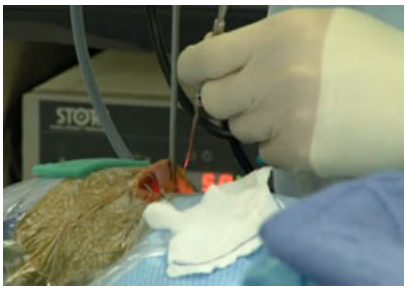
Prescribed minimum benefits - know your rights

Confusion still reigns over the interpretation of the Prescribed Minimum Benefits (PMB) regulations introduced by the Medical Schemes Act in January 2004. Ian Taylor, executive practice head - healthcare at PSG Konsult Corporate believes that it should not be viewed with the same trepidation as a 'dreaded disease'. "The best defence," he says, "is for members to be as informed as possible."



Here he demystify PMBs, which essentially covers a range of medical conditions which medical aid schemes have to cover - from emergencies to illnesses - that if left untreated would negatively affect the quality of your life.

The PMB programme was introduced to assist medical schemes in managing the costs related to chronic or serious illness, while ensuring that all medical scheme members have the right to access certain health services, regardless of the benefit option they have selected.

The Act requires all medical schemes to pay 'in full' for the medical care, pathology, radiology and medication costs related to: the diagnosis, treatment and care of any emergency medical condition in addition to a limited set of around 270 medical and 26 chronic conditions.

What does this actually mean to you?

By law, your medical scheme has to pay your claims for the diagnosis of and consultations or treatment of a PMB. None of these claims may be paid from your medical savings account.

Why is there such an uproar about PMBs?

Medical schemes are concerned that the interpretation of 'in full' in the regulation gives healthcare providers a 'blank cheque' to charge as much as they like for PMBs because they know the scheme is obliged to pay the full amount. Many instances of abuse and over-charging have already been recorded. This can have a significant negative financial impact for schemes - such as rising member contributions - if PMBs are charged at higher rates than similar medical procedures.

There is also some confusion around the correct definition and appropriate treatment of a PMB.

Will I have to co-pay for treatment?

Medical Aid Schemes have Designated Service Providers (DSP) but if you decide not to use the DSP then co-payment might be necessary. It would either be the difference between the actual cost and what the scheme would have paid if you had used its DSP or the percentage of co-payment as registered in the scheme's rules.

What is a DSP?

A Designated Service Provider (DSP) is the medical scheme's first choice healthcare provider when it comes to your PMB

condition. State facilities can be designated as a DSP but only where services are reasonably available and accessible.

Are there exclusions?

There are often rules put in place by medical schemes regarding which treatments and medicines they will or will not cover. However, when it comes to PMBs, there are minimum standards of treatment or protocols which should be followed. These are covered by legislation.

Which chronic conditions are covered as PMB's:

Addison's disease; asthma; bi-polar mood disorder; bronchiectasis; cardiac failure; cardiomyopathy disease; chronic renal disease; coronary artery disease; Crohn's disease; chronic obstructive pulmonary disorder; diabetes insipidus; diabetes mellitus type 1 & 2; dysrhythmias; epilepsy; glaucoma; haemophilia; HIV / AIDS; hyperlipidaemia; hypertension; hypothyroidism; multiple sclerosis; Parkinson's disease; rheumatoid arthritis; schizophrenia; systemic lupus erythematosis; ulcerative colitis

Knowledge is empowerment

PMBs can be a rather complicated subject and sometimes your medical scheme might not always be able to answer your query but as a good consumer learn to ask questions and be informed. However, if you are still unsure you can contact the Council for Medical Schemes on 0861-123-267.

Know your rights (a case study)

This case study below shows the importance of knowing your rights when it comes to PMBs and the implications of the diagnosis of a PMB.

The facts: A pregnant mother is on a medical scheme option offering "Unlimited" cover in a private hospital of choice. The marketing documentation refers further to "PMB" benefits being "Unlimited".

She was admitted for an emergency caesarean section and her baby was born prematurely, had a low birth weight and was admitted to ICU. Soon thereafter the case manager for the medical scheme advised the mother that she would have to make a decision regarding her newborn baby's treatment. She was advised that she had to choose whether the baby would be moved to a public hospital facility - and the medical scheme would pay for the baby's treatment in full as per the scheme rules, or remain in the private hospital's ICU unit and the scheme would pay for treatment at the same rate it would be paying at the public health facility. The balance of the accounts would be for the member's own account.

Because the mother could not guarantee payment for the substantial cost of ICU herself, the baby was moved to the Public Health facility.

The baby's condition is a PMB:
• Code 967N
• Diagnosis: Low birth weight (under 2500g and > 1000g) with respiratory difficulties
• Treatment: Medical management, including ventilation, intensive care therapy
Under its rules, this medical scheme has selected the State as its Designated Service Provider (DSP) for PMB's and is therefore justified in making this decision.

Comment: The facts of the case are that the mother was deeply distressed and did not wish her baby to be moved from the existing ICU where she was happy with the treatment received so far.

"Ultimately," says Taylor, "it is incumbent on members to be informed of the rules of their medical scheme regarding the cover for PMB's, particularly relating to hospital treatment and chronic medication. Do this directly with your scheme or make enquiries via your healthcare intermediary."

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