

BHF Info-line

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A monthly industry update brought to you by the Board of Healthcare Funders of Southern Africa

'Leading Change for Growth'

It is time once again for the industry to come together at the Annual BHF Southern African Conference which is to be held from the 12th – 15th June 2005 at Sun City.

Entitled, 'Leading Change for Growth' this conference will highlight the many significant issues affecting the industry and will bring together 500 – 600 of the country's executives to showcase the private healthcare sector's ability to lead the changes to ensure growth and prosperity.

As usual, the Conference Opening will be preceded by the BHF/Qualsa Golf Challenge which will take place during the day of Sunday the 12th June at the magnificent Gary Player Golf Course.

The theme of the conference is reflected in the programme which includes the following topics:

- **The Transformation of the Health System in SA through the Health Charter - *The role of the private sector?***
 - Equity
 - Access
 - Broad based empowerment
- **Collaborating for Transformation - *The National Health Act roll-out***
- **Social Health Insurance**
 - Affordability
 - The Risk Equalisation Fund
 - Designing a Basic Benefit Package
 - Alternative Solvency Measures
- **The Quest for Affordability through robust competition - *Restoring the balance between supply and demand forces***
 - Understanding the key drivers of medical inflation

- Vertical integration
- Price regulation
- **The business of medical schemes**
 - The case for MSA's in Benefit design
 - Solvency models
- **The Quest for Value - *How consistent, dependable, measured quality can improve efficiency in healthcare***
- **Medicines Pricing**
 - International Benchmarking
- **Walking the Talk - *The private sector's responsibility to the burden of disease***
 - HIV/AIDS workplace issues
- **Medical Schemes Under Threat from Expanded PMB's – *The results of a costing exercise***
 - The inclusion of ambulatory care
 - Implications to the REF
 - Defining limits for technology used for PMB's

Those involved in the healthcare sector in the Southern African region are urged to attend this conference where high-level debate and interactive sessions will ensure robust and innovative outcomes for the industry.

For further information, please contact Zola Mtshiya on zolam@bhfglobal.com or log into the BHF website on www.bhfglobal.com

Sponsorship opportunities:

Position your organization at the hub of the industry by sponsoring this prestigious event. Please contact Zola Mtshiya on zolam@bhfglobal.com for details. Sponsorship packages will be tailored to the specific requirements of individual organisations.

The Value of an Industry Body

As the representative body for the industry, it is imperative that BHF constantly engages with its members and provides assistance at both a strategic and operational level. The management team constantly keeps in touch with Boards of Trustees, and membership outreach prominently features in the process. As you will appreciate this takes time and in an endeavour to ensure that members are kept abreast of the activities of BHF, we have prepared a profile of

the current work being undertaken. To enable BHF to improve its service to members, we would very much appreciate receiving your input on matters which you feel the organisation should be addressing on your behalf. To access the profile, please log on to www.bhfglobal.com or e-mail heidik@bhfglobal.com

Meeting between BHF and the Registrar of Medical Schemes

BHF recently held a meeting with the Registrar of Medical Schemes to discuss a number of issues including communication and change management, ICD 10, NHRPL, training, benefit design and PMBs. Communication between the two is extremely important if the industry is to be prepared to address changes implemented, especially when stakeholders look to the BHF for recommendations, or when there are radical policy shifts.

When BHF raised the matter of ICD 10 codes and PMBs, stressing the increase of PMBs which are ambulatory in nature, the Registrar encouraged BHF to provide comprehensive responses to concerns, saying however, that while cost is not the main concern, BHF should point out areas where there are significant cost implications. A costing exercise is currently being undertaken, the results of which will be presented at the conference.

Trustee Development Programme

BHF will once again be offering a one-day Trustee Development Course, which will be held in Johannesburg on the 12th April 2005.

New and existing trustees of medical schemes are urged to attend the course which is designed to equip trustees with the requisite knowledge for effective governance of their scheme.

The programme will include the following sessions:

- 1. Review of market dynamics in light of the current and proposed medical scheme legislation in SA**
 - Medicines Pricing legislation
 - Social Health Insurance
 - The Risk Equalisation Fund
 - PMB's
 - Mandatory Cover
 - Solvency

- Tax Subsidy Issues

- 2. Trusteeship: Fiduciary and Statutory Functionality**

- General Responsibilities
- Fiduciary Duties
- High Risk Responsibilities
- Investing medical scheme funds

- 3. Designing benefits and contracting designated service providers**

- 4. Combatting medical scheme fraud through collective action**

The cost is R995 (excl VAT) per trustee. Course materials will be provided and all refreshments and lunch are included. To register, please contact Zola Mtshiya on zola@bhfglobal.com

DSP Guidelines

The Regulations relating to the Prescribed Minimum Benefits have imposed on schemes the liability for unlimited funding of a broad range of clinical services from the risk pool (as opposed to a limited ambulatory care benefit or personal savings account). In order to provide a mechanism for schemes to manage this additional risk, the option to control access for these services through a "designated service provider" is allowed, if specified in the scheme rules.

Designated Service Provider contracting is a relatively new undertaking for many schemes and in order to assist schemes with this process, BHF has commissioned the compilation of a concise, yet comprehensive guide to such contracting.

Copies of this document have been mailed to all member schemes. Further copies may be downloaded from the BHF website on www.bhfglobal.com.

Should you wish to provide feedback/input on the document, please e-mail zola@bhfglobal.com

Schemes contracting with DSP's may also wish to refer to an earlier BHF publication on Alternate Reimbursement Models, which can also be found on the BHF website www.bhfglobal.com.

