PRESS RELEASE

Reference: PMB regulation 8 amendment
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Press release 9 of 2015: CMS says amendment to PMB regulation 8 aims to assist members and schemes

The Council for Medical Schemes (CMS), regulator of the medical schemes industry, commented today on the proposed amendments to Regulation 8 - pertaining to prescribed minimum benefits (PMBs) made in terms of the Medical Schemes Act, 131 of 1998 (the Act).

PMBs include 270 serious health conditions, any emergency condition, and 25 chronic diseases. Regulation 8 of the Act explains that concerning PMBs, the medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the PMB conditions.

It was designed to offer maximum protection to members of schemes irrespective of which option they are on. PMBs aim to ensure that when members face catastrophic healthcare events it does not ruin them financially. It also aims to avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals, and to encourage improved efficiency in the allocation of private and public healthcare resources.

The CMS continues in its efforts to implement the Act, which was introduced with the specific intention of providing medical scheme members with access to care, protection from being risk-rated, full cover for a minimum set of benefits, and enabling members to utilise private healthcare facilities.

While the sub-regulation (1) ensures that PMBs have to be funded in full it also enables medical schemes to effectively manage the costs through the appointment of designated service providers (DSPs) who will render services at a negotiated rate, the use of drug formularies and other tools such as managed care interventions, protocols and the requirement to obtain pre-authorisation before services are rendered. Members using DSP networks are then protected against any additional costs, such as co-payments. In emergencies members may not have a choice but to use providers out of

network, but schemes may indeed penalise members for voluntarily making use of non-designated service providers if it is not an emergency.

It is our view that suggested amendments to Regulation 8 adds certainty in that:

- The requirement to protect members from having to pay for the set of PMBs out of their pockets remain and is clearly stated in sub-regulation (1) of the regulation which has not been amended.
- Proposed amendments affects sub-regulation (2), which specifically covers what a scheme may include in its rules regarding its efforts to protect members from service providers that charge higher rates, i.e. this paragraph relates to the appointment of designated service providers (DSPs).
- This restriction of the amendment to sub-regulation (2) is defined not only by the inclusion of the new paragraph (c) as an addition to sub-regulation (2), but also by the linkage of paragraphs (b) and (c) by the word 'and'.
- As such, the amendment defines the extent to which a scheme may be expected to pay if a member voluntarily elects to make use of the services of a provider listed with the Health Professions Council of South Africa, which is not listed on the designated provider list of the scheme. In such cases, the limit which the scheme is obliged to pay will be subject to the cost of the specific service as stipulated in the National Health Reference Price List (NHRPL) of 2006 plus an annual inflation of consumer price index (CPI) for every subsequent year. This is an aspect that was previously not defined, i.e. a scheme could arbitrarily decide what the member co-payment should be under such circumstances.
- Sub-regulation (3) which describe the circumstances under which a member may make use of a non-DSP on a non-voluntary basis as well as the protection afforded to members under those conditions, also remain unchanged and intact.

The CMS encourages stakeholders and the public to participate and contribute to the debate surrounding the proposed amendments to the regulation and to submit comments as requested by the National Department of Health.

The CMS also advises members to familiarise themselves with the rules of their medical scheme and to be aware what benefits are available on their chosen option. Members must ensure they visit a service provider who is a designated service provider (DSP) as part of the scheme option network to avoid facing co-payments.

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