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Date: July 2006

Circular No. 32 of 2006

IMPLEMENTATION OF PRESCRIBED MINIMUM BENEFITS

1. Introduction

The existing regulatory framework makes provision for a minimum set of benefits which all medical schemes must cover. These are the prescribed minimum benefits (PMBs), which have been defined in terms of Regulations 7 and 8. The Medical Schemes Act also provides for the manner in which the PMBs should be implemented.

We are aware, though, that these legislative provisions that define PMBs have not always been applied in a consistent manner. There are far too many instances where medical schemes, administrators and providers attach different interpretations to these PMB provisions and apply them differently. This has consequences for members' access to appropriate care, legal entitlement to prescribed benefits, quality and continuity of care, among others. There are also particular consequences for providers, medical schemes and the Regulator.

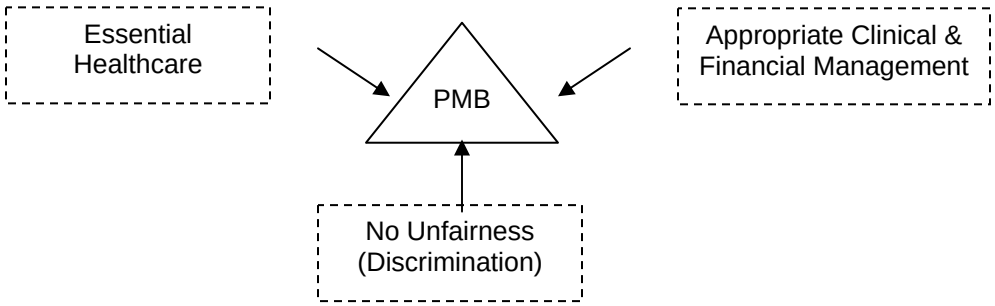
The Registrar of Medical Schemes convened a workshop recently on the implementation of PMBs. This workshop, which was attended by over 200 delegates, discussed the most pressing problems on PMB implementation in order to **engender certainty** on how these provisions should be given effect. The workshop also focused on identifying appropriate actions that all stakeholders need to take in order to meet their obligations in this regard.

This circular reflects our interpretation of the PMB provisions in the Act and applicable regulations.

2. Philosophical and policy foundations of the PMBs

There was broad agreement with the overall policy underpinnings of the PMB legislation – that medical schemes premiums should first cover essential, non-discretionary benefits and only

then be allocated to more discretionary services. The delegates furthermore noted the need to protect essential healthcare while also providing medical schemes with the ability to apply appropriate clinical and financial management techniques.



Regulation 7 defines PMBs to "…*consists of the provision of the diagnosis, treatment and care costs of –*

(a) the diagnosis and treatment pairs listed in annexure A, subject to any limitations specified… and
(b) any emergency medical condition;"

Regulation 8 requires that (subject to some specified instances) *"… a medical scheme must pay in full without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions."* The specified instances referred to above relate to the use of **designated service providers or managed care tools** to enable a medical scheme to manage its risk.

3. Having established the policy and legal foundations of the PMBs, the workshop focused on five key concerns with the implementation.

3.1 Are PMBs hospital-based only or can they be provided on an ambulatory basis?

We have already referred above to Regulation 7 that defines a **"**prescribed minimum benefit condition" as a condition contemplated in the diagnosis and treatment pairs listed in annexure A of the Regulations or any emergency medical condition.

The determination of whether a condition is a PMB is therefore **diagnosis** based, irrespective of any other influences. Once the diagnosis has been made, the appropriate care (treatment) is decided upon, and, the most appropriate setting is determined.

The Act and the Regulations do not specify the setting for the management of PMBs. To the contrary, explanatory note (2A) states clearly that, in respect of treatments denoted as "medical management" or "surgical management," note (2) describes the *standard* of treatment required, namely "prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition." Note (2) does not restrict the setting in which the relevant care should be provided, and should not be construed as preventing the delivery of any

prescribed minimum benefit on an outpatient basis or in a setting other than a hospital, where this is clinically most appropriate. The one exception in this regard is in the case of the mental illness chapter where mention is made of 'hospital-based management'.

Medical schemes are therefore required to provide benefits in respect of PMBs for services rendered on an outpatient basis or in a setting other than a hospital where this is clinically appropriate.

Schemes may, of course, use clinical and financial tools to manage PMBs. The workshop agreed on the need to investigate appropriate standardisation as one way of enhancing the schemes' ability to manage PMBs.

3.2 Designation of the public health sector as a DSP for PMBs

Regulation 7 defines a "designated service provider' (DSP) as *"a healthcare provider or group of providers* ***selected*** *by the medical scheme concerned as the preferred provider or providers to provide to its members diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions".*

The key requirements of the regulations are that:

- Members should be able to gain access to care for the prescribed minimum benefits without financial obstacles in at least one reasonably available setting, and
- Where a designated service provider is unable to accommodate or treat a member, the medical scheme remains liable for the full costs of the PMBs.

The Regulations permit medical schemes to designate the public sector as their DSP. Schemes are, however, obliged to assess whether services will be reasonably available and accessible to members. The Registrar's office will, during the process of registration of scheme rules, critically evaluate whether schemes have made a proper identification of DSPs and whether these services are reasonably available to members. Scheme rules that are found to have arbitrarily designated the public sector as a DSP without assessing whether services are reasonably available will be turned down.

