



COUNCIL FOR MEDICAL SCHEMES

Private Bag X34, HATFIELD, 0028
Hadeffields 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 AND STAKEHOLDERS

Circular No 6 of 2008

Telephone: 012 431 0534

Fax: 012 431 0634

Enquiries: c.cairncross@medicalschemes.com

Reference: PMB Review

Date: 6 March 2008

2008 REVIEW OF PRESCRIBED MINIMUM BENEFITS

1. In a collaborative effort between the Department of Health and the Council for Medical Schemes, a consultative workshop was held with 250 stakeholder representatives at Gallagher Estate on 15 February 2008.
2. At this workshop, the terms of reference of the review of the PMB's were discussed, and stakeholders presented their views on the process that should be followed in this review. These presentations are available at www.medicalschemes.com under publications: PMB review 2008.
3. The attached "Terms of reference for the 2008 review of prescribed minimum benefits funded by medical schemes" reflects the outcome of these discussions.
4. The attached "Governance, process, structure and objectives of the 2008 PMB review" document further expands on the functional groups and specifies their activities and objectives.
5. Individuals who wish to participate on the functional groups review must please submit their names, specific skill areas and contact details to c.cairncross@medicalschemes.com before 12h00 on 12 March 2008. Please indicate in which of the functional groups you would prefer to participate, individuals may serve on more than one of the groups.
6. A functional group workshop will be held in Gauteng on 17 March 2008. Details of the venue and the programme will be sent to participants by 13 March 2008. The workshop will start with a plenary session where the activities of each of the groups will be elaborated on, after which work on these areas will start immediately.

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

7. The purpose of this workshop is to finalise the work contents and processes of the functional groups and to consider timelines for each of the sub-processes. The number and dates of future functional group meetings, as well as future large workshops involving all stakeholders will also be established at this workshop.



Boshoff Steenekamp

REF Project Specialist: Council for Medical Schemes

TERMS OF REFERENCE FOR THE 2008 REVIEW OF PRESCRIBED MINIMUM BENEFITS

18 February 2008



1. Background

“The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions. A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS. These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

- (i) inconsistencies or flaws in the current regulations;*
- (ii) the cost-effectiveness of health technologies or interventions;*
- (iii) consistency with developments in health policy; and*
- (iv) the impact on medical scheme viability and its affordability to Members.”*

Explanatory note to Annexure A of the regulations to the Medical Schemes Act No. 131 of 1998

Mandatory minimum benefits form part of an essential range of interventions required to protect access to medical scheme cover for essential healthcare in the private contributory healthcare system in South Africa.

In the absence of a set of mandatory benefits to be carried by all schemes it is expected that medical scheme beneficiaries will face severe prejudice in the following areas:

1. Gaps in benefit designs will be used to exclude older and sicker people from risk-pooled benefits. This will result in reduced access to healthcare for many individuals for reasons beyond their control. This conduct will occur most particularly in those schemes that compete commercially for members.
2. Schemes will have limited incentives to manage the underlying costs of the healthcare covered, as they will be in a position to reduce benefits (i.e. shift the obligation onto members) as a way of controlling the costs of contributions. Again, this will be most prevalent in schemes that compete commercially for members.
3. It is virtually impossible for medical scheme members to understand up-front what benefits have been excluded from cover or the implications of that exclusion. This places them in the predicament that they will only find out where the critical gaps in cover are when they fall ill or require medical treatment.

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4. Medical scheme beneficiaries covered in schemes that compete commercially for members make up 73% of the total. Given this, the risk of a systemic downward spiral in benefits is high, if not inevitable, in the absence of mandatory minimum benefits.

The protection of risk pools within private healthcare markets involves an inter-related set of measures:

1. **Mandatory community rating:** this involves the prohibition of pricing health insurance cover on the basis of health status. If not in place, members of poor health status can be excluded from cover by increasing their contributions to reflect their health status.
2. **Open enrolment:** this removes the discretion health insurers have to select only preferred groups for membership. In the absence of such a measure, groups of “uninsurable” people develop who will not be accepted by any health insurer.
3. **Mandatory minimum benefits:** this removes the discretion health insurers have to establish selective gaps in cover which favour particular groups of members over others, and/or to surreptitiously remove important health needs from cover.
4. **Risk equalisation:** within an environment characterised by multiple competing health insurers, the requirements of mandatory community rating, open enrolment, and mandatory minimum benefits will prove unstable in the absence of a mechanism which equalises the prospective risk of using benefits faced by any scheme due to the differential health status of its membership.

Without the above, it will not be possible to achieve effective risk pooling within a private health system without taking the necessary step of eliminating the multiple insurer environment.

2. Purpose of the Review

The purpose of this review is to identify what changes to the regulations are required in respect of prescribed minimum benefits to further the goals of improved access, quality and reduced costs in healthcare.

