



PMB non-compliance workshop

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Policy Objectives of Medical Schemes Act, 1998

- Promote non-discriminatory access to privately funded health care
- Reduce unnecessary financial burden on the public sector
- Improve governance of medical schemes in the interests of members
- Promote greater financial stability in the industry
- Improve consumer protection through enhanced governmental oversight



Pillars of the MSA (131, 1998)

- **Community rating:**
 - Schemes must price contributions at average expected cost of the group, rather than loading premiums according to the risk status of individuals
- **Open enrolment:**
 - Medical schemes cannot deny membership of their scheme based on an assessment of the risk status of an individual
- **Prescribed minimum benefits:**
 - A minimum set of benefits that a medical scheme must offer to all its beneficiaries at full cost in at least one reasonably accessible setting
- **Governance:**
 - Establishment of Boards of Trustees, of whose membership 50% are required to be elected from amongst members



PMB non-compliance

- Noted with concern systemic industry-wide non-compliance fueled by commercial interests
- Acknowledge technical complexity of complying with PMB regulations
- BUT we have to uphold the law- MSA of 1998



Events leading to the PMB task team

- Circular 37 of 2009
 - Payment at cost
 - Payment delayed until after a Registrar ruling
 - Registered rules not implemented
 - Members bear the cost
- Meetings held with industry representatives
- Circular 9 of 2010
 - Proposes the establishment of a task team



Legal opinions

- Argue that regulations could be declared null & void
- Argument that CMS interprets the regulations not accepted, an appeal board ruling has given clarity on the “at cost” requirements in regulation 8
- Regulations are in force until they are amended or declared null & void by a court
 - Strong lobby to water down the regulations



Allegations of provider misconduct

- “Schemes are bleeding”
- Providers abuse the regulations, use it as a “blank cheque”, they charge 800% of NHRPL
- Await evidence in this respect
- Data available to the CMS does not show systemic abuse



Technical problems in dealing with PMBs

- Nature of PMB definitions in the regulations
- Benefit definitions are ambiguous
- Cannot merely rely on diagnosis and procedure codes
- Coding quality is poor
- Managed care requirements may lead thereto that even though the patient suffers from a PMB condition, reasonable managed care requirements must be met



PMB compliance Workshop and the Establishment of a PMB task team

- Aim is to establish a representative task team that would agree on funder and provider conduct
- Must protect medical scheme beneficiaries
- Important to get proper representation of all stakeholders



Today's programme

- Presentations by stakeholders
- CMS presentations
- Establishment of a mandated task team
 - Council for Medical Schemes;
 - Department of Health;
 - Medical schemes;
 - Medical specialists and general practitioners;
 - Hospital groups; and
 - Consumer groups and beneficiaries of medical schemes