The Council for Medical Schemes'

CMS News

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COSTING OF PMBs

STRUCTURAL ISSUES

Plus

UNINTENDED CONSEQUENCES FOR HEALTHCARE FUNDING

the prescribed minimum benefits issue

CMS
Council for Medical Schemes

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EDITORIAL

In his 1841 essay "Compensation", Ralph Waldo Emerson wrote: *"In the order of nature we cannot render benefits to those from whom we receive them. But the benefit we receive must be rendered again, line for line, deed for deed, cent for cent, to somebody."*

This sums up how prescribed minimum benefits (PMBs) work. They ensure that all medical scheme members receive certain minimum health services regardless of their chosen option. They assist in unforeseen health conditions such as emergency hospitalisation, cancer and rare chronic illnesses which may have devastating financial outcomes for families.

Because PMBs are driven within a health insurance environment, based on social solidarity, the young pay for the old, and the healthy pay for the sick in the same way the young would only appreciate PMBs when they are old. This is true to Emerson's *"the benefit we receive must be rendered again, line for line, deed for deed, cent for cent, to somebody."* PMBs also ensure that the old are not unfairly discriminated against because of their age and/or disease.

This issue unpacks all you need to know about this basic benefit as a member of a medical aid. Since there are close to 300 PMB conditions including 27 chronic diseases, there will generally always be a lot to be said, from the administrators', doctors', medical schemes' and members' perspectives - Editorial Committee.

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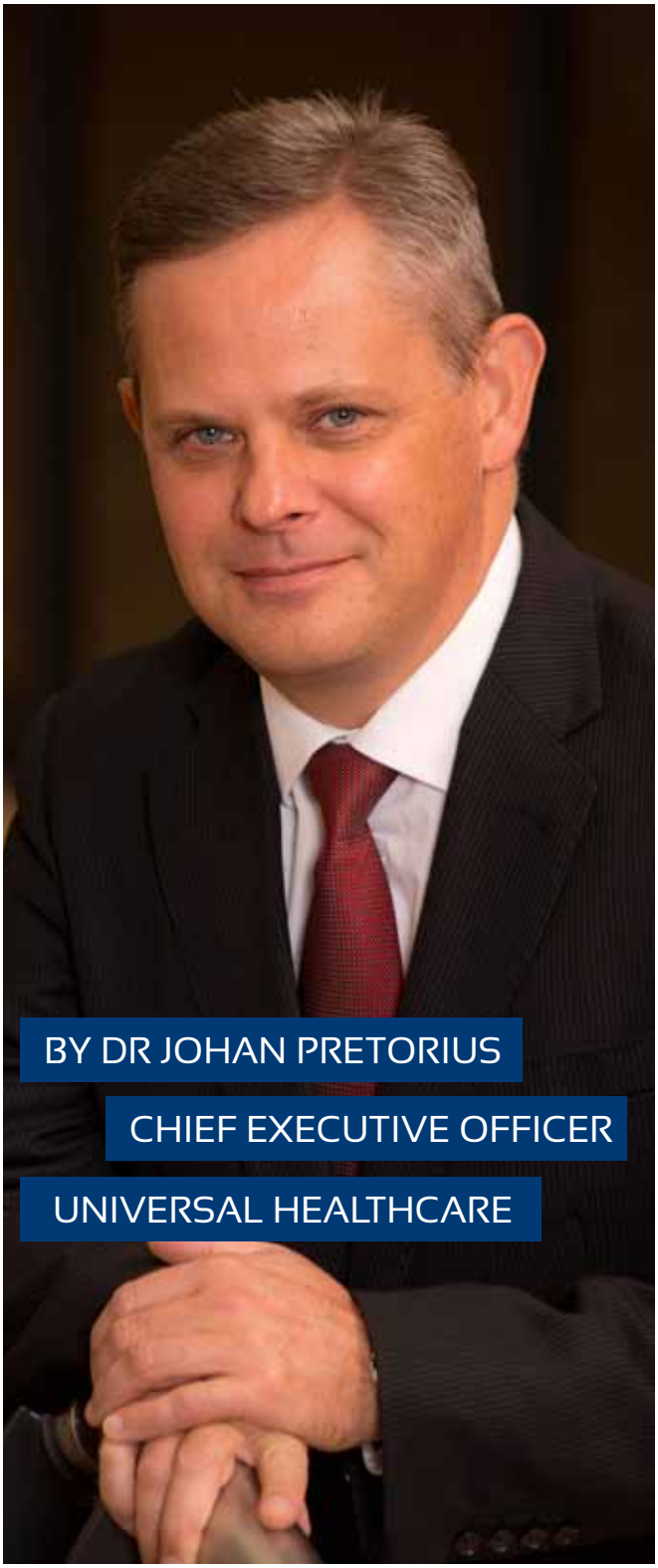
THE PMB CONUNDRUM



BY DR JOHAN PRETORIUS
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Prescribed minimum benefits (PMBs) are best described as a double-edged sword. As a medical doctor first and foremost, I view PMBs as an invaluable resource in saving the lives of patients. From a medical scheme and healthcare funding perspective however, it is the straw that could break the camel's back if left unchecked.

Let's look at a typical example of PMBs at work. Mrs X is a forty-five-year-old woman who presented with acute abdominal pain, which had persisted over a period of several days, leaving her unable to breathe at times. The pain she experienced was worse after meals, and she was constantly nauseous.

A visit to her general practitioner resulted in a diagnosis of irritable bowel syndrome (spastic colon) and she was given some pain medication to alleviate the worst of her symptoms. The pain medication made very little difference and that night she was taken to the emergency unit at her local hospital. A number of tests were conducted but as these proved inconclusive she was not hospitalised but put on a drip in the emergency unit. She was sent home with stronger pain medication and anti-inflammatories. At this stage her condition was not a PMB and she was therefore required to fund the tests as well as the treatment received at the emergency facility from her medical savings account.

Back at home very little had changed. The pain was now so severe that an emergency appointment was made with a gastroenterologist who examined her, conducted a few additional tests and diagnosed her as having gallstones, which resulted in inflammation of the gallbladder (acute cholecystitis). She was immediately hospitalised as acute cholecystitis can progress to gangrene or perforation of the gallbladder if left untreated.

Gallstones and acute cholecystitis constitute one of the 270 medical conditions which, in terms of the PMB regulations, must be covered along with all emergency conditions, which Mrs X's case had clearly become. While the earlier, mistaken diagnosis of irritable bowel syndrome was not a PMB, once a correct diagnosis was made it was abundantly clear that the medical condition was a PMB. This may not necessarily be picked up by a medical scheme or healthcare administrator at the time when the doctor's bill for the first examination was received, as the codes for the two different conditions are literally poles apart. Also, Mrs X was not seeing the same healthcare provider throughout her ordeal. Only an astute and well-informed healthcare consumer who knows her way around PMB conditions would be able to make the necessary representations to her medical scheme.

Of equal interest is the fact that tonsillitis is not listed as PMB while otitis media (an ear infection) is categorised as a PMB. Another example is osteoarthritis, which, although sometimes totally debilitating, is not a PMB while rheumatoid arthritis is classified as a PMB. Without doubt, there are a few inconsistencies when it comes to PMBs. The last PMB amendment occurred in 2003, when the definition of PMBs was extended to include a comprehensive list of chronic diseases. Until 2003 PMBs pertained specifically to the hospitalisation of medical scheme members.

While the CMS has submitted draft amendments to the Medical Schemes Act to the Department of Health in August 2013 the initial intention of reviewing and updating the algorithms, treatment plans and list of diseases classified as PMBs on a regular basis has unfortunately not come to fruition. Ten years down the line it would be highly beneficial for patients, medical practitioners and medical schemes if PMB conditions and the general modus operandi underpinning them could come under the spotlight sooner rather than later. Early indications are that it is unlikely that the amendments proposed by the CMS will come into effect before the end of 2015.

> *"As a medical doctor first and foremost, I view PMBs as an invaluable resource in saving the lives of patients"*

At last year's fourteenth annual Board of Healthcare Funders conference in Cape Town, Christoff Raath, Chief Executive Officer of the Health Monitor Company, drew attention to problems with the current regulatory environment for PMBs which he said had created "a perverse incentive for doctors to class procedures as PMBs so that they could command higher rates". He attributed this to the fact that the current regulatory environment stated that medical schemes had to fund PMBs in full.

He cited the example of Health Monitor's analysis of medical scheme spending on anaesthetists between January 2010 and July 2013, which revealed that the cost per member had almost doubled for PMBs but yet remained almost unchanged for non-PMBs. This is quite possibly the greatest dilemma faced within the healthcare-funding environment.

PMBs – there is hope yet

Without doubt all is not gloom and doom in so far as PMBs are concerned. There are quite a few mechanisms that can be used to alleviate some of the perceived difficulties created by PMBs. For example, the selection of a well-functioning designated service provider (DSP) network can make a considerable difference in arresting high costs. Within Universal Healthcare we have also found that constructive and transparent engagement with healthcare providers can make tremendous inroads in stemming the tide of seemingly uncontrolled healthcare expenditure.

The implementation of single exit pricing (SEP) for the pharmaceutical industry in 2004 has done a great deal to curtail high expenditure on the medicines front. Similar legislation or guidelines, if implemented in close consultation with healthcare professionals, could serve the industry well.