It is therefore advisable for schemes to assess the availability of public sector services through contracting with the public sector or to explore provision of PMBs in other settings.

3.3 PMBs, tariffs, co-payments and deductibles

Medical schemes are obliged to pay the costs of PMBs in full and without co-payments or deductibles were members obtained such service from the DSP. This is also the case in those instances where a member obtains services involuntarily from a non-DSP. A co-payment may be levied where a member voluntarily obtains services for PMBs from a non-DSP provider. Schemes need to be careful that the level of the co-payment does not result in an effective denial of a PMB benefit.

The workshop also identified a concern that specialists have in general resisted DSP arrangements with schemes; sometimes on the basis that the ethical rules of the Health Professions Council (HPCSA) require that contracts be made available to all providers. It was reported that this has in some cases resulted in schemes facing high charges for PMBs. While this is a matter that we need to return to and find appropriate solutions, it was noted that it is important for schemes to communicate the PMB benefits clearly to members. It should also be understood that provision for full payment of PMBs applicable to involuntary use of non-DSPs is about guaranteeing access to care, and is not about providing a "blank cheque" to providers. It is primarily about addressing the issue of schemes defaulting PMB cover to a single provider (e.g. the public sector) and then denying members access to PMB benefit in the event of unavailability of service from that provider. Consequently it ought to be appropriate only in exceptional circumstances, and not as the "normal" form of reimbursement for PMBs.

3.4 PMBs, treatment protocols and formularies

Regulation 15H and 15I requires that protocols and formularies:

(a) ..... "must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability;"
(b) .... must be provided "to health care providers, beneficiaries and members of the public, upon request;" and
(c) ...must make provision "for appropriate exceptions / substitution ...where a protocol has been ineffective or causes or would cause harm / adverse reaction to a beneficiary, without penalty to that beneficiary".

The key requirement here is to make these protocols and formularies transparent and available so that members and others can judge the extent to which these protocols and formularies are based on evidence. It is also important for medical schemes to develop policies in line with Regulation 15H (c) with regard to appropriate substitution of drugs on their formularies.

The workshop also noted the mechanism provided in the Regulation for resolution of disputes on protocols. Explanatory note 2 to annexure A states that *"...where significant differences exist between public and private sector practices, the interpretation of the Prescribed Minimum Benefits should follow the predominant public hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist. Where clinical protocols do not exist, disputes should be settled by consultation with provincial health authorities to ascertain prevailing practice."*

Many delegates felt that this mechanism is inadequate and unworkable, and it was agreed that more work needs to be done to provide greater clarity on this issue. It was suggested that CMS facilitate the development of protocols in terms of this section, in an effort to help improve access to essential healthcare. The protocols will ensure consistency in the application of the legislation.

3.5. PMBs, condition specific waiting periods and disclosure of pre-existing conditions

The meeting noted the view that imposition of waiting periods is a tool aimed at mitigating adverse selection. These waiting periods should not be imposed in a manner that is inconsistent with the provisions of the Act.

A condition specific waiting period is defined in the Act as meaning:

> "…*a period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the twelve-month period ending on the date on which an application for membership was made;"*

Condition-specific waiting periods may accordingly only be legally imposed in respect of conditions that an applicant suffered from during the ***twelve (12) month*** period before an application for membership of the scheme is made.

Whilst medical schemes may be entitled to request health related information from members in order to manage certain sickness conditions, condition-specific waiting periods may under no circumstances be imposed on members for conditions falling outside the 12 month period referred to in the Act. People who were beneficiaries on another medical scheme for at least two years and apply to join another medical scheme within three months are also not liable for imposition of a condition specific waiting period.

Once a scheme has elected to apply a waiting periods, these must also be applied consistently to all new applicants and cannot vary depending on the applicants' situation or circumstances, otherwise this would constitute unfair discrimination in terms of section 29 of the Act.

A member must disclose illness conditions that he or she sought medical advice, diagnosis, treatment, or care for in the 12 months preceding the date of application for membership.
Thus, condition-specific waiting periods can only be placed on conditions present within the 12 months prior to application, and not on complications arising subsequently, unless a proven causal relationship exists. It would be unfair to a member to be excluded for potential complications that he/she may not have been aware of at the onset of membership. A member cannot anti-select a scheme with an unknown condition which was not even present before application.

4. *Other issues*

An all-encompassing issue that was raised during the discussions related to communication and information on PMBs provided to members. It was clear that, for a number of reasons, information and communication to members on their entitlement to PMBs, the operations of DSPs and related matters remains poor at best and non-existent at worse. It was agreed that the Registrar would coordinate a smaller team which will include BHF, other scheme volunteers, provider groups and interested parties, to provide recommendations on how to improve communication and information on PMBs to members.

It was also agreed that there is a need for greater enforcement of the PMB requirements by the regulator, and that the Registrar should initiate the necessary enforcement actions against trustees and principal officers of medical schemes who permit practices to occur in clear contravention of the schemes' registered rules and the provisions of the Act.

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REGISTRAR OF MEDICAL SCHEMES