



COUNCIL FOR MEDICAL SCHEMES

Private Bag X34, HATFIELD, 0028
Hadefields Block E, 1267 Pretorius Street, HATFIELD

Phone: +27 (0) 12 431-0500
Fax: +27 (0) 12 430-7644

[Http://www.medicalschemes.com](http://www.medicalschemes.com)

TO: ALL PRINCIPAL OFFICERS, BOARDS OF TRUSTEES OF ALL MEDICAL SCHEMES, ALL ADMINISTRATORS AND OTHER INTERESTED STAKEHOLDERS

Telephone: 012 431 0534
Fax: 012 431 0634
Enquiries: Dr B Steenekamp
E-mail b.steenekamp@medicalschemes.com
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COMPLETION OF REF STUDY 2005, IMPLICATIONS FOR REF DEFINITIONS AND DATES FOR REF GRID SUBMISSION IN 2007

On behalf of the Council for Medical Schemes, Professor Heather McLeod led the seven month REF Study 2005 which was completed recently. The results were presented to RETAP (the Risk Equalisation Fund Technical Advisory Panel) and will be presented to the Council shortly.

The REF Study 2005 was the largest research project to date on the price of Prescribed Minimum Benefits in South Africa. Four administrators participated in the study: Discovery Health (Pty) Ltd, Medscheme (Pty) Ltd, Old Mutual Healthcare (Pty) Ltd and Metropolitan Health Group (Pty) Ltd. These administrators provided services for some 4.249 million lives in 2005 or 63.4% of all medical scheme beneficiaries. The REF Study 2005 was provided with nearly 50 million member months of data or the equivalent of 4,2 million members. This was an extraordinary data set on which to perform the Study and the work has produced many new insights into REF, chronic disease in medical schemes and the impact of chronic disease on the price of PMBs.

The Council for Medical Schemes records its gratitude to Heather McLeod and the staff of the four administrators for making this study possible. In particular, we would like to thank Pieter Grobler of Medscheme, Brett Mill of Discovery Health, Paul la Cock of Old Mutual Healthcare, Dr Andrew Good of Qualsa and Dr. Geet Solanki of Fifth Quadrant who represented MHG.

Five studies were performed using the data as part of REF Study 2005:

Chairperson: Prof. William Pick Vice-Chairperson: Dr Saadiq Kariem Chief Executive & Registrar: Patrick Masobe

1. A definitive study of the prevalence of chronic disease in medical schemes.
2. Analysis of the impact on REF Grids of using various auto-chronic definitions.
3. Analysis of the impact on REF Grid Counts of the REF Entry and Verification Criteria v2.
4. Development of the REF Contribution Table 2007 [Base 2005, Use 2007].
5. The consideration of gender as a risk factor for REFCT2007.

The results of parts 1 to 3 have been published as sets of slides on the Council website. To access these slides, please click on the following links:

1. [Study of the Impact of REF on Autochronic Definitions – April 2007.](#)
2. [Study of the Prevalence of Chronic Disease in Medical Schemes.](#)
3. [The Impact of the Verification Criteria on the REF Grid Count](#)

Parts 4 and 5 are reported on together in a report on the methodology used for REFCT2007. This report, as well as the REF Contribution Tables to be used for 2007, will be published shortly.

In the meantime, there is a need to notify medical schemes of three changes in definition for REF data to be submitted for 2007

Changes to REF Data Definitions for 2007

1. Use of Treatment Date, not Payment Date.

The REF Entry and Verification Criteria v2 were released on 11 May 2006 and are to apply in full from 1 January 2007. That document provides definitions for ascertaining whether a person with each of the chronic diseases is a "treated patient" for the purpose of REF. The typical definition in the REF Verification Criteria v2 says: "Evidence of payment of claims for any product included in the ATC categories below, in two different calendar months in the three calendar months preceding the current month:".