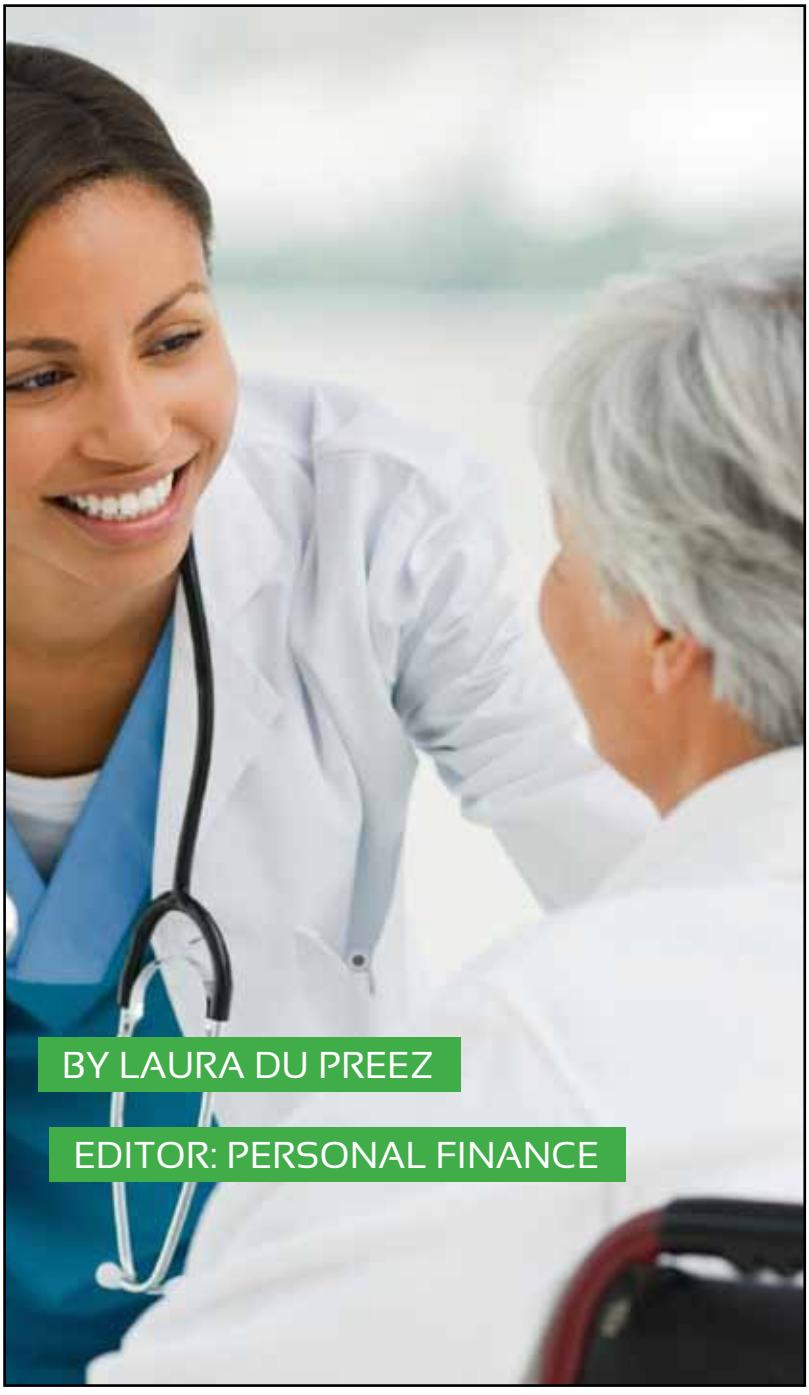
To get back to a previous point, PMBs have been in existence now for more than a decade and the time has come for an urgent review of the listed diseases and how best the PMB system can be put to use in the interests of patients, medical practitioners and medical schemes alike.

In closing, the time has come for medical schemes to become patient advocates who will do what is needed to fight for the rights of patients. This however also means that runaway costs need to be kept in check in order to ensure the sustainability of the industry. It requires that all the stakeholders work together.

People are living longer and as time goes by PMBs and their funding will become more and more of an issue. The fact that our population is becoming so much older is in no small measure attributable to medical science and to medical schemes that are able to fund a level of care, which we could never have imagined twenty years ago.

In 1998 there was an estimated 135 000 people worldwide over the age of 100. This figure is expected to double by sixteen times to reach 2,2 million in 2050. Given these figures and the high cost of caring for older citizens – who are often the ones suffering from PMB conditions – it is becoming imperative that the necessary mechanisms be put in place to provide the appropriate levels of care while ensuring the sustainability of the medical schemes industry within South Africa.

PMBS AND THE PRIVATE HEALTHCARE CONSUMER



BY LAURA DU PREEZ

EDITOR: PERSONAL FINANCE

The prescribed minimum benefits (PMBs) offer medical scheme members an important protection from financial catastrophes that can result from ill-health or accidents, but the benefits may at times be lost if members or their doctors don't have a good understanding of their rights and how to enforce them. Members are becoming more aware and doctors are at times assisting by informing members when their condition is a PMB, but a lack of knowledge can still result in a member being denied benefits to which they are entitled.

Doctors attempting to stick strictly to consultation times often have little time to educate members about their illness and their entitlement to treatment, or to complete the necessary forms for members to be able to claim for PMBs.

Some practitioners print messages such as "This treatment falls within the prescribed minimum benefits (PMBs) and should be settled by your scheme in full" on their bills or refer patients to their office administrators, but when bills remain unpaid by medical schemes, they turn on the member saying the payment of the bill is their responsibility.

Here are few common problems members need to navigate through to get the benefits to which they are entitled.

1. Emergency treatment for which doctors charge more than scheme rates

Despite the fact that a condition may have been an emergency one that should be covered by the PMBs regardless of what the practitioner charges, medical scheme administrators do not always recognise claims as those relating to an emergency and may only pay claims up to the scheme rate unless challenged.

When a member suffered internal bleeding and cardiac arrest and was admitted to intensive care for a week before passing away of major organ failure in 2012, a restricted medical scheme administered by a large administrator paid all the hospital bills amounting to some R121 000 but only some of the R53 045 in claims submitted by the treating doctor, anaesthetist, radiologist, blood supplier and paramedics.

The member's estate faced unpaid bills of R36 488, but fortunately the treating doctor put a message on his bill to the effect that it related to a PMB and should be covered in full.

The widow then queried all the unpaid bills and they were later settled in full by the scheme, but had she not done so, she would have been left a lot worse off.

The administrator claimed the procedure codes and diagnostic (or ICD10) codes were incomplete, resulting in the claims not being identified as PMBs and paid as such.

ICD stands for the "International Statistical Classification of Diseases and Health-related Problems" and the codes were developed by the World Health Organization to enable the medical industry to define and communicate medical and health information into a standard format.

Late on a Friday during the Christmas week last year, another member received confirmation that she had broken her foot and an orthopaedic surgeon would need to operate the next morning and insert a pin. The surgeon reassured the member that the hospital would obtain authorisation and his bill and that of the anaesthetist would be covered as a PMB.

But again a large administrator failed to recognise the operation as an emergency procedure and paid only part of the bill. The claim statement stated that the treating doctor was not one of its designated service providers and charged rates above the scheme's rate.

The payment of the claim was only settled in full when the member challenged it and the doctor motivated that it was an emergency procedure. The follow-up procedure to remove the pin, was not, however, covered as the scheme did not regard this as an emergency.

2. Members referred to doctors who are not designated service providers

To contain the costs of the PMBs, schemes may appoint designated service providers that members are expected to use to enjoy full cover. This may extend to a network of specialists.

But if a member's general practitioner (GP) refers them to a specialist who is not a member of that network, the member is faced with a difficult decision of following the GP recommendation and paying the additional cost, or choosing a specialist in the network who is not known to the member's GP.

3. The diagnostic test without the right code

The diagnosis of a PMB condition should also be covered in full, but often when a member is sent for a diagnostic test, the diagnosis is not yet certain, so the pathologist or radiologist uses a "z" code to indicate an undiagnosed condition.

Only when the doctor reads the test results is a diagnosis confirmed, but in the meantime the bill

for the test is submitted to the member's medical scheme and not paid as PMB as the "z" ICD10 code that is not recognised as one covered by the PMBs.

Members can resubmit these claims, but the claim may need to be accompanied by a letter from the treating doctor, which can be hard to obtain from a busy healthcare practitioner. Pathologists and radiologists will not amend the codes and resubmit the claim on a member's instructions.

Members who need diagnostic tests, scans or other treatment regularly for a chronic condition need to ensure they get forms completed by their doctors with the correct ICD10 code from their doctor already inserted.

4. The condition that seems to be but isn't a PMB condition

Members and their doctors often have an idea that their condition is a PMB, but in the fine print it turns out the condition is not a PMB.

For example, high blood pressure or hypertension is a PMB but a member of a large open medical scheme found her claim for the treatment of mild form of this condition rejected and was informed by her scheme that the dose of medication prescribed was too low to meet the criteria to qualify as a PMB.

Recently a doctor assured a patient that the removal of suspected basal cell carcinoma would be covered by the PMBs, but the claim was not paid in full. On confronting the scheme, the member was told the scheme needed to see the histology report and only if the cells removed were of particular depth, would their removal qualify as treatment in terms of the PMBs.

5. The emergency that isn't an emergency

The PMBs cover all medical emergencies, but problems arise when what appeared to be an emergency turns out on diagnosis to be a non-emergency.

Members are finding their claims for consultations in emergency rooms and tests done to establish whether the emergency was indeed a life-threatening condition are not paid for by their schemes.

The Council for Medical Schemes Appeal Committee confirmed in a 2011 case that a large open scheme did not have to pay for the two electrocardiogram tests performed on a member who experienced chest pains after a golf game as the tests proved he had no heart problems.

The Appeal Committee said the scheme would have been obliged to pay only for any treatment the man had received prior to the diagnosis being made.

Members or their dependants sent to an emergency room are typically in no condition nor do they have the knowledge to dispute the need for them to be sent.

Who would question a retirement village nurse who calls an ambulance for an elderly resident suffering chest pains or think twice about advice from a school to take a child who has fallen from a playground jungle gym and injured his head to the emergency room?

