PRESS RELEASE

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Press release 7 of 2012: Guaranteed medical scheme benefits stand

The BHF and SAMWUMed have failed to convince a court to allow them to appeal against a judgement in which the court had confirmed that the prescribed minimum benefits (PMBs) guaranteed to members of medical schemes stand – and that the BHF had no legal standing to challenge a provision of the Medical Schemes Act in the first place.

Their application for leave to appeal against the judgement of 7 November 2011 was dismissed with costs by the North Gauteng High Court in Pretoria on Friday.

The BHF is the Board of Healthcare Funders of Southern Africa, a representative body for medical schemes and administrators. SAMWUMed is the South African Municipal Workers' Union National Medical Scheme.

The Registrar of Medical Schemes and Chief Executive of the Council for Medical Schemes (CMS), Dr Monwabisi Gantsho, reiterated his concern over the BHF's allegedly frivolous use of funds to initiate legal action, exacerbated by the fact that the BHF had little chance of succeeding in the first place.

"The BHF is funded by member schemes who in turn are funded by the monthly contributions they receive from their members," said Dr Gantsho. "It is extremely worrisome that members' funds are being used to fight provisions which, ironically, are there to protect members' interests."

The BHF and SAMWUMed had been trying to challenge Regulation 8 of the Medical Schemes Act 131 of 1998 for almost a year. Regulation 8 states that medical schemes must pay for the diagnosis, treatment and care of all PMB conditions in full, or at the price charged by the healthcare provider. The BHF and SAMWUMed were seeking to have the Regulation interpreted to mean that schemes must pay for PMB conditions only up to the scheme tariff, effectively changing the meaning and purpose of the PMB provisions in the Medical Schemes Act.

The CMS was one of 13 respondents in the matter. Other respondents included the Minister of Health, the Hospital Association of South Africa (HASA), the South African Private Practitioners Forum (SAPPF), and the South African Medical Association (SAMA).

The CMS is the custodian of the Medical Schemes Act and has always stood by a straightforward interpretation and implementation of the provisions on PMBs.

More details on the matter can be found in CMS's press release 9 of 2011, available on our website (www.medicalschemes.com), entitled *Guaranteed benefits for medical scheme members must be paid in full:* http://www.medicalschemes.com/files/Press%20Releases/PressRelease9Of2011.pdf.

Friday's ruling can be found at the following link: http://www.medicalschemes.com/files/Judgements%20on%20Appeals/AppealAppBHFvsCMSNOthers%20.pdf.

Reminder: what are PMBs?

The Medical Schemes Act guarantees members of medical schemes access to a set of prescribed minimum benefits, commonly called the PMBs.

The purpose of PMBs cannot be overstated: PMBs are there to ensure that members are protected against health events which could otherwise ruin them financially.

As the name implies, PMBs are the minimum, as opposed to the maximum, benefits that your medical scheme must legally cover, regardless of the benefit option you are on.

PMBs cover the diagnosis, treatment and care of roughly 300 of the most serious, often life-threatening, and most expensive health conditions, including 270 diseases such as tuberculosis and cancer, any emergency condition, and 25 chronic conditions, including epilepsy, asthma and hypertension. PMBs cover catastrophic costs, not preventative or primary care.

Your scheme must pay for PMB conditions in full (as per the healthcare provider's invoice) and from its risk pool; it is not allowed to use your personal medical savings account to pay for PMB conditions.

There are medical interventions over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. Anything above PMBs is covered per your scheme's discretion.

PMBs go hand in hand with DSPs. A designated service provider (DSP) is a preferred healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but be aware that when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment.

The CMS publishes an electronic newsletter on members' rights to PMBs, called CMScript. All issues are available on our website (www.medicalschemes.com).

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