3. Focus of the Review

The review will encompass the following:

1. Any gaps or inconsistencies in the current set of prescribed minimum benefits and appropriate measures to address them;
2. The specification of a comprehensive set of essential benefits appropriate for coverage by medical schemes;
3. The prescribed minimum benefits that should accompany the implementation of the Risk Equalisation Fund;
4. The constraints associated with the implementation of a set of prescribed minimum benefits consistent with the comprehensive set of essential benefits noted in (2);
5. Any measures required to ensure the sustainability of any package of prescribed minimum benefits;
6. The identification of specific measures required to ensure the cost-efficiency of selected prescribed minimum benefits; and

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7. To clarify the relationship that should exist between the prescribed minimum benefits and the public health system.

4. Process Requirements

The process will involve the establishment of a participative process involving all key stakeholders affected by the regulations.

The process will be governed by a steering committee, comprising of officials of the Department of Health and the Council for Medical Schemes. A project manager will coordinate the activities of participatory functional groups that will comprise of individuals serving in their personal capacity.

The output of this process will support the focus of this review and includes the definition and specification of a comprehensive essential healthcare package; considering the identified restraints, a full specification of what should be in place when the REF is introduced; the identification of prerequisites for the full implementation of the essential comprehensive package; and the proposed measures that are required to ensure sustainability of the package.

5. Proposed Timelines

The participative process is set to begin in February 2008 and to reach finality on the full package by the end of July 2008. Thereafter, the inputs received will be incorporated into draft regulations.

The resultant work on the REF risk factors and weighting tables will be completed later.

GOVERNANCE, PROCESS, STRUCTURE AND OBJECTIVES OF THE 2008 PMB REVIEW

16 March 2008



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

1. Background

In accordance with the Terms of Reference of the 2008 PMB review, a project is undertaken whereby the current set of PMB's are reviewed in accordance with legislation. This document defines the governance structure and the role of the respective sub-groups of the project team.

2. Governance structure

The process will be governed by the PMB Review Steering Committee, comprising of officials of the Department of Health, the Council for Medical Schemes, and the leaders of the three functional groups (who will also be officials). The REF Project Specialist will serve as project manager and will coordinate the activities of the functional groups.

The Steering Committee will consider the proposals by the functional groups and to draft the regulations that give effect to these.

3. Functional Groups

Three functional groups will be established. These functional groups may establish sub-groups that require specialised skills or have specific sub-objectives. Even though the work by the **PMB Definition group** must be completed before the REF and Sustainability groups could finalise their work, work should commence simultaneously and continue in an iterative and parallel manner.

The purpose of the **PMB Definition group** is to deal with the definition and specification of the comprehensive essential PMB package in an *insured environment*. Key activities will include:

- Consideration of first principles that will be applied in the definition of the respective packages, including the principles that would be applied to judge whether benefits are “*insurable*” or not
- Application of the principles to describe a essential comprehensive package (Full package)
- Costing of the full package
- Description of the constraints that prevents the introduction of the essential comprehensive PMB package
- Definition of the package that should be implemented with the REF
- Definition of a potential LIMS PMB package
- Consideration of the constraints associated with the implementation of the full PMB package
- The relationship between the prescribed minimum benefits in the insured environment and the basic benefit package envisaged for the public sector.

The purpose of **REF group** is to support the PMB Definition group with the costing of the essential comprehensive package and to develop REF risk factors and the REF weighting table. The REF group will collaborate closely with RETAP and its final recommendations will be considered by the REF steering committee and RETAP. Key activities will include:

- A key priority that must receive urgent attention is the specification of data that will be urgently collected from medical schemes that will be used to cost the PMB's, identify the REF risk factors and develop the REF weighting table.

- Consideration of the previously defined first principles that will be applied in the selection of REF risk factors
- Support on the costing of the full package defined by the PMB Definition group
- Identification of the REF risk factors for the revised PMB's
- The development of an REF weighting table (contribution table)

The purpose of ***PMB Sustainability group*** is to expand on the factors identified by the PMB definition group that threatens the sustainability of the implementation of the full PMB package, as well as the factors that are hindrances to the implementation of open enrolment, community rating, essential comprehensive PMB's and risk equalisation. Key activities will include:

- Consideration of first principles that needs to be applied to consider the threats to sustainability.
- Recommendations on how to limit overcharging and balance billing for PMB benefits.
- Recommendations on the measures that must be applied to ensure the sustainability of the full package.

4. Project output

The output of this process will support the focus of this review and includes:

- The definition and specification of a comprehensive essential healthcare package; considering the identified constraints
- A full specification of what should be in place when the REF is introduced;
- The identification of prerequisites for the full implementation of the essential comprehensive package;
- The proposed measures that are required to ensure sustainability of the package.

5. Proposed Timelines

The participative process is set to begin in February 2008 and to reach finality by the end of July 2008. Thereafter, the inputs received will be incorporated into draft regulations.

Specific milestones are:

- **Data request** from medical schemes for the costing, REF risk factors and weighting table study – **4 April 2008**
- Initial proposals on the measures that are required to ensure sustainability of the PMB package – **30 April 2008**
- The definition and specification of a **comprehensive essential healthcare package** – **31 June 2008**
- **Costing** of the comprehensive essential package – **30 October 2008**
- A full specification of what should be in place when the REF is introduced – **30 November 2008**
- **REF Risk factors and weighting table** – **28 February 2009**