



# Medical schemes ... knowledge and skills

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Cape Town, October 2004



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# The Medical Schemes Act: pertinent provisions



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# Essential sources

- Medical Schemes Act 1998
- Medical Schemes Act, Regulations: regulation 8 (PMB's) and regulation 15ff (managed care)
- CMS Managed Care Policy Document Aug'03:
  - 4.5.2 PMB- managed care subject to reg 15ff
  - 4.5.5 limitations only nr of consultations
  - 4.5.7 specialist conformation
  - 4.5.8 not detract from 'essential content of PMB's
  - 4.6 co-pays "reasonable"
- HPCSA Undesirable business practices policy



# General principles



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# Medical Schemes Act (section 1, p1.19)

- What is the “business of a medical scheme”?
- The primary relationship is -
  - between scheme and member
  - regulated by RULES of the scheme (e.g. best option...) (section 44 p1.30)
  - WITHIN framework of the Act and Regulations Scheme
  - under auspices of Board of Trustees (a “framed” contractual relationship)
- Based on social security (solidarity, community rating)



# Medical Schemes Act

There is a different legal relationship -

- between provider and patient regulated by the ethical duties of, e.g. the doctor and
- the contractual relationship between provider and patient (its treatment and payment)
- Except: managed care agreement...



# Medical Schemes Act

Within the contractual relationship between scheme and member, there are limits to what scheme can and cannot do, e.g.:

- The fiduciary duties of trustees (and duty to obtain accurate information) (section 57 p1.33)
- No discrimination on age, sex, past or present state of health, ... the frequency of rendering of relevant health services (section 29(1)(n))
- PMB and extension to chronic conditions
- Utilisation of managed care (see regulation 15)
- Discrimination into Equality Act of 2000



# PMB's and DSP's



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# Prescribed Minimum Benefits (regulation 8 – p1.41) (general rule)

- Rationale for PMB conditions?
- Listed in Annexure A to the Regulations
- 270 plus 25 chronic conditions
- Schemes must pay in full & without co-pay for
  - Diagnosis, treatment and care costs
- May require that services from DSP (reg 8(2))  
...
- May use formularies, pre-auth (reg 8(4)),  
BUT...



# Prescribed Minimum Benefits (regulations 8) (limitations)

- Rules of scheme must provide level & scope, but not lower than set out below:
- Annexure A – list (p 1.57):
  - 270: must pay for “medical management”, “surgical management”, “hospital-based...”
  - Who determines what constitutes “med mgmt”?
  - 25 CDL: as prescribed in algorithm
- Cannot drop below (‘Explanatory notes’) (p1.55):
  - Public sector care
  - If conflict or no protocol, refer to province
  - Set LEVEL of care, not SETTING



# Prescribed Minimum Benefits (regulations 8) (limitations)

- May have protocol, formulary and/or managed care limits, BUT:
  - Not less than PMB level & chronic algorithms (for lowest options)
  - Subject to reg. 15D (know on what basis limitations are being made and how to appeal, etc.) (p1.49-50)
  - Subject to reg. 15H & I (exceptions to protocols and formularies if ineffective or (would) cause harm or an adverse reaction without penalty to pt) (p1.52)
  - Subject to reg. 15G (limits on cover of certain diseases – evidence-based + cost-effective + affordable) (p1.52)
  - All interventions must be reasonable, fair and based on sound evidence (see “fair treatment project”).



# Prescribed Minimum Benefits (regulation 8) (Co-pay's)

- Co-pays (levied by *scheme*) only if:
  - Patient voluntarily sees non-DSP (reg 8(2)(b) – p1.41)
  - Patient knowingly declines clinically effective and appropriate drug (not clinically ineffective) (reg 8(5) –p1.42).
- Co-pays must equal real difference in price as closely as possible (CMS MC doc par 4.6.3)
- Co-pays must be specified in rules of scheme
- Co-pays not out of savings!



# Prescribed Minimum Benefits (regulation 8) (Co-pay's)

- NO co-pay if patient involuntarily sees non-DSP, i.e.:
  - Service not available from DSP or would not be provided without unreasonable delay;
  - Immediate medical or surgical treatment for a PMB was required under circumstances or at locations which reasonably precluded obtaining such treatment from a designated service provider; or
  - No designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.



# Managed care



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# Managed care (reg 15 p1.46)

## Definitions:

- managed care = risk assessment and health care management “clinically and financially” to facilitate cost-effectiveness and appropriateness
- rule-based & clinical management-based programmes = formal techniques to monitor... necessity, appropriateness, efficacy, and efficiency)
- evidence-based medicine = conscientious, explicit and judicious use of current best evidence ... where actual clinical experience is integrated with best available external clinical evidence
- “participating provider” vs “designated provider”



## Managed care

- all limitations to entitlements (e.g. protocols, formularies, etc.) submitted to Registrar 30 days before takes effect (reg 15A(2).)
- CMS managed care document:
  - Limiting the nr of consultations...
  - Specialist confirmation only if clinically appropriate
  - Co-payments not from savings accounts
  - PMB's from separate pool BUT indiv complaints
  - Therapeutic substitution... (cf Act 90)



## Managed care (reg 15D –p1.49)

- Protocol with PROCEDURES to evaluate necessity, appropriateness, efficiency and afford'y
  - Procedures for intervention
  - An APPEALS procedure
  - Data sources and clinical review criteria
  - Organisational structure that will assess managed care and report to scheme; peer review -
  - Principles for managed care programmes:
    - » transparent and verifiable criteria
    - » professional subject to peer review
- » member, provider and public entitled to ....



## Managed care

- Provider has right to inform patients of care required and assist!
- HPCSA 1999-Ruling for drs
- Exhaust internal remedies
- Section 47: where a written complaint on any matter in the Act... = written particulars to scheme
- Section 48: “any person” appeal when aggrieved...
- Call on HPCSA: clinical appropriateness, clinical independence (MDPB P.O. Box 339, Pta, 0001 (Tel 012 338 9367)



## Managed care (reg 15H & I p1.52)

- Protocols & formularies:
  - on evidence-based medicine, cost effectiveness & affordability
  - appropriate exclusions where:
    - ineffective
    - causes or would cause harm to beneficiary / adverse reaction
    - if exception: no penalty to member!
  - Public, member and provider access to -
    - document with clear description of managed care programmes
    - procedures and time limitations for appeals
    - limitations placed on rights or entitlements incl. restrictions on disease cover, protocols and formulary exclusions



# Financial issues and payment



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## Manner of payment

- Section 59(1) must pay in in 30 days
- Reg 6: If account is erroneous or unacceptable, scheme must inform dr and member within 30 days and provide 60 days to rectify!
- If scheme fails, must PROVE that account is in FACT erroneous or unacceptable
- Section 59(3) in case of fraud, misconduct, etc. scheme may withhold SUCH amount...



# Liability



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# Liability for providers...

- If harm befalls patient due to decision of scheme or managed care organisation:
  - Potential criminal or civil liability (depends on causality and test of reasonableness)
  - US case law: *Wickline v California* :  
“cost limitation not be permitted to corrupt medical judgement” (may be used in SA as persuasive authority)
  - SA case law: Afrox case only when gross negligence would indemnity not be upheld
  - Margate care (pre-auth)...



THANK YOU!

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