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PRESCRIBED MINIMUM BENEFITS AND DESIGNATED SERVICE PROVIDERS

1. Introduction

1.1. The following guidelines are provided in respect of the implementation of amendments to regulations 7 and 8, made in terms of the Medical Schemes Act, 1998 ("the Act"), in relation to the delivery of prescribed minimum benefits (PMBs). The text of these regulations is appended as Annexure 1.

1.2. The development of these guidelines follows discussions that have taken place between the Council for Medical Schemes and stakeholders, including various trustees, schemes, administrators and organizations such as the Board of Healthcare Funders and the Actuarial Society of South Africa.

1.3. The amendments to regulation 8 take effect from 1 January 2004, and accordingly have implications for benefit structure and rule design of medical schemes for 2004.

2. Legislative intent

2.1. The intention of defining the scope of the prescribed minimum benefits (PMBs) as the Minister has done in regulation 8, is to ensure that the minimum benefits are always available to beneficiaries of medical schemes in accordance with the intention of section 29(1)(o) of the Act. Section 29(1)(o) provides:

"The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the

following matters ... (o) The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed."

2.2. Section 29(1)(p) of the Act protects public hospitals against unfunded utilization by medical scheme members. It provides that in the event that a PMB is obtained from a public hospital, and is not different from the entitlement in terms of a service available to a public hospital patient, no limitation shall apply to the reimbursement in respect of that service.

2.3. However, the primary intention of the legislation is to ensure availability of a minimum set of funded health care benefits to beneficiaries of medical schemes, rather than to promote the use of public sector facilities by medical schemes.

2.4. Unfortunately, many medical schemes interpreted the previous formulation of regulation 8 (which remains in effect until 31 December 2003), to entitle them to restrict availability of PMBs to public sector facilities – regardless of availability of those benefits to their members in those facilities, and without necessarily making arrangements with the relevant public sector facilities for the accommodation of their members.

2.5. In cases where public hospitals lacked beds for patients referred by medical schemes, some schemes determined that their benefit obligations to the members in respect of PMBs had been extinguished.

2.6. The consequence of this interpretation was that members most in need of access to minimum benefits were at risk of these benefits being effectively unavailable to them – contrary to the intention of the legislature as articulated in section 29(1)(o) read with section 67(1)(g) of the Act.

2.7. In response, amendments to regulation 8 were gazetted on 4 November 2002, to take effect on 1 January 2004. These amendments introduced the concept of "designated service providers", the intention of which is to ensure PMBs are at all times reasonably available to beneficiaries of medical schemes in some or other setting without financial obstacle (i.e. with no out of pocket expenditure to the member).

3. Designated Service Providers ("DSPs")

3.1. Definition

3.1.1. As defined in regulation 7, "'designated service provider' (DSP) means 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."

3.2. Failure to identify a DSP in rules

3.2.1. A medical scheme which fails to identify a DSP in its rules will be subject to the obligation imposed by regulation 8(1) to pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions. This obligation is only made subject to the provisions of regulation 8, which allow certain limitations on PMBs through the use of DSPs and other mechanisms.

3.2.2. The Registrar will accordingly not approve rules which do not identify a DSP unless they provide for unlimited liability of the scheme to pay the costs of PMBs in any setting. Medical schemes are therefore strongly advised to identify one or more DSPs in their rules.

3.3. Contracting

3.3.1. In order to identify a provider (or network of providers) as a DSP, it is not necessary for a medical scheme to enter into a contract with that provider. It is only necessary to identify that provider as a DSP in the rules of the scheme. However, as discussed below, contracting (or other arrangements) with DSPs is advisable as it will:

3.3.1.1. provide the scheme with greater assurance of availability of PMB services to its members (and consequently decrease the likelihood of involuntary use of non-DSPs); and

3.3.1.2. enable the scheme to determine financial and managed care conditions for the delivery of care to its members by the relevant DSP.

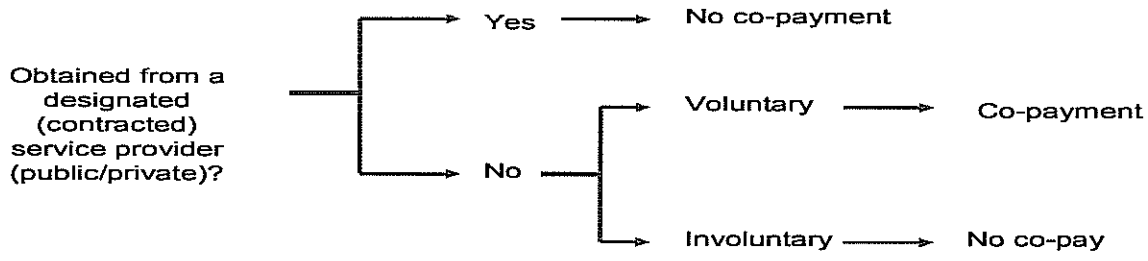
3.4. The State as a DSP

3.4.1. It is permissible for a medical scheme to designate only the State (i.e. public sector facilities) as its DSP. Use of public sector facilities for the delivery of PMBs, where those benefits are reasonably available, remains an option – in any event, no limitation can apply to reimbursement of PMBs provided in these facilities in terms of section 29(1)(p) of the Act.