There are medical schemes that have introduced a casualty benefit to cover tests and treatment in an emergency room regardless of the diagnosis from the scheme benefits rather than potentially depleting a member's savings account.

6. The standard treatment that is not suitable

Many members lose out on their scheme's paying for their treatment of a PMB because the standard treatment is not suitable and their doctors recommend alternatives.

The Medical Schemes Act allows schemes to develop treatment plans for a PMB as long as that treatment is equal to or better than the minimum treatment standards for each PMB condition as provided for in the law, with treatment provided in state healthcare facilities being regarded as the absolute minimum.

The regulations also state that if you have a poor response to, or will come to harm following the treatment plan a scheme provides for a PMB condition, the scheme is obliged to provide an appropriate exception.

A member of a large open scheme had to take her case to the Council for Medical Schemes when the scheme refused for a R10 000-a-month biologic recommended by her doctor for rheumatoid arthritis after the standard treatment failed.

The scheme argued the biologic was not cost-effective, but did not recommend an alternative and neither did her doctor, leaving the member in a constant pain as the case went on appeal to the Council's Appeal Board.

Days before the appeal was finally to be heard, the scheme agreed to pay the cost of the biologic. In cases where treatment is expensive and the consequences dire, a doctor may help a member to claim by motivating for the alternative treatment.

But a member on relatively inexpensive treatment for cholesterol or hyperlipidemia, also a PMB, found her doctor recommended a slow-release medicine which was not on the scheme's standard basket of treatment. The claim was denied and the doctor explained that the more expensive medicine was better for the patient's health but did not assist with any motivation to the scheme.

7. Establishing what is and isn't covered by the PMBs

Minimum treatment standards for each PMB condition in the regulations under the Medical Schemes Act are often vague referring only to "medical management" or "surgical management" of the condition.

As schemes are obliged to provide a standard of care for a PMB condition that is at least equal to that provided in state healthcare facilities, they often reject treatment for a PMB condition saying it is not common practice for public health facilities to provide such treatment. Members can find it difficult to prove otherwise as cases before the Council for Medical Schemes and its Appeal Committee evidence. In 2011, the Council for Medical Schemes ruled that a restricted scheme had to pay the physiotherapy claims of a member with multiple sclerosis.

The scheme had been paying the man's physiotherapy claims from his medical savings account and said although the algorithm that deals with the minimum treatment that schemes have to provide for the PMBs that refers to "supportive care", this was not elucidated.

The Council for Medical Schemes (CMS) found that a Pretoria state hospital did provide physiotherapy, including hydrotherapy, to state patients with multiple sclerosis and therefore ruled that scheme should likewise pay for physiotherapy.

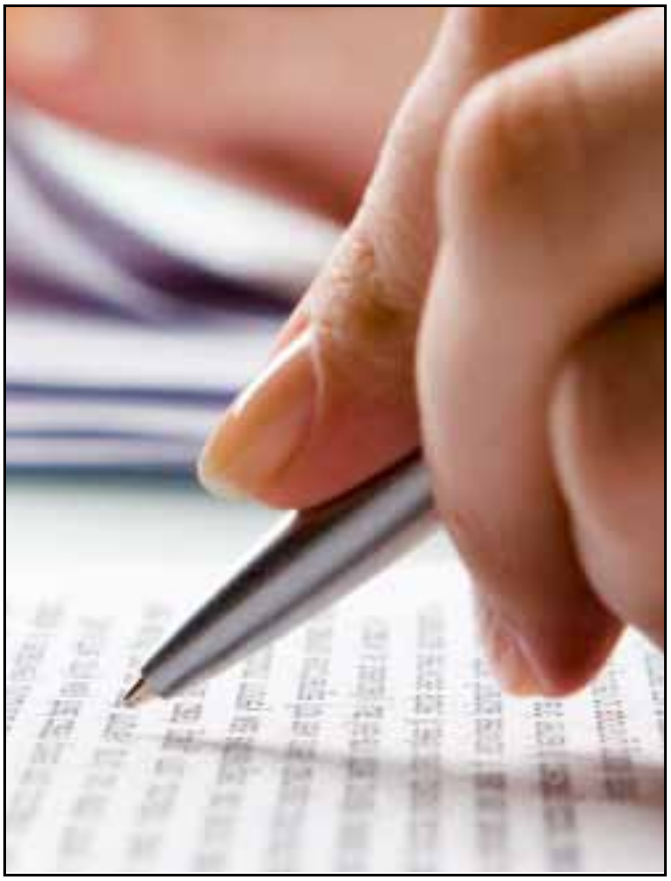
According to the 2011 Annual Report of the CMS, two members of a large open scheme won their cases after the scheme refused to pay for reconstructive surgery following their mastectomies. The Appeal Committee found reconstructive surgery was the prevailing practice in the state hospitals.

According to the ruling, a note in the PMB regulations states that the practice in both private and public sectors should be considered when determining the "surgical management" of any PMB.

The Appeal Committee chairman pointed out that only where there are significant differences between the prevailing practice in the private and public sectors, should schemes construe "surgical management" to mean "predominant public hospital practice".

8. The PMB that is only paid after reams of paperwork

Many members give up the battle to get a claim paid as a PMB when confronted with forms that schemes insist are completed before a claim is paid as a PMB or when forms for chronic conditions need to be resubmitted annually. It can be difficult to get these forms completed by busy practitioners and some practitioners charge for the time it takes them to complete these forms.



BY DR ANTON DE VILLIERS
HEAD: RESEARCH AND MONITORING
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PRESCRIBED MINIMUM BENEFITS

Costing of the prescribed minimum benefits (PMBs) and structural issues affecting affordability of the PMB package

Introduction

The prescribed minimum benefits (PMBs) are a set of defined benefits designed to ensure that all medical scheme members have access to certain minimum health services, regardless of the benefit option they have selected. The aim is to provide members of medical schemes with access to continuous care to improve their health and well-being and to make healthcare more affordable.

PMBs form an important component of the policy principles designed to facilitate access to healthcare services. PMBs operate within a health insurance environment, based on the principle of social solidarity where the focus is on risk-pooling and cross-subsidisation between the young and old and the sick and healthy to protect households against the devastating financial consequences

of potentially catastrophic health events. Pooling also deals with the accumulation and management of contributions so that members of the pool share collective health risks, thereby protecting individual pool members from large, unpredictable health expenditures.

The PMB provisions in the Medical Schemes Act 131 of 1998 eliminate unfair discrimination on the basis of health status and address unfair risk selection by medical schemes by removing their ability to separate insurable and uninsurable (or less insurable) individuals through benefit design. PMBs, therefore, protect access to healthcare by protecting access to "insurance" for less preferred risks. The overall objective of the PMB package is to protect medical scheme members against severe financial and economic shocks associated with access to healthcare services.

Local experience and international evidence shows that there is a need to have a holistic regulatory approach to private healthcare. This approach should seek to regulate effectively and efficiently both the supply and the demand side of the market. The absence of such a balanced approach may ultimately result in a direct adverse impact on the provision, affordability, and long-term sustainability of the PMB package.

There are some people who will argue that the mandatory payment for prescribed minimum benefits (PMBs) in full by medical schemes, as envisaged by the Medical Schemes Act 131 of 1998, may result in medical schemes suffering significant financial prejudice in the long term and even possible bankruptcy.

This article focuses on the following issues regarding the PMBs:

- the importance of the PMB dispensation;
- the cost of PMBs;
- structural issues which impact on the affordability of medical scheme cover;
- the necessary processes which require to be put in place to ensure the long-term sustainability of the medical schemes industry.

Membership of medical schemes

Between 2000 and 2012, medical schemes membership grew from 6.7 million to 8.7 million lives. The enrolment numbers increased significantly from 2006 with the inception of the Government Employees Medical Scheme (GEMS); it led to 1.6 million more lives being covered between 2006 and 2011 within the restricted schemes market. The growth in the GEMS membership is probably the result of affordable contributions due to the subsidy policy of government.

Unfortunately there was no significant growth in the open schemes industry. The growth in membership is important for the protection of risk pools, especially growth in the younger age bands. This trend in membership can be seen in Figure 1.