This definition should have been on the basis of "treatment date", not "payment date". It is possible to manipulate payment dates so that payment for multi-line scripts falls across two months, whereas "treatment date" cannot be manipulated in this way. A failure to change the definition opens up the measurement of REF risk factors to manipulation. These risk factors should not be subject to manipulation by medical schemes, managed care organisations, administrators, providers, intermediaries or the beneficiaries.

Pricing in medical schemes and for the PMBs for REF is done on the basis of "treatment date" not "payment date". If we do not adopt the definition of

“treatment date”, there will be more beneficiaries qualifying for REF shadow payments than envisaged in the pricing of the table for 2007.

2. No Chronic Conditions for Age Under 1

During the REF Study 2005 it was found that only 0.97% of beneficiaries under one year old had chronic diseases. The majority of chronic member months for Under 1s were for Asthma, with 90.9% of chronic disease for this age group. COPD and bronchiectasis accounted for 2.7%, HIV for 3.0% and epilepsy for 1.9% of the less than 1% with any chronic condition.

After considering the very small number of cases, and comments from industry experts and the pricing team, we have decided to default all Under 1 chronic cases to NON (no REF chronic condition). Thus the pricing for REFCT2007 has been done on the basis that there is no allocation of Under 1s to any chronic disease or multiple chronic disease and that all Under 1s are treated as NON. This decision needs to become part of the REF Verification Criteria for 2007 and not wait for the next version of the document to apply for 2008, which is not expected until later in 2007.

For data extraction for REF Grids in respect of 2007 and onwards, medical schemes thus no longer need to attempt to identify chronic disease for Under 1s. All beneficiaries under age 1 should be defaulted to the NON column.

3. Use of Auto-chronic Definitions

An important part of the REF Study 2005 was the opportunity to understand the impact on the REF Grid Counts of so-called “auto-chronic” processes which are sometimes used to identify lives as chronic. There had been considerable interest at RETAP and Council in understanding the persistently high chronic disease counts from some administrators. For this Study, MHG agreed to provide three additional columns in their data extraction showing how an auto-chronic diagnosis could potentially be made. We are particularly grateful to MHG for sharing this information with the pricing team and thus helping the whole industry to learn from the results.

The outcome of this part of the Study was that the only acceptable chronic definition was where there was a granted authorisation for a CDL disease, even if the authorisation was found in a year outside the Study period. Note that during 2005 many schemes worked hard to obtain the required authorisations and this work continued into 2006. All other auto-chronic definitions / and or claims identification methods were found to be not acceptable for the REF pricing. By extension, all other

auto-chronic definitions are unacceptable for REF shadow payments from 2007 onwards.

To re-iterate, in terms of REF submissions: the only **acceptable** chronic definition is where there is a granted authorisation for a CDL disease, even if the authorisation is found in a period outside the submission period.

All other auto-chronic definitions are **unacceptable** for REF purposes. Unacceptable definitions include:

- any diagnosis made from a claim that contains an ICD-10 code from a healthcare professional (even if the dispensing provider or the prescribing provider on a claim was a medical practitioner (GP or Specialist)); and
- any diagnosis made by proxy using the medicine or class of medicine prescribed to arrive at a diagnosis (for example, a NAPPI-ICD crosswalk or any similar tool).

The document ***Guidelines for the Identification of Beneficiaries with REF risk factors in accordance with the REF entry and verification criteria***, has been amended to reflect the changes described below in paragraphs 1 to 3. Version 2.1 has been published on the CMS website. Note that certain technical omissions and errors have also been corrected in Version 2.1.

Dates for REF Data Submission for 2007

Quarter 1 2007:

Electronic submissions must be completed by 19 June 2007, and signed hard copies must be submitted by 22 June 2007. Note that the hierarchy of costs of the respective CDLs are required to accurately identify beneficiaries with REF risk factors have been published in Version 2.1 of the guidelines.

Dates for the submission of the remaining three quarters will be advised in due course.



T. Patrick Masobe
Registrar of Medical Schemes