



CMScript

*Member of a medical scheme?
 Know your guaranteed benefits!*

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The regulations to the Medical Schemes Act provide for specific principles that medical schemes may use to manage the financial risk associated with PMBs. These principles include designated service providers, managed care protocols and formularies

Designated Service Provider, Medicine Formularies and Managed Healthcare

As a member of a medical scheme or a healthcare provider you are probably aware of the concept of prescribed minimum benefits (PMBs).

Section 29 (1) of the Medical Schemes Act specifies matters for which rules shall provide. Subsection (o) stipulates that medical schemes must fund the minimum benefits that are prescribed by the Minister of Health. Subsection (p) says that no limits may be applied in paying for these services and that the minimum services provided and paid for by medical schemes may not be less than the services that is offered in public hospitals.

Regulation 8 stipulates that any benefit option offered by a medical scheme must pay in full for the diagnosis, treatment and care of the PMBs. No co-payments may be charged and no deductibles be used. It is however important to remember that the regulations go on to provide for certain financial principles to be used by medical schemes when funding PMBs. This issue of the CMScript focuses on these financial and management principles.

Management Principles

The regulations to the Medical Schemes Act provide for specific principles that medical schemes may use to manage the financial risk associated with PMBs.

These principles include:

- Designated service providers
- Managed care protocols
- Formularies



<http://arizona.edu/images/research/healthcare/temp.jpg>

Designated Service Providers

A designated service provider (DSP) is a healthcare provider (doctor, pharmacist, hospital, etc.) that is a medical scheme's first choice when its members require diagnosis, treatment or care for a PMB condition. Most schemes have a DSP for hospital services, chronic medication and healthcare practitioner/specialist services.

Regulation 8 (2) indicates that if a member uses the DSP the account must be funded in full by the scheme. If a member voluntarily chooses not to use the DSP and uses a different hospital, doctor or pharmacy, the medical scheme may charge the member a co-payment.

Medical schemes have to ensure that beneficiaries have easy access to DSPs. If there is no DSP within reasonable distance of your work or home, then you can visit any provider and the scheme is obliged to pay.

When you suffer an emergency condition, or are involved in an accident, you may go to the nearest healthcare facility for treatment, even if it is not a DSP. In such a case your scheme must cover the costs.

Schemes also have to ensure that the DSPs of their choice can deliver the services needed and without members having to wait for unreasonably long periods of time. Where a DSP is unable to accommodate or treat a member, the medical scheme remains liable for all the costs of treating the PMB condition at a non-DSP.

The state's healthcare facilities may be appointed as the DSP. Before they can be listed as such, schemes have to make sure that their members can get to the facilities and that the required treatment, medication and care are available and accessible.

Regulation 8(3) specifies three instances when using a non-DSP is deemed involuntary and no co-payment may be charged.

- The service is not available from the DSP or cannot be provided without unreasonable delay. In other words the time that a member needs to wait to receive medical care is unreasonable. Although unreasonable is not defined in the Act, it is interpreted as being a period of time that is fair and sensible.
- Immediate medical/surgical treatment for a PMB condition is required under circumstances or at locations that reasonably preclude the beneficiary from obtaining such treatment at a DSP. This can best be explained with the following example: If the DSP for the medical scheme is the state sector, but the public servants at the facility are on strike and no medical services are available, the circumstances prevent members from using the DSP.
- There is no DSP within reasonable proximity of the beneficiary's ordinary place of business or personal residence. This means that the DSP is not within a fair and sensible distance from the member. In such a case the member may be allowed to use a non-DSP. In some instances medical schemes are willing to pay for road transport for a member who lives very far from the DSP rather than allowing members to use a non-DSP.
- As a member of a medical scheme it is your responsibility to familiarise yourself with the DSPs that have been appointed by your medical scheme.

Managed Care Protocols

"Managed health care' means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes."

"Managed health care organisation' means a person who has contracted with a medical scheme in terms of regulation 15A to provide a managed health care service."