Figure 1: Medical schemes membership 2000–2012

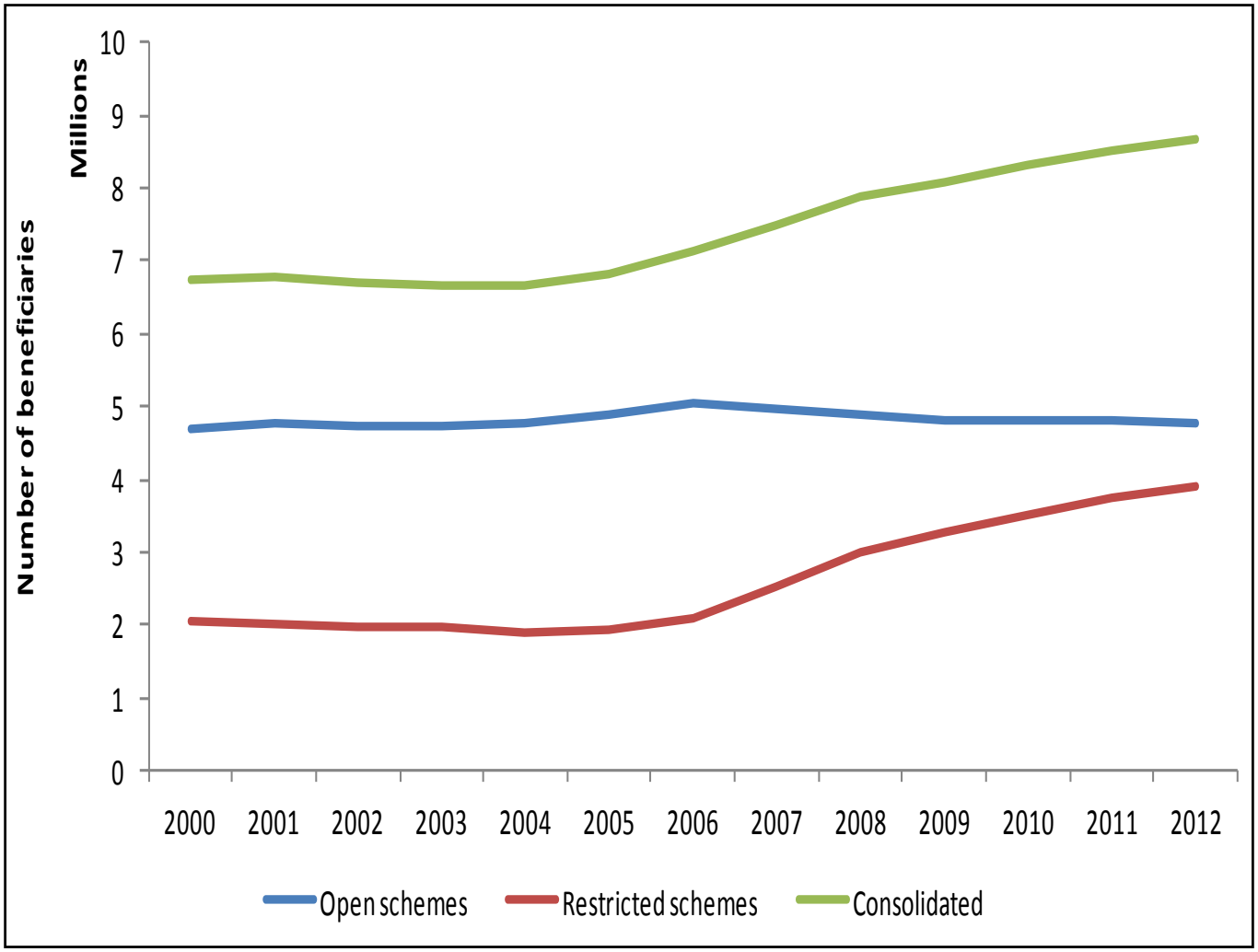
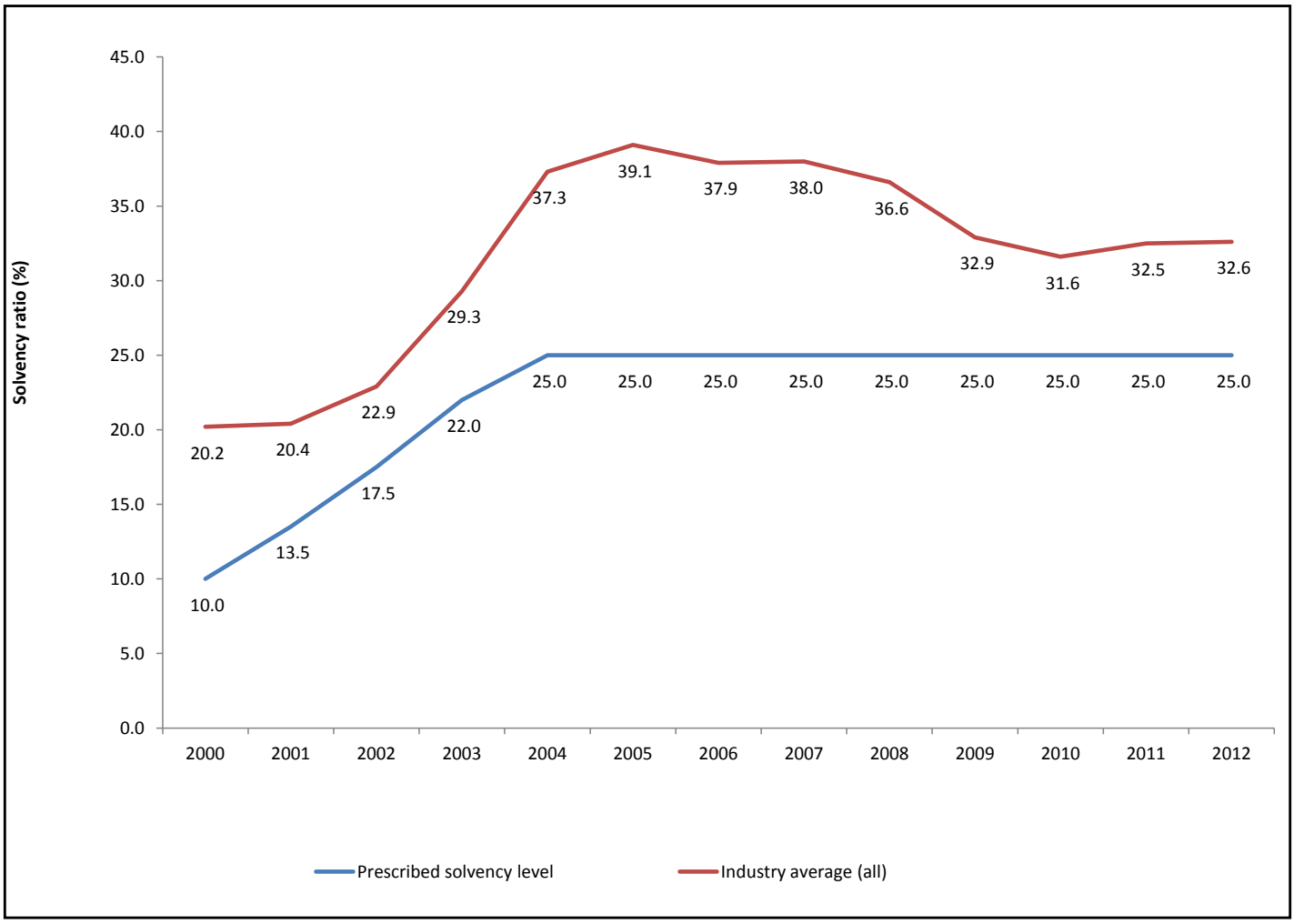


Figure 2: Solvency of the medical schemes industry 2000–2012



Solvency of the industry

The solvency ratio of the medical schemes industry from 2000 to 2012 is shown in Figure 2. The industry is healthy in terms of the reserves it has accumulated over time. The solvency ratio for 2012 was 32.6%, well above the statutory requirement of 25.0%.

The solvency framework is currently a discussion point in the medical scheme industry and there are stakeholders who argue that a risk-based solvency framework is more applicable to the medical scheme industry than the current 25% solvency level and those who support the risk-based solvency framework are of the opinion that the revised framework will save the industry money and will also make healthcare more affordable. Much more research is needed before an alternative solvency framework is adopted and the research must include a proper analysis on market structure and the impact that it will have on the industry in total and not only selected medical schemes.

Affordability and sustainability of the PMB package

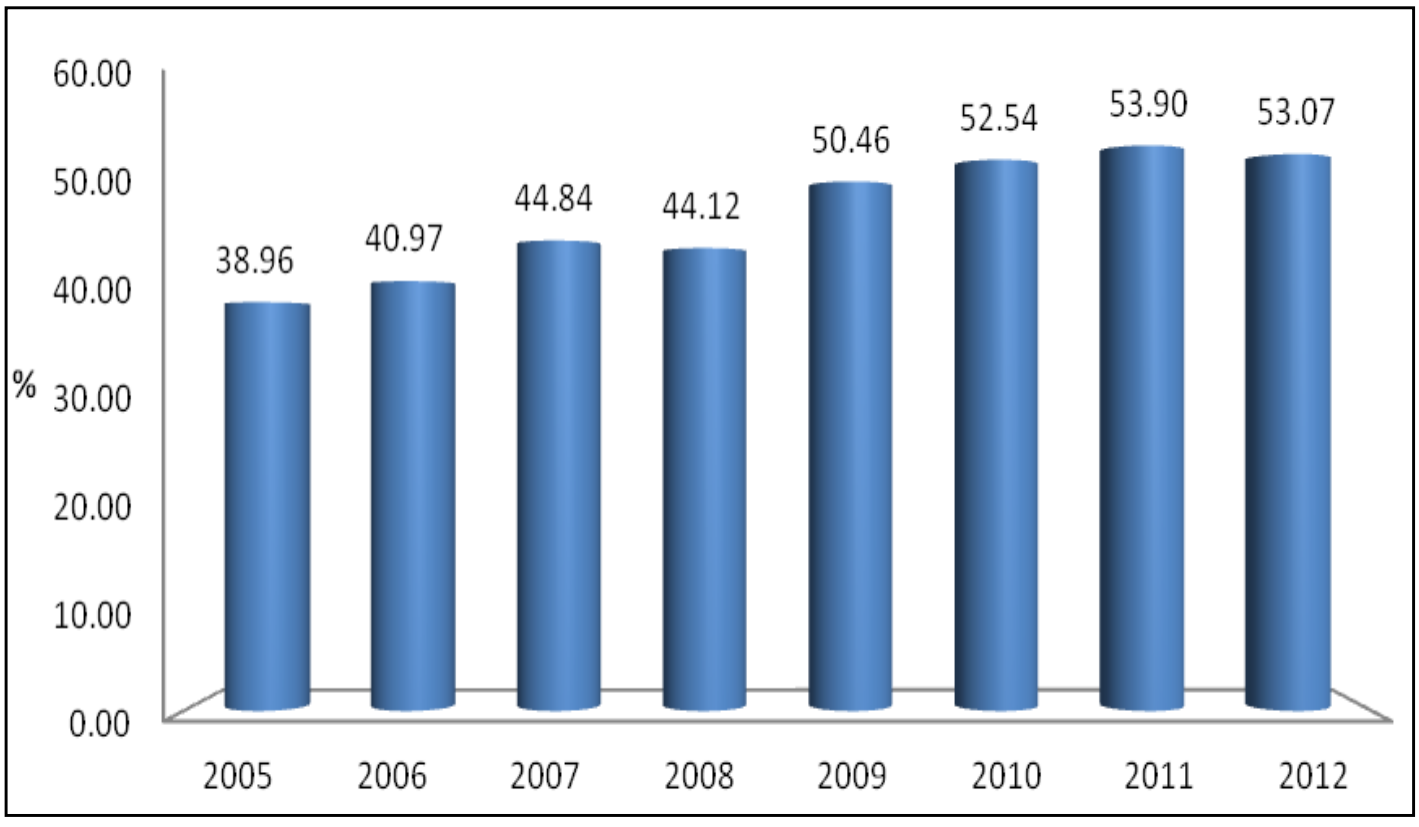
In 2002, the CMS commissioned the Centre for Actuarial Research to conduct research on the affordability of the PMB package within the medical schemes industry. This study found that "the complete PMB package was well covered within overall industry expenditure on benefits, and was therefore unlikely to put upward pressure on contributions. After meeting costs associated with the PMB package, schemes in general were observed to still have more than half of their pooled contributions available for other benefits and non-healthcare costs in excess of those already accounted for in the PMB price".

