NEWS

## EXPANDED CHRONIC BENEFITS FOR 2004

Medical schemes will be forced to cover an expanded list of minimum benefits from 1 January 2004, but this need not push up consumer contributions, said the Council for Medical Schemes.

According to a Council survey, the average cost of the present package of compulsory benefits, as well as soon to be compulsory chronic disease cover per beneficiary, was estimated at R2 156 annually (at 2001 prices) within the private sector. Most schemes charge premiums well in excess of this, some as much as five times the price of the package.

From next year, schemes will have to cover 25 chronic diseases like high cholesterol, kidney disease and diabetes, in addition to existing compulsory minimum benefits. All designated hospitals will have to enter a service agreement guaranteeing certain minimum standards. This means that medical aids will not be able to arbitrarily send patients to a hospital based solely on the fact that it is cheaper.

The survey by UCT's Centre for Actuarial Research used data collected from 18 million member months on Medscheme's database. It found that, using 2001 figures, it would cost about R640 per month for a family of four in the private sector and R417 in the public sector.

Council spokesperson, Pat Sidley, said that in order to predict 2004 costs, schemes and administrators would have to calculate the effects of inflation and changing claiming patterns, such as caused by HIV / AIDS. Researchers recommended that a risk equalisation system be instituted to ease the load of schemes with older memberships. The study estimated non-healthcare expenditure for the package at an average of 5.3% of total costs, well below the recommended benchmark of 10%.

Contribution increases above 10% were leading many members to resign from medical aids entirely or opt for cheaper, no-frills options. She attributed this inflation to the price of imported technologies and providers not prescribing generics whenever possible.

Gary Taylor of Medscheme commented that medical inflation was rising dramatically around the world, and that coverage of diseases like HIV / AIDS and depression was costing schemes about 19% more.

## MORE INTERIM FEE HIKES FOR 2003

Amendments to the Medical Schemes Act enabling 'defined groups' to switch schemes without incurring waiting periods or exclusion penalties, could contribute to further increases to medical aid contributions in 2003.

NMG-Levy Consultancy recently published that although 'modest' contribution increases of 8-10% were implemented for 2003, scheme members could face further hikes due to the costs brought about by such legislative changes. Newcomers with pre-existing conditions or in older age groups could make frequent high claims that would reduce reserves. Forty years is considered a good average age for scheme membership and the percentage of pensioners is critical. Currently the health department includes younger member dependents when assessing the proportion of pensioners per scheme, which makes the statistic rather meaningless.

Andrew Sykes, CE of NMG-Levy, said that 'the spectre of interim fee hikes emerged in 2001, but it was assumed to be a temporary phenomenon. If new regulations encourage bad risk groups to move around different schemes, there could be serial rate rises at scheme after scheme, taking the rate of increase for the year as a whole way above 10%'.

Increases in contribution rates could also be influenced by reductions in the benefits offered by schemes or higher co-payments, as well as the fluctuating value of the Rand.

## NTSALUBA WARNS PRIVATE SECTOR

The price of private health care was a major driver of medical inflation, which could price the industry out of significant growth prospects, recently stated Ayanda Ntsaluba, the Director-General of Health.

Ntsaluba said that the government had initiated an investigation into the biggest hospital cost drivers, such as surgical expenses. He argued that the government has tried to contain private hospital costs over recent years by limiting the number of new licences in order to increase patient volumes and minimise incentives for overservicing. He said that the government is cautious in its approach to interventions in the private sector: 'It is critical that we don't cause any more problems or turbulence. The public sector will not be able to absorb the consequences of an imploding private sector'.

There are 104 000 beds in state hospitals and 24 000 in private facilities. Private hospital groups such as Netcare, Afrox and MediClinic currently have an estimated occupancy rate of about 60%, which tends to encourage overservicing. Many private hospitals overcapitalised when the number of medical aid members was expected to increase, but the market has remained flat at about 7 million lives covered. Hospital costs due to importing technology with a weaker Rand and increased medicine bills, have meanwhile led inflation in the sector to soar.