Managed care interventions must be used to ensure that appropriate interventions aimed at improving the efficiency and effectiveness of healthcare are implemented. The managed care provisions include techniques such as pre-authorisation, the application of treatment protocols and the use of medicines formularies. Most medical schemes provide services in the form of a basket of care that lists all the services included in the protocol e.g. number of consultations etc. It is important to be aware that the protocols are based on the services necessary to manage members with stable conditions.

All managed care protocols must be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability. This means that even if there is scientific evidence for the efficacy of a specific treatment, it may not be cost effective, affordable or appropriate to prescribe in the South African environment.

If a member voluntarily chooses to use a different treatment protocol the scheme may charge a co-payment (e.g. a member chooses to have a laparoscopic appendectomy instead of open surgery which is the standard of care in the state sector).

It may be clinically necessary to have more consultations and other interventions to manage a member's disease than is stipulated in the protocol. The provision of these exceptions is discussed below under exceptional circumstances.

As a member of a medical scheme you have the right to request the medical scheme provide you with the protocol that applies to your specific disease. Regulation 15H (b) stipulates that the medical scheme must provide such protocol to healthcare providers, beneficiaries and members of the public upon request.

Formularies

A formulary is a restricted list of medicines used to treat a specific medical condition that medical schemes pay without charging a co-payment. Formularies must be developed on the basis of evidence-based medicine, taking into

account considerations of both cost effectiveness and affordability. As with managed care protocols, even if there is scientific evidence for the efficacy of a specific drug, it may not be considered cost effective, affordable or appropriate in the South African environment.

When a formulary drug is clinically appropriate and effective; and the member knowingly declines the treatment and chooses to use another drug instead, the scheme may impose a co-payment.

As a member of a medical scheme you have the right to request the medical scheme covers the costs of the protocol that applies to your specific disease. Regulation 15I (b) stipulates that the medical scheme must provide such formulary to healthcare providers, beneficiaries and members of the public upon request.

Exceptional Circumstances

Although the regulations allow medical schemes to implement managed care protocols and formularies, there are instances where these principles cannot be enforced. Regulation 15H (c) and 15I (c) highlight certain exceptions.

15H. Protocols. —If managed health care entails the use of a protocol—

(c) provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary.

15I. Formularies. —If managed health care entails the use of a formulary or restricted list of drugs—

(c) provision must be made for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.

Regulations 15H (c) and 15I (c) determine that medical schemes must make provision for appropriate exceptions where a protocol or formulary drug has been ineffective or has severe side-effects or cannot be used due to allergic reactions. In these cases the medical scheme must allow for the member to have different treatment without charging a co-payment.

Payment of Claims

The regulation stipulates that all PMB claims must be paid in full without any penalty or co-payment or deductible. This does not prevent medical schemes from using the financial management principles discussed in this article.

The regulation further stipulates that co-payments must

be stipulated in the scheme rules. The co-payments may be the difference between the actual cost and the cost of a DSP or formulary drug. Co-payments may also be a percentage of the total cost and, in the case of medicine, the generic reference price (GRP). The GRP is usually the average amount of all generic substitutions in each medicine class.

PMB accounts and co-payments may not be paid from the medical savings account. Medical schemes may however pay PMB accounts from the annual sub-limits first but when the sub-limit is depleted the medical scheme must continue paying PMB accounts from the risk pool.

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PMBs

Prescribed minimum benefits (PMBs) are defined by law. They are the minimum level of diagnosis, treatment, and care that your medical scheme must cover – and it must pay for your PMB condition/s from its risk pool and in full. There are medical interventions available over and above those prescribed for PMB conditions but your scheme may choose not to pay for them. A designated service provider (DSP) is a healthcare provider (e.g. doctor, pharmacist, hospital) that is your medical scheme's first choice when you need treatment or care for a PMB condition. You can use a non-DSP voluntarily or involuntarily but be aware that when you choose to use a non-DSP, you may have to pay a portion of the bill as a co-payment. PMBs include 270 serious health conditions, any emergency condition, and 25 chronic diseases; they can be found on our website by accessing the link provided (www.medicalschemes.com/medical_schemes_pmb/index.htm).