While the analysis on the affordability of the PMB package undertaken in 2002 showed positive results, Figure 3 shows a concerning trend with regards to the PMB cost (community rate) and risk benefits (Net Relevant Expenditure) between 2005 and 2012. Figure 3 shows that, over time, there has been a decrease in the risk benefit amount per beneficiary per month (pbpm) in relation to the PMB amount pbpm.

The PMB cost as a percentage of Net Healthcare Expenditure grew from 38.96% in 2005 to 53.07% in 2012, which is an indication that, over time, the PMB package has been crowding out other risk benefits, but overall 47% of risk benefits paid out by schemes are for non-PMB claim.

This observation could be as a result of a variety of demand- and supply-side factors such as changes in beneficiary profiles, coding practice, provider behaviour, and benefit option design, all of which influence the PMB cost in various degrees. Benefit option design and movement of beneficiaries between benefit options could also be a result of affordability issues where schemes over time reduced non-PMB risk benefits to stay competitive in terms of their contributions. Furthermore, the National Health Reference Price List (NHRPL) published by the Department of Health in 2009 was declared null and void by the Gauteng High Court, leaving a vacuum in the determination of tariffs within the medical schemes industry. However, medical schemes in total pay a significant proportion of risk benefits on top of the PMBs.

Figure 3: Cost of PMBs & benefits paid from the risk pool

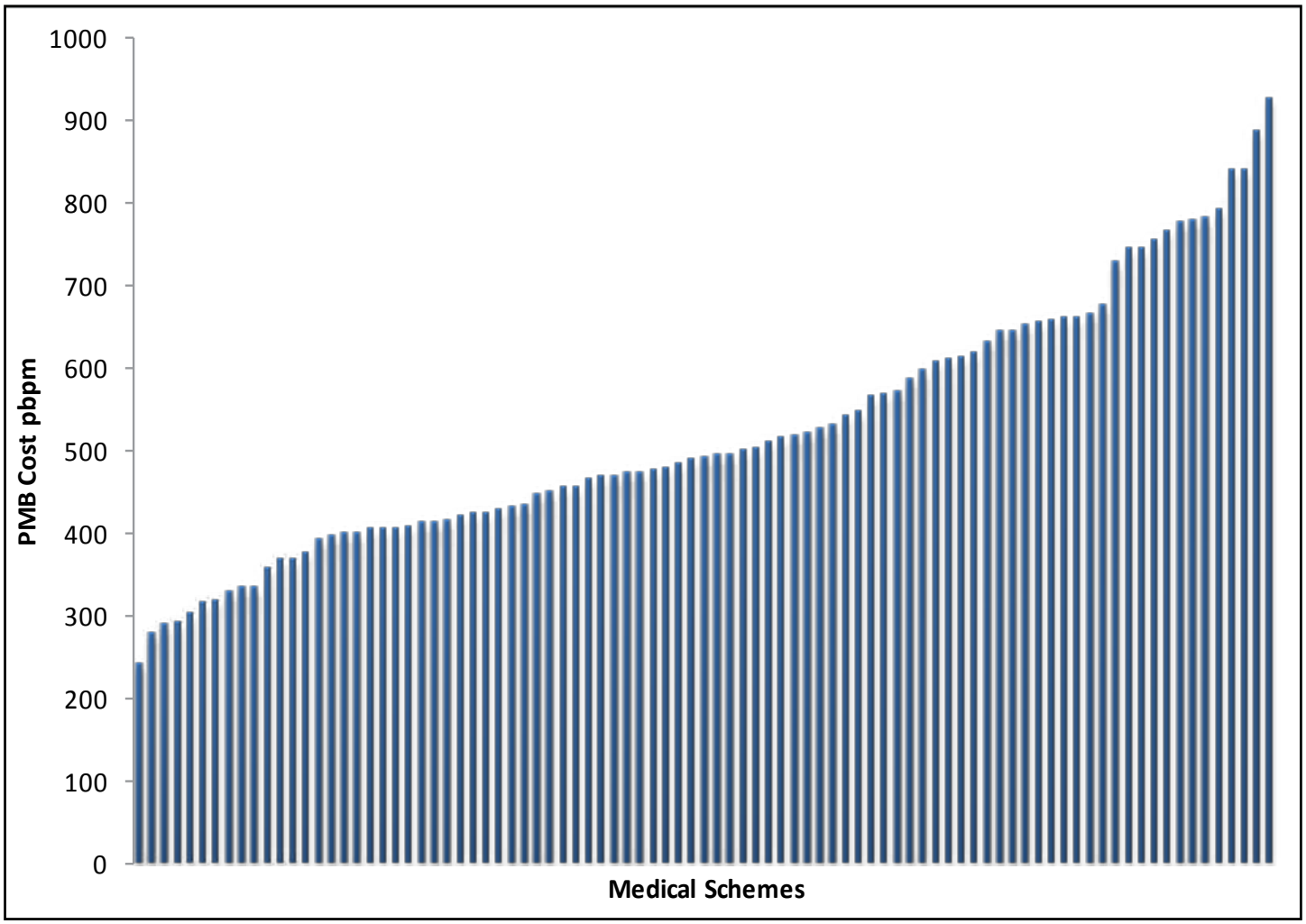


On provider behaviour, there has been poor harmonisation of regulatory provisions for the determination of the scope of provider practice and tariffs; this situation has led some providers (outliers) to abuse the PMB legislation. In addition, the CMS, through engagement with medical schemes, has been made aware that certain providers are abusing the definition of "payment at cost", resulting in a "blank cheque" approach where healthcare services are provided excessively and/or charged at higher fees for PMB conditions. It must, however, be noted that this is a minority group.

There have also been instances of "diagnosis creep", where related non-PMB conditions are coded as PMB conditions and remunerated at higher-than-average levels. Furthermore, there is a need to create an awareness among members to better their understanding of the meaning of "payment at cost" since this relates to the contracted designated service providers (DSPs) by medical schemes. Within this context, the level of supplier-induced demand continues to persist within a market that is highly concentrated.

The estimated cost of the PMB package per beneficiary per month (pbpm) per medical scheme for 2012 is shown in Figure 4. The cost varies between R240.60 pbpm and R925.32 pbpm. Figure 4 also illustrates that medical schemes are facing different risks. Based on differences in the risk profiles of medical schemes, it is clear that they do not compete on equal grounds. A system of risk adjustment is crucially required to adjust the risk so that all medial schemes compete on equal ground; this would force medical schemes to be more efficient.

Figure 4: Estimated cost of PMBs per scheme for 2012



The estimated cost of the PMB package for the industry for 2013 is R508.20 pbpm. Unfortunately the CMS does not have access to personal income information which could be used to calculate the cost of PMBs as a percentage of income for the medical schemes industry. The Household Survey by StatsSA could also be helpful to calculate affordability ranges of the PMB package and healthcare cover in general. The CMS is in the process of improving its systems to enable it to collect more detailed information on PMBs.

Furthermore, it would appear that the medical schemes industry has experienced an increase in the prevalence of chronic conditions between 2006 and 2012 (possible change in risk profiles). The top 10 chronic conditions that demonstrated the fastest growth within this period were hypertension (HYP), hyperlipidaemia (HYL), diabetes mellitus type 2, hypothyroidism, glaucoma, rheumatoid arthritis, bipolar mood disorder (BMD), Parkinson's Disease, chronic renal disease, and systemic lupus erythematosus (SLE), which is an autoimmune disease. Bipolar mood disorder experienced the highest increase in this period.

However, it is not possible at this stage to isolate the different components of the trend, i.e. changes in beneficiary profiles, coding practice, provider behaviour, and benefit option design. It is not clear if this trend represents a real increase in the prevalence of the chronic disease conditions, but it is important to monitor the trend and to collect further information on PMBs. The trends can be seen in Figures 5 to 7.

