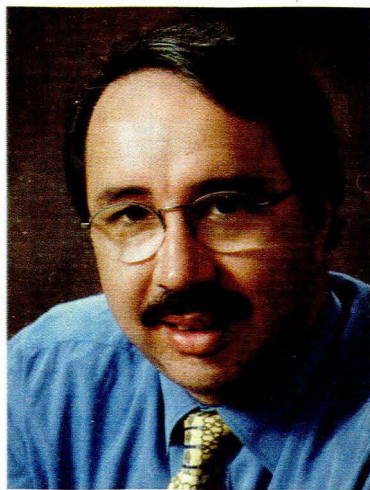
Medical savings accounts are attractive to various constituencies including employers, employees, healthcare consultants, brokers, and health fund managers.

A medical savings account functions on the basis that a proportion of members' contributions is set aside in a savings account within the medical scheme. Members are entitled to fund their day-to-day expenses from these savings accounts, as well as shortfalls in other benefits provided by the scheme. If there is a balance left at the end of a period it is for the member's benefit and will not be used to cross-subsidise other members.

The aim of a savings account is to provide the member with a sense of ownership over the spending of every healthcare rand. The reasoning behind this is that savings would change members' behaviour and that this would ultimately result in a reduction in utilisation levels. The health fund manager must therefore design a set of benefits that distinguish between the controllable and uncontrollable expenses and it is then anticipated that savings/personal accounts would be used to fund the controllable expenses.

The health fund manager must furthermore try to put mechanisms in place to ensure that members who incur unexpected high expenses (for instance after a motor accident) are not placed in a position where they are denied healthcare because of financial constraints. It is for this reason that these products are normally designed with an element that is often referred to as a 'safety net'. The 'safety net' will take care of the member if the member's savings account has been utilised fully.

Government is concerned over medical savings accounts because there is a belief that medical savings accounts distort the cross-subsidisation principles within a medical scheme. I believe they have the potential to do so, but it would be incorrect to state that this is always the case. It all depends on



Anton Roux

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what proportion of the contribution will go towards the savings account.

The Department of Health is also concerned about the potential income tax advantages created by a savings account. If contributions are paid on a salary sacrifice basis, a potential situation exists where pre-tax income of an individual can be used to fund expenses that would otherwise not have been paid for by the medical aid society. An example of this would be if the member were to buy vitamins from a pharmacy and subsequently claim the amount against the balance in the savings account.

*The advantages of the saving scheme concept can be summarised as follows:*

1. It provides members with a sense of ownership.
2. Provided incentives are sufficient, members might change behaviour patterns.
3. It encourages lower utilisation levels with a reduction in cost.
4. Consumers who use fewer benefits during the year will gain financially.
5. The financial reward to the member will be an incentive to become a more educated consumer of healthcare benefits.
6. The bargaining power on price and utilisation of services is placed firmly in the hands of the individual.
7. Accumulated amounts in the personal account can be transferred to future retirement funding.
8. Provided other medical schemes have a

similar mechanism in place, accumulated funds from one savings account could be transferred to accumulated funds of another savings account within another medical scheme.

*The disadvantages of savings schemes can be summarised as follows:*

1. It assumes that consumers can diagnose and treat a large number of minor ailments. It furthermore assumes that the consumer would know when circumstances are serious enough to justify medical intervention.
2. It only concentrates on abuse of medical schemes by members and does not address provider abuse. Where the savings schemes are coupled with re-imbursing the member for the actual expenses and not at the Scale of Benefits, there is an incentive for providers to raise prices to make up for the decreased

utilisation.

3. It places the bargaining responsibility in the hands of the consumers, who have reduced bargaining power as individuals and less information and expertise available to them. This exact same item has also been mentioned as an advantage, because it hinges on the level of education of the specific consumer.



4. The portion of contributions that otherwise would have been available for cross-subsidisation is no longer available for that purpose. If the size of the savings/personal account is not pitched at the right level, the consequences can be disastrous. If, in the opinion of the member, the savings account is too small, no behavioural change will take place and an element of the cross-subsidisation will have been lost.

5. If, on the other hand, the savings/personal account portion is disproportionately large in relation to the individual's income, the individual might deliberately withhold medical treatment in order to obtain the maximum savings benefit.

6. This, in turn, might result in members having to use other risk pools created in the benefit structure because a minor event has now become an uncontrollable event.

7. Preventive care might also be withheld if the incentive not to use the 'own account' is too large.

8. The savings account might disproportionately benefit the wealthy and educated. Under a salary-sacrifice contribution system, savings are created on a pre-tax basis and those employees who earn the most, will get the largest tax break.

9. The future integration into managed care options might be problematic as it is unclear how it will interface with managed care interventions.

10. There may be a loss of data if the medical scheme administrator does not maintain accurate records on how the amounts in the savings accounts are utilised.

## CRITICAL SUCCESS FACTORS OF MEDICAL SAVINGS ACCOUNTS

Savings accounts can be dangerous but very effective. The correct value of the savings/personal account has to be determined and this will vary according to income group, family size, and of understanding of the principles of the specific consumer group. This is where most medical scheme savings/personal accounts fail or succeed.

Extremely careful consideration must be given to controllable, uncontrollable and 'bad luck' expenses. Examples of these might be orthodontics or confinements, e.g. is falling pregnant a controllable or uncontrollable expense? Is the hospitalisation relating to a confinement controllable?

During March 1997, the South African Institute of Chartered Accountants issued accounting guidelines for medical funds. An important aspect of these guidelines is that debit and credit balances within the savings accounts should be disclosed separately. Provision should be made for potential bad debts with reference to debit savings account balances. Furthermore, the rules of the specific medical aid scheme should allow for debit balances.

**'Most savings accounts fail or succeed in determining the correct value of the account.'**

Credit balances should be reflected as liabilities or as reserves, again depending on the rules of the fund. If any portion of the savings account 'vests' in the fund when a member is no longer a member, then an argument can be made out to treat such amounts as reserves.

Cost reductions have been experienced by schemes that adopted savings accounts. In my opinion, the bigger the abuse by members and providers prior to introduction, the bigger the cost reductions after introduction of the savings account.

Healthcare inflation can be explained by the following example:

	Year 1	Year 2	% Increase
Number of consultations for a family of 4 during the year (utilisation)	10	12	20%
Consultation cost per year	R60 x 10 = R600.00	R63.60 x 12 = R763.20	6%
Average cost of medicine/year	R1 800.00	R2 376.00	10%
Treatment of a back (disc) problem			
Scan for the year (Technology)			
CT scan — year 1	R206.00		
MRI scan — year 2		R2 778.00	1 249%
Total annual cost	R2 606.00	R5 917.20	127%

Healthcare inflation has price increases, utilisation increases, and improved/advanced technology as components. The example of a CT scan and a MRI scan is extreme, and I do not suggest that healthcare professionals must not use

improvements in these facilities, however, it is important to note that technological improvements have an impact on healthcare inflation. A savings account only addresses the increase in level of utilisation. The only mechanism available in the long-term to maintain healthcare expenditure in the long run is managed care.

In conclusion, I would like to pose the following question: Are high-risk individuals encouraged by financial incentives to change their behaviour? I do not believe that any financial incentive makes anybody an educated healthcare consumer. If disease and death don't encourage an individual to change his lifestyle, I question whether any financial incentive would.