Ntsaluba said that schemes have so far not been able to address the problems caused by the fee-for-service model. 'Schemes have found it more convenient to increase premiums,' he added.

Negotiations between hospitals and medical schemes and administrators to introduce other forms of billing have begun but have tended to exclude smaller schemes and low-cost options. Other billing methods under consideration are fixed fees, daily and capitation fees.

Ntsaluba praised the private sector's level of sophistication, saying that it would back up the government's intentions of attracting more foreign investment and tourists to South Africa.

## BHF PROPOSES RARE DISEASE FUND

The Board of Healthcare Funders recently wrote to its members to suggest that medical schemes volunteer to initiate a separate, shared fund to cater for specific rare conditions that usually create significant financial risk.

Included on the proposed list of diseases are Gaucher disease, an inherited enzyme deficiency disorder, haemophilia, cystic fibrosis, cochlear implants, interferon-treated multiple sclerosis and chronic myeloid leukaemia. It would for instance cost between R600 000 and R700 000 to treat one individual with Gaucher disease, which has now been included as a prescribed minimum benefit.

Thiru Appasamy, BHF's Manager for Statistics and Informatics, said that the concept was still being developed and that it would only work with buy-in from most medical schemes. The list of conditions might include HIV / AIDS.

Shaun Matisonn, principal of Discovery Health, commented that such a fund might protect individual schemes from 'adverse selection fallout'. He said schemes are currently deterred from offering best practice care unless other schemes did so because if few schemes offered treatment for particular expensive conditions, then all the sufferers of those diseases flocked to that limited number of firms.

**LEGISLATION**

## SUMMARISED HIGHLIGHTS OF THE LATEST AMENDMENTS TO THE REGULATIONS OF THE MEDICAL SCHEMES ACT: FINAL PART 3

By Elsabé Klinck



**Regulation 15B & C: Accreditation of managed health care organisations (new)**

A number of criteria must be fulfilled before an organisation can be accredited as a managed care organisation, such as having the necessary resources, systems and skills. Accreditation will be granted for a period of 24 months, but the Council will have the power to withdraw, amend or add to such an accreditation after the organisation's submissions have been considered by the Council.

**Regulation 15D: Standards for managed health care (new)**

The medical scheme must ensure that a written protocol for managed care is in place as part of the managed care contract, that describes:

- procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of services
- procedures for interventions
- methods to inform beneficiaries and providers of the outcomes of these procedures
- data sources and clinical review criteria used in decisions
- an appeals procedure for decisions that adversely affect the entitlements of the beneficiary in terms of scheme rules
- mechanisms to ensure consistent application of clinical review data and decisions
- data collection and analytical methods used in assessing utilisation and price of services
- provisions of ensuring confidentiality of clinical and proprietary information
- the organisational structure that will assess managed care activities and report to the scheme (e.g. ethics committees or quality assurance committees)
- the staff position responsible for the day-to-day management of managed care programmes

The above types of information in managed care agreements will greatly assist doctors in challenging decisions or behaviour that may negatively affect on payment for services by a scheme.

All managed care programmes should be based on clinical review criteria for evidence-based medicine. Cost-effectiveness and affordability should also be taken into account. However, these programmes should:

- be evaluated periodically to ensure relevance
- use transparent and verifiable criteria in decision-making
- be administered by qualified health professionals whose decisions are subject to periodic peer review.

The beneficiary, provider or any member of the public is entitled to demand:

- a document that contains a clear description of the managed health care programmes
- the procedures and timing limitations for appeal against utilisation review decisions adversely affecting the beneficiary
- any limitations on rights or entitlements of beneficiaries, including, but not limited to, restrictions on coverage of disease states, protocol requirements and formulary exclusions / inclusions.