Figure 5: Top 10 most prevalent CDL conditions in 2012: 2007 – 2012

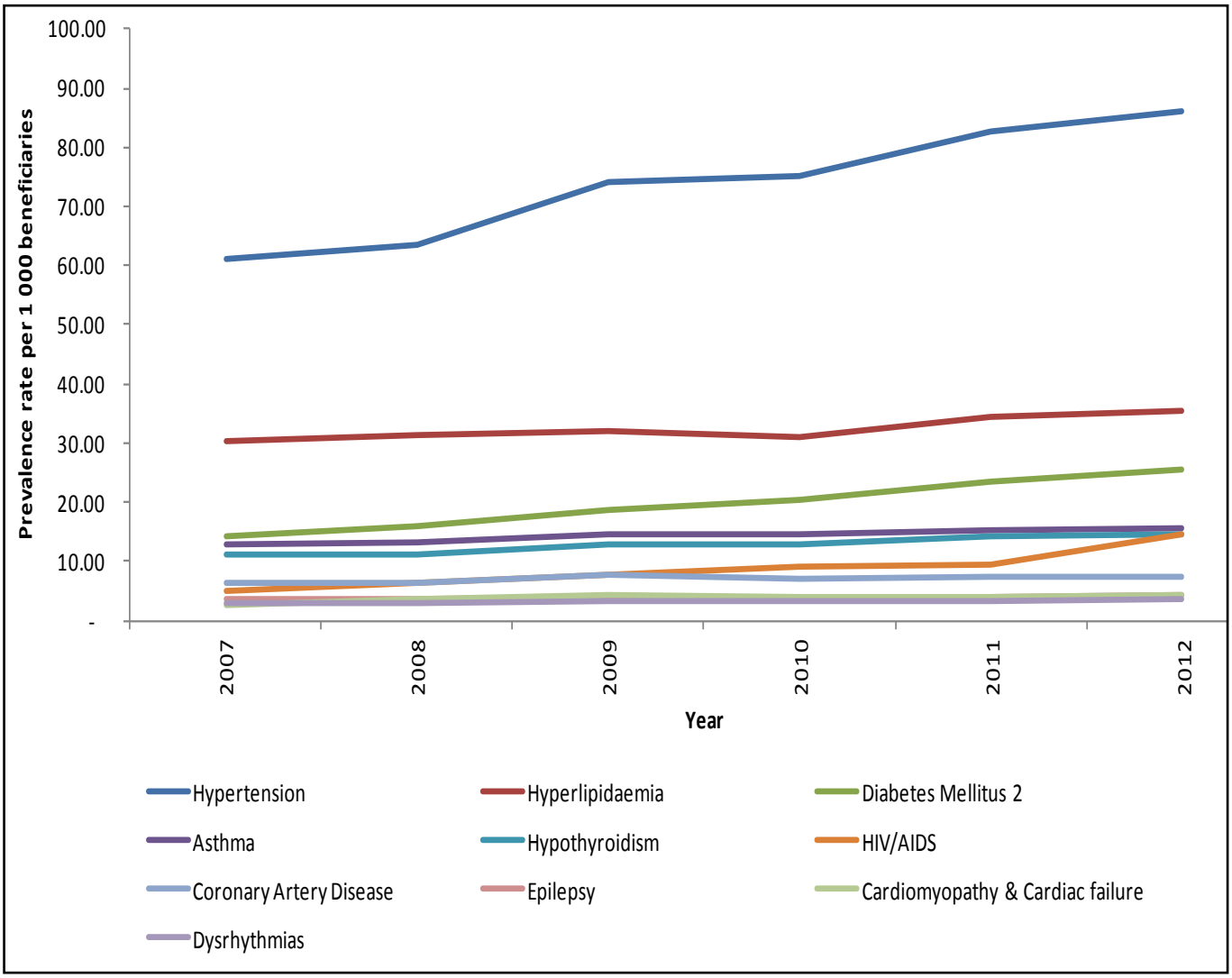


Figure 6: Top 8 most prevalent CDL conditions in 2012: 2007 – 2012 (HYP & HYL omitted)

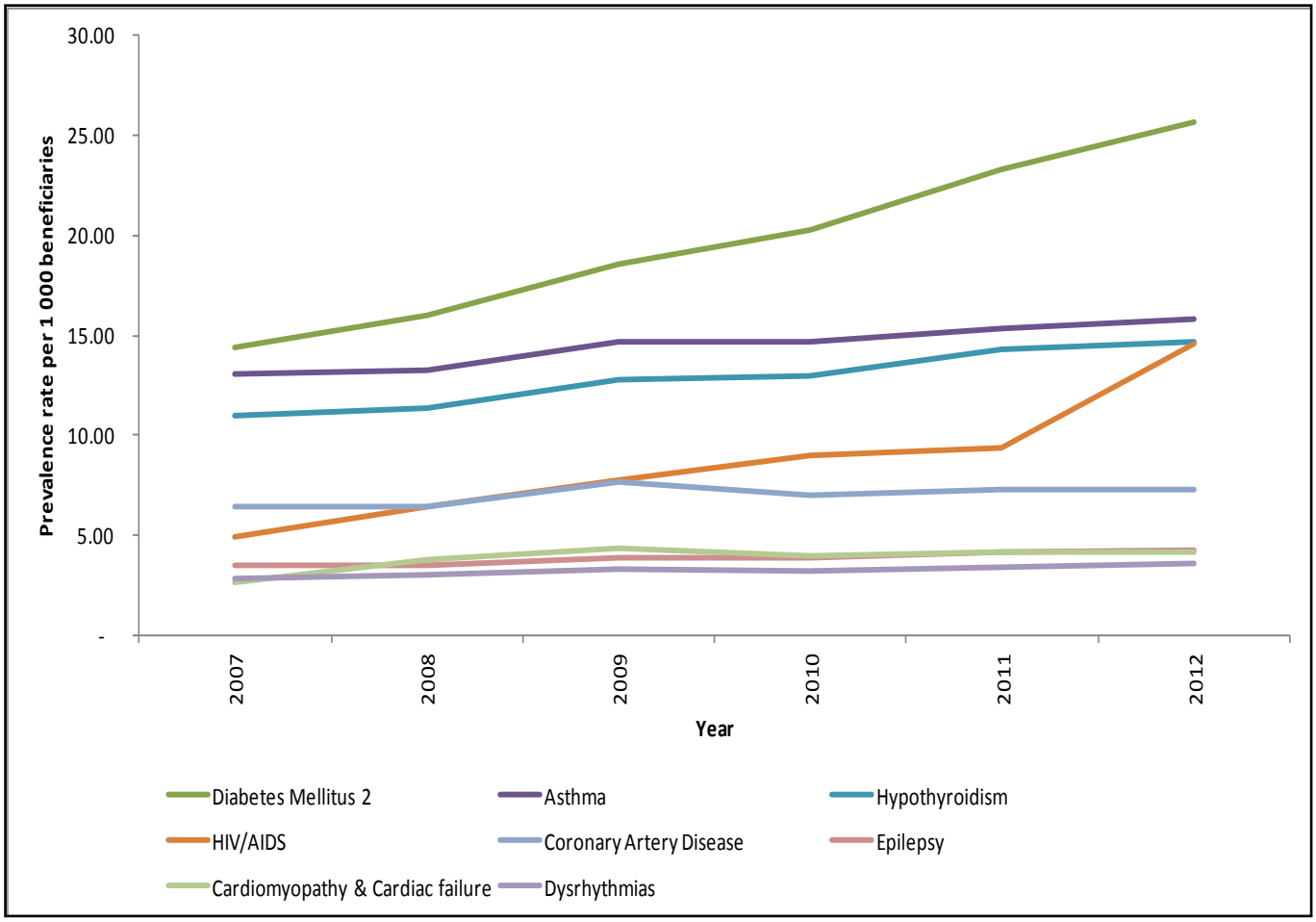
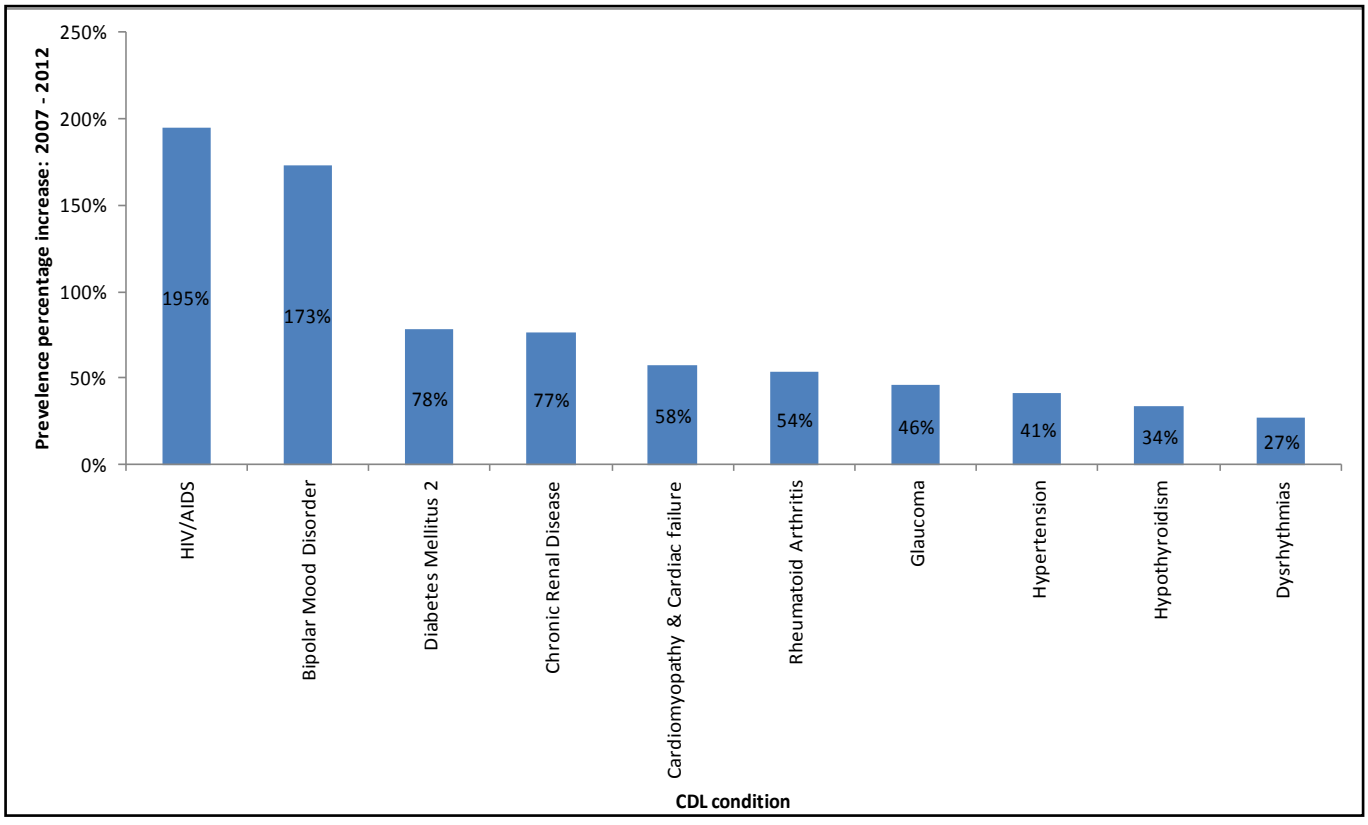


Figure 7: Top 10 fastest increasing CDL conditions: 2007– 2012



Medical schemes manage this behaviour through regulated managed care interventions such as contract arrangements to provide full cover to members at better rates, but schemes which tend to benefit from such arrangements are those that have economies of scale compared to the small and medium schemes. Most schemes are price-takers during tariff increase negotiations, especially in the absence of tariff guidelines.

