Prescribed minimum benefits: What the changes mean

Will the proposed amendments end up benefitting schemes and sticking it to their members?

By: LETITIA WATSON

MEMBERS ARE confused and doctors are worried, but medical schemes sighed with relief when the Minister of Health, Dr Aaron Motsoaledi, published proposed changes to the Prescribed Minimum Benefits (PMBs) regulations in the Government Gazette last month.

An amendment to Regulation 8 of the Medical Schemes Act has been long overdue—and it happened in the middle of (and maybe partly because of) a court case against the Department of Health regarding PMBs and the Competition Commissions’ inquiry into the private healthcare market.

A red-hot thorn in the side
Medical schemes have lamented PMBs as a major cost driver since their introduction in 2004. Regulation 8 currently requires schemes to pay for the diagnosis, treatment, and care of PMBs—which include 270 conditions and 27 chronic illnesses—at provider cost in full, regardless of which benefit option the member belongs to.

According to schemes, this has opened the door for service providers to charge specifically higher for PMB conditions, as they had the certainty that the bill would be footed. “Some providers charge exorbitant fees for PMB services, and due to this regulation, medical schemes were forced to pay these fees,” says Dries la Grange, chief executive of Bestmed, one of the country’s largest open schemes.

The open-ended costs relating to PMB conditions make it hard for schemes to manage expenditure on claims. They say that the raised expenditure results in high health inflation, translating into higher premium increases for members.

This guarantee of payment apparently also created an incentive for service providers to up-code certain conditions as PMBs, with the benefit of increasing their revenue, and (on the other hand) assisting patients to access scheme risk benefits. Bipolar mood disorder, for instance, is eligible for PMB coverage, but other forms of depression are excluded. It is alleged that many patients are subsequently coded as having BMD. Ditto for pneumonia (which is a PMB) and bronchitis (which is not).

The amended regulation proposes that schemes be allowed to limit what they pay for prescribed minimum benefits to the rates set out in the 2006 national health reference price list (NHRPL), adjusted at consumer price inflation, or at a rate agreed with the service provider.

What worries members
Schemes say that the proposed amendments will ultimately translate into lower average premium increases for members. Members are concerned, however, that if schemes be allowed to limit what they pay for PMBs, they will end up paying the difference between the scheme rate and the service providers’ fee out of their own pocket—and although the draft regulations do not appear to compromise the care provided, members are worried that capping the cover could reduce access to the quality of healthcare they currently receive.

Dr Humphrey Zokuva, managing director of the Board of Healthcare Funders, which represents some schemes, says that members will not be faced with co-payments, “as the medical schemes must pay in full the regulated fee. This is the case even when the fees are negotiated outside the 2006 NHRPL model.”

Notwithstanding the changes to Regulation 8, co-payments for PMBs are not new. Although PMBs are covered in full, this doesn’t mean that members can pick and choose between medication and service providers. Schemes have their own cost-curtiling measures such as using designated service providers (DSP), as well as networks of specific doctors and hospitals to supply services at a pre-agreed rate. If members use non DSPs on a voluntary basis, they could be faced with co-payments.

Dr Johnny Broomberg, chief executive of Discovery Health (DH), says that one interpretation of the amended regulation, which appears to be the intention of the National Department of Health, is that health professionals will remain free to set their own charges for PMB treatments. “If this is correct, it does mean that where schemes do not have payment arrangements, members of those schemes might face more frequent (and perhaps higher) co-payments, since doctors will continue to charge at above the scheme rate (generally equivalent to NHRPL 2006 inflation adjusted) for all services, but schemes will no longer be obligated to pay these fees in full for treatment of PMB conditions,” he says.

Impact limited for some
For members of schemes that already have agreements in place with service providers, the impact of the new regulation should be limited since the vast majority of provider claims are paid in terms of the contracted rates.

Broomberg says, however, that if the regulations are implemented as proposed, those schemes which have not implemented contracted payment arrangements would now have to decide whether to increase their tariff costs by introducing payment arrangements in order to avoid their members experiencing PMB co-payments. Also, according to Neil Nair, principal officer of SAMWUMED, schemes will be required to ensure that
MEDICAL COVER

members receive uninterrupted treatment and care for PMBs, without benefit limits or co-payments.

Treating providers fairly
The uncertainty around reasonable reimbursement weighs heavily on health care professionals. The amended regulation refers to rates set out in the 2006 NHRPL, adjusted for consumer price inflation, but the South African Private Practitioners’ Forum (SAPPF) says that it does not represent the actual costs of running a private practice.

In July 2010 a High Court ruling declared the publication of the NHRPL invalid, rendering any such rates null and void. This ruling is applicable to the 2008 and 2009 price lists, and is retrospective. It found that the process by which the rates were determined to be unfair.

Dr Chris Archer, chief executive of the SAPPF, says that the reference price list has no relation to the actual input costs of health professionals. As just one example of numerous input cost factors that the 2006 NHRPL doesn’t take into account, he cites the steep increase in malpractice insurance premiums for obstetricians over the past ten years. Over the past decade, Archer says, the annual premium increased from around R16 000 to R450 000, with expectations of over R1 million by 2018. Doctors should be able to cover costs such as these.

Archer also says that the proposed amendment flies in the face of the Health Department’s submission to the Competition Commission, which proposes a cost-based tariff that is independently produced.

Health professionals also fear being bullied into accepting network tariffs that are set at levels below cost. In their submission to the Private Health inquiry, the South African Medical Association states that despite perceptions that medical practitioners are in a strong position because the market is reliant on their skills and services rendered, the converse is actually the case. “Medical doctors in the private sector are almost entirely reliant on the medical funding industry to remain in business. It is, in fact, the scheme industry which occupies the dominant market position.”

Broomberg adds that the amended regulation could encourage those providers who have not entered into such contracts to join contracted payment arrangements, since they may otherwise face an increase in bad debts and collection costs as they will have to collect co-payments much more frequently.

According to Broomberg, the payment arrangements of schemes administered by DH typically reimburse providers from 55% to 117% above the inflated NHRPL figure. Archer however argues that the agreements are not negotiated, but imposed on health care practitioners. “If reimbursement is limited to scheme rules, it will bankrupt the provider industry. No industry in the world can survive if input costs are not considered,” he says.

Where to from here?
The amended regulation is in draft form, and will remain open for comment for three months before being finalised. It is very likely that it will be challenged by various parties, and that the process of implementation will be somewhat delayed.

The court case between Genesis Medical Scheme and the Minister of Health is also under way. Last year, SAMWUMED and Genesis took the Minister to court to have the regulation requiring cover of PMBs at cost to be set-aside. SAMWUMED has subsequently withdrawn its court application.

Genesis argues that although the minister may determine the list of conditions that comprise the PMBs, he has no power to regulate the scope of payment. The Minister has indicated that he will not be opposing the case.

Many organisations that could be affected by the outcome have applied to join the case, including the Treatment Action Campaign, the South African Depression & Anxiety Group, People Living with Cancer, Mediclinic Southern Africa, the Hospital Association of South Africa, the Council for Medical Schemes, and the SAPPF.