3.4.2. However, responsible medical schemes should not be relying on the public sector only as a default provider, but should be exploring contracting options in both the public and private sectors. This is important both from an efficiency perspective and also to proactively deal with circumstances where those minimum benefits are not reasonably available to beneficiaries through the public sector.

4. Conceptual Model for Delivery of PMBs

Figure 1



4.1. Figure 1 above provides the conceptual model underlying the provisions of regulation 8:

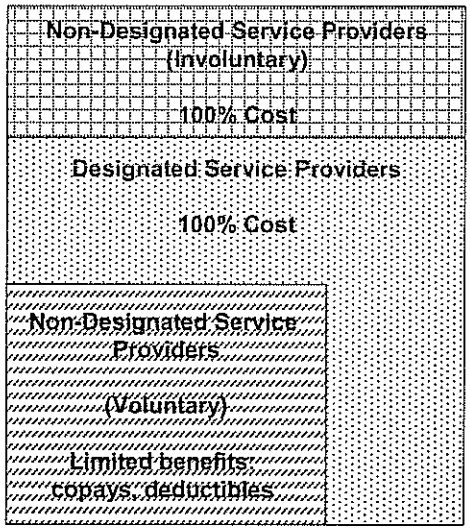
4.1.1. Members who obtain a PMB from a DSP should not face out of pocket payment (see regulation 8(2)(a)).

4.1.2. Members who voluntarily obtain a PMB from a non-DSP face a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme (see regulation 8(2)(b)). In the absence of a statutory definition of "copayment," we interpret it broadly to include specified percentages of accounts payable by members, or amounts payable by members in excess of predefined benefit limits.

4.1.3. Members who involuntarily obtain a PMB from a non-DSP do not face out of pocket payments (see regulation 8(2)(b), read with regulation 8(3)).

4.2. Appropriate benefit design should be conceptualized as in Figure 2.

Figure 2



4.3. The diagonally dashed block represents PMBs obtained from service providers other than DSPs. Benefit design in this sector can include the use of limitations such as copayments and deductibles.

4.4. Members can opt to utilize limited benefits in this sector before utilizing DSPs, or can opt to use DSPs as their providers of choice for the delivery of PMBs. Members who use DSPs (the dotted section of Figure 2) for the delivery of PMBs will not face out-of-pocket payment.

4.5. If a member opts for the use of a DSP, but involuntarily must go "out of network" to a non-DSP (the checked section of figure 2) for reasons specified in regulation 8(3), that member will again not face out-of-pocket payment.

5. Involuntary use of non-DSPs

5.1. Regulation 8(3) provides:

"For the purposes of subregulation (2)*(b)*, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence."

5.2. Concerns have been raised regarding the apparent vagueness of certain terms in regulation 8(3). The use of imprecise terms such as "reasonable" is common in legislation for the reason that attempts to a hammer down detailed and unambiguous specifications in legislation *a priore* inevitably lead to regulating through exception. The intention is clearly for guidelines on the application of these provisions to emerge through the development of precedent after application of these provisions to specific situations. In this case, authoritative precedent is likely to emerge through complaints resolution processes by the Registrar, Council or the Appeal Board, or through the courts.

5.3. As Council, we intend to expedite the development of precedent on this issue by instituting a special fast-tracking procedure for complaints relating to application of these provisions and publishing determinations on these complaints on our website. In this way, any uncertainty that may be generated by the wording of these provisions will rapidly be reduced.

5.4. In the meantime, we recommend that medical schemes quote the provisions of regulation 8(3) *verbatim* in their rules, and consider putting in place a form of preauthorization for the involuntary use of non-DSPs to (1) determine PMB status of the relevant condition; (2) ascertain unavailability of care in the relevant DSP; and (3) as far as possible, facilitate access to appropriate care in a DSP or other appropriate provider.

6. Payment "in full"

6.1. In the case of PMBs obtained from a DSP or involuntarily obtained from a non-DSP, the scheme is obliged to pay "in full, without copayment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions."

6.2. In those circumstances, the scheme is not entitled to limit this in their rules to a particular tariff schedule which would expose the member to an out-of-pocket payment if the provider were to charge in excess of that tariff. Provision for this is not made in the regulations, and it would defeat the objective of ensuring that members have access to minimum benefits in some or other setting without facing an out-of-pocket payment. However, schemes are not exposed to unlimited liability in this regard because:

6.2.1. where the public sector is the DSP, fees are charged according to the UPFS;

6.2.2. in respect of other DSPs, schemes can enter into specific fee arrangements;

6.2.3. involuntary use of non-designated service providers should be exceptional, and can be further limited by –

6.2.3.1. contractual or other arrangements with DSPs for accommodation of members; and

6.2.3.2. effective case management, in conjunction with pre-authorisation, to verify the need for involuntary utilization; and

6.2.4. excessive or anti-competitive pricing can be taken up with the HPCSA or Competition Commission.