Structural issues affecting affordability of the PMB package include the following:

- Absence of mandatory membership by the employed population
  * This limits the cross-subsidisation between the young and old, the healthy and sick.

- Absence of a risk adjustment mechanism
  * Such a mechanism is required to assist in the redistribution of risk among medical schemes. Its continued absence results in a skewed market structure where some schemes continue to benefit from their risk profiles while others continue to experience worsening demographic profiles.
- Price regulation
  * Collective bargaining within the industry is critically important to address supply-side price issues.

- Healthcare technology assessment
  * Uncontrolled introduction of new healthcare technology may result in cost increases without an improvement in the quality of care.

- Continuous PMB review
  * The Medical Schemes Act 131 of 1998 prescribes that the PMB Regulations must be reviewed at least every two years.
  * A revision of the PMB definitions may make the PMB package more affordable.
  * The PMB Code of Conduct should be revised. (A consultative process was followed in 2010 with the medical schemes industry to establish a PMB Code of Conduct and the same process should be followed in the revision of the Code of Conduct.)
  * The CMS and the Department of Health should speed up the revision process of the PMB definitions, and crucial assistance and support from the Department of Health is required to ensure that the Regulations on the revised Chronic Diseases List (CDL) algorithms are timeously published.

- Beneficiary registry
  * A beneficiary registry would allow the CMS to monitor the movement of beneficiaries between benefit options and medical

schemes (risk profiling). It could also assist in calculating family income. If linked to the South African Revenue Service (SARS), it would also be very helpful in affordability studies and support the development of the proposed National Health Insurance (NHI) Fund. The Department of Health could use the beneficiary registry to verify medical scheme membership when members utilise state facilities.

- Health insurance products
  * There is a need to understand the relationship between PMB coverage and the uptake of health insurance products (demarcation).
  * Health insurance products inherently risk rate individuals thus discriminate on the basis of their demographic and health profile. PMBs do not discriminate against members' health status or benefit options they belong to. PMBs do not risk rate on the basis of health status of individuals.

- Solvency framework
  * More research is needed to understand the impact of different solvency frameworks on the industry. The research must include a proper analysis on market structure and the impact that it will have on the industry in total and not only selected medical schemes.

- Benefit design
  * The review process of the PMBs and clarity on the envisaged benefit package in government's white paper on National Health Insurance (NHI) will inform possible changes to the PMBs. One can also argue that the current PMBs are predominantly curative and that it should be expanded to include more preventative care.

Conclusion and recommendations

The provision of the PMB package forms a crucial cornerstone of the legislation governing the medical schemes industry and presents an essential buffer against the dumping of medical scheme members on the overburdened public health system. In essence, the PMB package is materially sound, non-discriminatory against members and there is no reason to have any cause for concern. While the observed trends are a concern, there are nevertheless solutions to address the systemic problems facing the private health sector. It is important that the medical schemes industry, the CMS, and the Department of Health cooperate very closely to consider proper academic exploration and researched economic arguments to implement the solutions.

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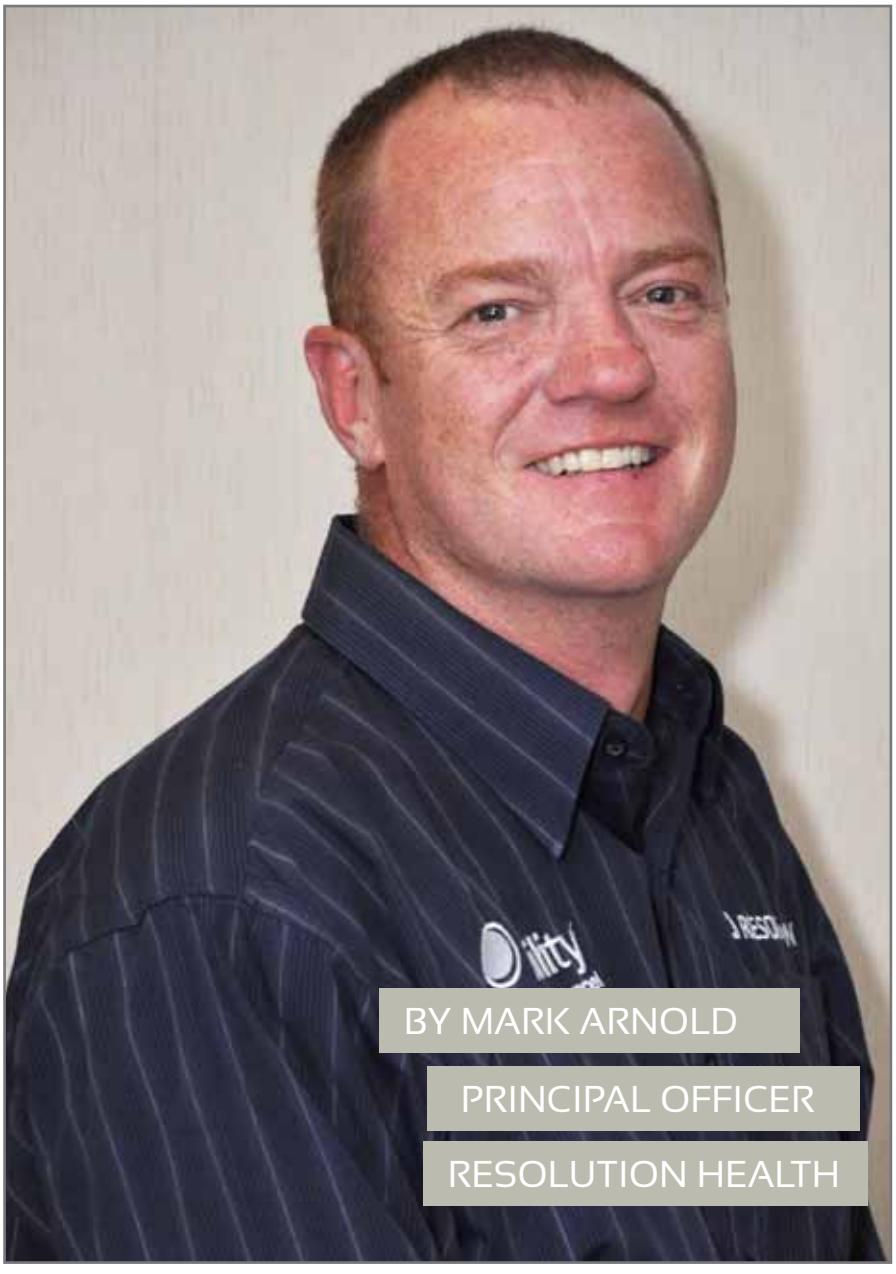
LEVELLING THE PLAYING FIELD WITH THE AID OF PMBS



BY MARK ARNOLD

PRINCIPAL OFFICER

RESOLUTION HEALTH

While prescribed minimum benefits (PMBs) have certainly had the added advantage of helping to ensure a minimum level of cover for medical scheme members, they have also had some less positive, quite unintended consequences for the healthcare funding industry that are important to consider. One of the more significant consequences is that PMBs have made it extremely difficult for medical schemes to maintain control of healthcare costs.

By law, medical schemes must cover the treatment of more than 270 medical conditions in hospital and 26 chronic diseases defined in the Chronic Disease List (CDL), as well as all emergency conditions.

Largely due to PMBs, even the cheapest benefit packages provided by medical schemes put private health-

care insurance out of reach of most South Africans before even covering any additional benefits. The setup of a task team by the Council of Medical Schemes (CMS) back in 2006 to investigate how a Low Income Medical Scheme (LIMS) option could be established using a different set of PMBs for low-income members unfortunately failed to gain a foothold in the industry.

The strategy proposed by the task team included various principles to curb costs and ensure more affordable healthcare funding models as part of the previously envisaged Social Health Insurance (SHI) model. Principles included the introduction of PMBs, cross subsidisation of PMB benefits via the Risk Equalisation Fund, as well as mandatory cover for all formally employed citizens. Within such a scenario, medical scheme coverage would have increased to approximately 15 million lives, immediately releasing the burden on the state while ensuring more affordable coverage to formally employed citizens.
PMBs were intended to form part of a broader risk pooling exercise, which unfortunately never materialised. As a result, we are now left with only one piece of a broader strategy, leading to escalating costs throughout the healthcare industry to the detriment of medical schemes and their members.

