

The ABC of PMBs

This is a newsletter dedicated to prescribed minimum benefits – or PMBs in short. Published by the Council for Medical Schemes, regulator of the industry, CMScript aims to provide consumers with useful information on those diseases and conditions that each medical scheme must cover in full.

What are PMBs?

PMBs are the minimum – as opposed to maximum – healthcare benefits which must be covered by each medical scheme in South Africa. These benefits are prescribed by the Minister of Health as mandated by the Medical Schemes Act.

Your scheme must pay for the diagnosis, treatment and care of your PMB conditions in full, without imposing co-payments or using Any deductibles, and it must pay for them from its risk pool; your savings account cannot be used to fund PMBs.

Important to remember is that you are entitled to PMBs regardless of the benefit option to which you belong; whether you are on the low-cost hospital plan or the most comprehensive option is irrelevant. (Medical schemes do offer hospital plans but they differ from those of traditional insurance companies precisely because they cover PMBs – and because medical schemes, unlike other insurance vehicles, are not allowed to risk-rate.)

PMBs protect households against catastrophic health events. We all fall ill; we all grow old. And accidents do happen.

What is covered?

PMBs cover the most serious and often life-threatening conditions and diseases, and specifically those that are non-discretionary. PMBs cover the diagnosis, treatment and care of the following:

- any emergency medical condition
- 270 diseases called the Diagnosis and Treatment Pairs or DTPs, including cancer and hypertension
- 26 chronic conditions on the Chronic Diseases List or CDL, including diabetes, epilepsy and asthma

Although PMBs must be funded in full, the Medical Schemes Act does allow schemes to use certain measures to manage the financial risk associated with the unpredictable health needs of their members.

It is extremely important that you understand the implications of these measures so that you do not end up facing co-payments.

What measures do schemes use to manage PMB costs?

Designated service providers or DSPs are healthcare providers such as doctors, specialists and hospitals which have entered into agreements with schemes to provide their services at a negotiated price. Each scheme has its own DSPs and using the correct DSP for your PMBs guarantees that your scheme will cover your PMB conditions in full (at cost). If you choose to use a non-DSP, you may face a co-payment.

A medicine formulary is a list of medications that the scheme is willing to fund for the treatment of PMB conditions. Feel free to ask your scheme for the formulary list for your specific benefit option and discuss the available medicines with your doctor. If you choose to use medicine not listed on the formulary, the scheme is allowed to charge you a co-payment. But there are specific circumstances where schemes cannot enforce a co-payment and must make provision for appropriate exceptions or substitutions, including where the formulary medicine has proven ineffective or would cause you harm or an adverse reaction.

Section 29(1) (o) of the Medical Schemes Act gives the Minister of Health the power to prescribe the scope and level of PMBs, and this is done in Regulations 7 and 8 of the Act.

The care provided in respect of PMBs cannot be less than that provided to a patient treated in a state facility.

Managed healthcare protocols must be developed on the basis of evidence-based medicine and must take into account considerations of cost-effectiveness and affordability. Medical schemes must provide their protocols to healthcare providers, beneficiaries and members of the public if asked to do so.

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