7. Diagnostic Procedures Resulting in Unconfirmed PMB Diagnosis

7.1. Diagnostic procedures which give rise to non-confirmation of a PMB diagnosis are not regarded as PMBs. However, schemes are expected to be reasonable and not deny cover for diagnostic procedures which were performed in a bona fide attempt to verify a likely PMB diagnosis.

7.2. Schemes can also implement appropriate diagnostic protocols, provided that these are based on evidence based medicine, taking into account considerations of cost-effectiveness and affordability.

7.3. In respect of urgent hospital admissions for suspected PMBs, however, attention is drawn to Explanatory Note 7 to the regulations, as well as the definition of "emergency medical condition" in the regulations.

8. Risk Mitigation Strategies

8.1. Risk management strategies should focus largely on reducing the need for beneficiaries to involuntarily use non-designated service providers.

8.2. Key to achieving this is maintaining reasonable benefit limitations in the voluntary environment. A possible knee-jerk response of schemes to the regulations by wholesale slashing of benefits in the voluntary environment would be counter-productive, as it would result in greater "involuntary" use of DSPs and increase the likelihood of members finding DSP care unavailable and accordingly involuntarily using non-DSPs.

8.3. Obviously too, contractual and other arrangements with DSPs for the accommodation of scheme beneficiaries is a critical risk mitigation strategy. The greater the assurance to medical schemes through contracts or other arrangements

that their beneficiaries will be adequately accommodated within DSPs, the less likely the members will involuntarily have to use non-DSPs. Schemes should use this opportunity to explore possibilities of genuine and appropriate risk-sharing arrangements with providers.

8.4. Various managed care initiatives will be a pivotal part of the spectrum of scheme risk mitigation activities, including effective case management and development of clinically appropriate treatment protocols. Pre-authorisation is also appropriate, and may be used for instance, for the authorization of involuntary use of non-DSPs.

8.5. Failure to obtain pre-authorisation as provided for in the rules of a scheme where this is reasonably required, clearly communicated to members, and is feasible under the circumstances could potentially attract reasonable penalties defined in the rules.

8.6. In this regard, regulation 8(5) provides that these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

8.7. Managed care interventions must, however, comply with all the relevant provisions of Chapter 5 of the regulations.

9. Diagnostic Information on Accounts

9.1. Council has committed itself to supporting processes which encourage accurate usage of ICD10 (including provider training initiatives) in conjunction with the Department of Health with a view to establishing ICD 10 as an industry-wide mandatory requirement as of 1 January 2005.

9.2. In the meantime, Council cannot support rejection of claims by medical schemes on the basis that such claims do not include a relevant ICD10 code. There is no legal basis for such rejections.

9.3. However, given the inclusion of ICD10 coding in the gazetted therapeutic algorithms for the chronic disease list (CDL), Council accepts that schemes may require in their rules that the relevant ICD10 codes in relation to only the CDL may be considered necessary for CDL claims *to be treated as PMBs* by schemes. This is a consequence of reading regulation 5(f) in conjunction with the gazetted algorithms.

9.4. In addition, as a general principle, if a claim submitted by a provider does not contain diagnostic information (through description or coding) which will allow a determination to be made that the claim is for a PMB, the scheme will be unable to

classify the claim as a PMB and the claim could be treated as a non-PMB subject to ordinary benefit conditions.

10. **Medical savings accounts and copayments**

We reiterate Council's position that legitimate co-payments in respect of PMBs cannot be paid out of medical savings accounts, as this would amount to a contravention of regulation 10(6), which prohibits the cost of prescribed minimum benefits, as defined, from being paid from MSAs. The definition of "prescribed minimum benefit" does not differentiate between co-payments and other costs of PMB treatment.

TP Masobe
REGISTRAR OF MEDICAL SCHEMES

ANNEXURE 1
Amended Regulations 7 and 8

7. Definitions. -- For the purposes of this chapter –

'designated service provider' means a health care 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;

'emergency medical condition' means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's life in serious jeopardy;

'prescribed minimum benefits' mean the benefits contemplated in section 29(1)(o) of the Act, and consist 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 in Annexure A; and

(b) any emergency medical condition;

'prescribed minimum benefit condition' mean a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition.".

8. Prescribed Minimum Benefits – (1) Subject to the provisions of this regulation, any benefit option that is offered by 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.

(2) Subject to section 29(1)(p) of the Act, the rules of a medical scheme may, in respect of any benefit option, provide that –

(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

(b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no copayment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(3) For the purposes of subregulation (2)*(b)*, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

(4) Subject to subregulations (5) and (6) and to section 29(1)(p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition."

Sincerely,

TP Masobe
REGISTRAR OF MEDICAL SCHEMES