The situation has been exacerbated due to the pricing of PMBs not being regulated. Some providers are charging as much as 500% or more than the recommended tariffs for PMBs because they know the schemes have to cover them by law. Providers are consequently not willing to contract at lower tariffs and are able to charge such high fees because of a shortage of and great demand for their highly specialised skills. Health Minister Dr Aaron Motsoaledi has long said that a hospital-centric structure and rampant commercialisation in the private health sector are contributing to driving up costs. According to the CMS, hospital services accounted for 36.7% (R37.9 billion) of scheme benefits paid to healthcare providers in the 2012 financial year while specialists accounted for 23.3% (R24 billion) of this expenditure.

We believe that there is a need to go back to a more primary care-focused model in the private sector. So, for example, medical scheme members should be channelled through GPs instead of being allowed to go straight to specialists. However, the PMBs in their current form discourage such behaviour and instead tend to encourage hospitalisations.

South Africa's private medical funding industry, compared to most other countries, covers a very rich set of benefits the equal of which is not to be found elsewhere in the

world. This situation is exacerbated due to very few private patients using state sector hospitals as a treatment option as is the case in developed countries. In addition, the competitive nature of the private healthcare environment further aggravates the situation and helps prevent schemes from driving down costs.

What is needed is a regulatory model that places all medical schemes on an equal footing so that schemes can reward GPs for quality outcomes. This would ensure that care is not compromised and significantly improved.

Implementing a patient-centred healthcare system where schemes' funds are freed up to cover more preventative care, such as regular diagnostic tests and health screenings, would ensure that members require less hospitalisation. Schemes could still provide continuous care to members with fewer PMBs, or at least have the tariffs regulated for PMBs within specified limits.
A two-tiered PMB structure, with a shorter, more primary care-orientated list of PMBs for lower income earners, could assist medical schemes in providing more affordable healthcare coverage to those who previously could not access it.

The implementation of PMBs and subsequent scrapping of the National Health Reference Price List (NHRPL) by the High Court exacerbated the problem. The establishment of a framework within which funders as an industry could negotiate and agree tariff structures with health service providers will assist in controlling the rising costs associated with PMBs. If medical schemes need to pay for all PMB treatments and medications, it is important for schemes to be able to influence the costs of this by agreeing to an upfront Reference Price List (RPL) with hospital groups and healthcare specialists.

> *"The situation has been exacerbated due to the pricing of PMBs not being regulated".*

WHAT IS **PMB LEVEL** OF CARE?

BY DR MAMAQHAWE A. HOOHLO

SENIOR MANAGER: CLINICAL UNIT

COUNCIL FOR MEDICAL SCHEMES

The Medical Schemes Act of 1998 (MSA) provides a legal framework for what prescribed minimum benefits (PMBs) are and what PMB level of care consists of. At a practical and multiple stakeholder level the articulation of PMB level of care is complex, however, this brief article attempts to highlight a few of the principle tenets behind answering what is PMB level of care.

Why ask?

PMB level of care is essential healthcare, subject to a review process. It is a minimum basket of care that all members contributing to the risk pool are entitled to. Members are not prejudiced based on the level of contributions they can afford. It provides fairness and ensures that regardless of members' health status and risk all scheme members have access to a basic level of health protection.

A presumption of appropriate clinical and financial management is made that ensures that PMB level of care results in health protection of members while safeguarding the financial viability of the medical scheme. This last responsibility is shared by the appointed officials in the governance structures of the medical schemes. By extension, a well-informed member base then shares this responsibility with the officials to ensure access to PMB level care is sustainable.

Sweet and short

PMB-level of care is summarised as Diagnosis and Treatment Pairs (DTPs) found in Annexure A of the Regulations of the MSA and in the Therapeutic Algorithms for Chronic Conditions, the Chronic Disease List (CDLs). The level of care includes diagnosis, treatment and care with respect to the DTPs and CDLs. As espoused in the Code of Conduct in respect of PMB benefits published in 2010, the prevailing practice in the State is deemed the PMB level of care. The Council for Medical Schemes has been progressively coordinating with stakeholders to define PMBs wherein the level of care, with respect to diagnosis, treatment, and care, is clearly articulated. The process is underpinned by the principles of evidence-based medicine, cost effectiveness, and affordability.

It's complicated

The MSA further empowers medical schemes to ensure both appropriate clinical and prudent financial governance of the schemes with regards to PMB level of care. Within the bounds of evidence-based medicine, proven cost effectiveness, and affordability, the schemes may put into place scheme rules with regards to PMBs. These rules can include use of managed care protocols and formularies. The schemes may also stipulate the use of designated service providers (DSPs). Effective and demonstrable communication to members is the cornerstone of ensuring that these interventions are adopted by members and are seen as valid financial risk interventions. Where these interventions prejudice the access to the PMB level of care significantly for members then they cannot be used as a restriction to full access of care, nor would the members incur a co-payment penalty. A simple example would be an available DSP whose suite of services does not cater for a member's specific PMB condition.

Exceptions to the measures above in accessing PMB level of care is in emergencies. Members access emergency care as PMB level of care. This feature extends to all settings, levels of health care, and stages of treatment. Emergency care thus is not subject to possible managed care processes such as pre-authorisation or restrictions such as use of DSPs. As espoused in the PMB code of conduct, provider responsibilities include ensuring that emergency care is clearly identifiable in claims. PMB level of care may also extend to clinical interventions outside of the stipulated protocols and formularies in exceptional circumstances. Where the protocol has been used and is no longer effective, an evidence-based, proven and appropriate alternative may be used. This deviation is subject to the same cost effectiveness and affordability test as protocols and formularies in place. This same exception extends to clinical interventions in protocols and formularies that pose a risk of an adverse event on the member.

Clinical practice is an evolving field in both the public and private sectors and at varying rates for different health conditions. Tracking those changes and ensuring the PMB level of care is defined and fine-tuned, adds to the complexity of what constitutes PMB level of care. It is a simple answer that is riddled with rules and exceptions, and resting on shifting ground.

KNOW YOUR **CONSUMER RIGHTS**

What should you know before joining a medical scheme?
What are your rights as a member?
Who do you go to if you have a grievance?

In South Africa March is dedicated to the rights of ordinary consumers. Many organisations use this time of year to intensify their awareness programmes on consumer rights. The Consumer Protection Forum (CPF) is one such organisation and member organisations under the CPF banner organise and coordinate joint programs to ensure that ordinary consumers are empowered, specifically in March and throughout the year.

Members of the forum include regulatory bodies such as the Council for Medical Schemes (CMS), Financial Services Board (FSB), Independent Communications Authority of South Africa (ICASA), National Credit Regulator (NCR) and National Energy Regulator of South Africa (NERSA), as well as Provincial Consumer Directorates for all nine provinces in the country.

The Council for Medical Schemes was established under the Medical Schemes Act 131 of 1998. The organisation is mandated to regulate the medical schemes industry, thus ensuring that consumers have fair and equitable access to medical care. Furthermore the organisation has a duty to educate the public and to resolve disputes related to medical schemes free of charge.

WHAT SHOULD I KNOW BEFORE JOINING A MEDICAL SCHEME?

1. Do your research before selecting a medical scheme to make sure that the scheme meets your needs.
2. Find out what other medical schemes offer and compare them. This can be done through active research of comparing medical scheme benefits and rates.
3. Understand what prescribed minimum benefits are and under what circumstances the chosen scheme provides such cover to you.
4. Find out the chosen medical scheme's reserves (solvency ratio), and non-healthcare expenditure, such as administration costs, to ensure the right medical scheme is selected for your needs and that they are in good financial health.
5. If you already have a medical aid, have a closer look at the various options your own scheme provides. By doing so you could substantially reduce your monthly contributions.
6. Do not use your medical savings to buy sunglasses and other non-medical items, as you could need your savings when emergency hits.
7. Attend your scheme's Annual General Meeting to meet its Board of Trustees and nominate new Trustees to serve on the Board.

WHAT ARE YOUR RIGHTS AS A MEMBER OF A MEDICAL SCHEME?

1. You need to be aware that the Medical Schemes Act prescribes that at least 50% of the Board of Trustees (the governing body of a scheme) must be elected among the scheme members and by the members.
2. You have an obligation to always take part in the annual general meetings where members may voice opinions, ask questions and present motions.
3. Information is a powerful tool; consumers are advised to always be informed when making decisions that impact on their finances and health. This will ensure that they are acquiring the right products/services in relation to their needs and financial situation. What better way to further enjoy the benefits of this right than participating in some of the decision-making processes?

HOW DO I LODGE A COMPLAINT WITH CMS?

As a medical scheme member, it is your right to complain whenever you feel that you have been treated unfairly. Complainants are advised to follow the due process tabulated below for an efficient resolution of their disputes.
To initiate the complaint process the complainant must:

1. Lodge a complaint with the scheme – with the principal officer then the dispute committee if you're not satisfied with the response from the principal officer.
2. If no resolution was reached, lodge the complaint with the Registrar's Office at the Council for Medical Schemes (CMS).
3. CMS will escalate the complaint to full Council in cases of no resolution.
4. If there is still no resolution, the matter will be served at the Appeals Board.

HOW TO CONTACT THE REGISTRAR'S OFFICE, FULL COUNCIL AND APPEALS BOARD

Website
www.medicalschemes.com

Physical Address
Block A,
Eco Glades 2 Office Park,
420 Witch-Hazel Avenue,
Eco Park,
Centurion,
0157

Postal Address
Private Bag X34,
Hatfield,
0028

Phone
0861 123 CMS (267)
(012) 431 0584 (Complaints Call Centre)

Fax
(012) 431- 0560 (Complaints Fax)

Email
complaints@medicalschemes.com

Consumers are reminded to always be cognisant of their rights as well as responsibilities in order to make the right decisions which impact their financial and health situation.

CMS News

COUNCIL FOR MEDICAL SCHEMES

This is a publication by the Council for Medical Schemes (CMS)

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