NHRPL Issues

Numerous queries have arisen from recent changes to the NHRPL. In response to BHF's request for clarification on six major and recurrent issues, please see the questions and responses from the Council for Medical Schemes below.

Question 1

The Practice Type was previously linked to the practice number discipline code using two digits to identify the discipline. The CMS has changed this to a five-digit number. The first digit identifies the professional board and the second two identify the discipline. Our concern is that in some cases these discipline indicators are incorrect and, in addition, no provision has been made for disciplines with three digits.

Response

While the discipline code is three digits, with the first digit grouping disciplines by professional board groupings, it is highly unlikely that any discipline will have more than 99 sub-disciplines, consequently a third digit for sub-disciplines is unnecessary. The CMS has changed the practice type to add intelligence to the practice type number. This change should not cause hardship to schemes as the second and third digits are identical to the BHF practice type. Schemes and BHF must enhance systems to cross-match the new practice type with current systems.

The NHRPL discipline codes allow for certain logical inconsistencies, created by incremental development of the BHF practice type system, to be removed. The codes have been designed to be consistent with discipline groupings applied in the relevant statutory bodies, considered more appropriate given the Council's status as a statutory authority. For instance, some disciplines recognised by the HPCSA are not yet incorporated in the BHF practice type system. As schedules are developed for these disciplines, their NHRPL discipline type will simply slot into the logical coding cluster. This does not require the PCNS to change its practice types since the database incorporates conversion tables.

Question 2

The Access database is different from printed versions, (MSWord and Excel). An example given was that the Excel spreadsheet for medical practitioners stated "Specialists" for radiology and pathology sections, whereas some specialists had only basic equipment equivalent to that owned by a GP. The Rand Conversion Factors are also not in the printed version. Will the MSWord document have this information or has it been deleted? If so, how will all relevant parties know what the RCF is?

Response

It is difficult to include all the information in the master database in the printed version of the schedules. The spreadsheet should be interpreted in conjunction with the relevant billing guidelines. The practice type "10000" should be interpreted as "designated speciality" whereas code 10099 refers to general practitioner or non-designated specialists.

With reference to the rand conversion factors, the spreadsheet should contain a separate sheet listing all rand conversion factors. This has been inadvertently omitted and will be rectified in the next version.

We will do our best to deal with all problems brought to our attention. For instance we have undertaken to reissue version 2.05 printed versions with new formatting to address all concerns raised as soon as possible.

BHF is of the opinion that more needs to be done to ensure that the Word and Excel documents should contain exactly the same information as the Access database.

Question 3

Modifier 0036. The current schedule allows a GP to charge the same as a specialist anaesthetist for the first hour, and thereafter 80% of the specialist rate. This may have a major impact on schemes.

Response

Failure to effect this change in the 2004 list was an error on the part of the CMS/SAMA when it introduced consistency in the GP/specialist differentials. This has been rectified in the 2005 list. Though CMS accepts that it may have a financial impact, it claims to have no basis on which to revert to the previous formulation without being inconsistent with the principles governing GP/specialist differentials throughout the medical schedule.

Question 4

Deletion of prenatal visits (2601 and 2602). Normal consultation fees apply with ICD 10 codes. Most practitioners are not ready for ICD 10 and postponement of the date to 1st July 2005 complicates matters further.

Response

CMS could find no principled justification for the lower consultative rates in 2601 and 2602. No other discipline was singled out in this manner in the medical list. The funder input obtained was that it was an historical anomaly which had not changed because of the significant financial impact of removing the codes. Under the circumstances, gynaecologists and obstetricians felt legitimately aggrieved. The only reason these codes would have been maintained (albeit at higher consultation rates) would have been as diagnostic markers for benefit category purposes. At the time, CMS was satisfied that implementation of ICD 10 coding purposes at the beginning of 2005 would adequately provide the necessary diagnostic marker. It did not foresee delay of ICD 10 implementation to July 2005 as a problem. While this has created a problem, rectifying it by a temporary change to the NHRPL will be problematic and will cause unnecessary confusion in billing.

BHF is not entirely satisfied with this reply and will follow the issue up with the CMS.

Question 5

The use of 3 decimal points for the unit value instead of 2. Schemes and administrators are using a 2-decimal system. BHF previously used 2 decimal points and rounded off on the basis that monetary values ending with a 1-4 cent value have been rounded off downwards, and that 5-9 cents have been rounded off upwards. On an individual-by-individual basis the difference may seem insignificant, but based on volumes processed it is potentially considerable.

Response

The CMS maintains that given the level of precision required for the NHRPL, it requires the use of 3 decimal points in the rand conversion factors. It advises that where systems have not been updated to accommodate this they should be.

BHF is not entirely satisfied with this and has done an exercise to test the rounding changes and found that in some cases the difference is significant (above R4.00)

Question 6

Late announcement of increases. New tariffs with significant impact on claims were released long after schemes had to register their contribution increase. For instance, a 34% increase for GPs was released only at the end of November. Earlier, when apologies were made for the late release of some schedules, schemes were told that most of the unreleased schedules would be in line with CPI.

Response

CMS claims to have done its best to announce any increases with significant financial impact for schemes as far in advance of the deadline for benefit and contribution changes as possible but admits to not being entirely successful. However, the experience has given CMS a better understanding of what is required. The process for 2006 is commencing much earlier and CMS is confident that it will be able to provide timely indication of increases this year.

Health Quality Assessment

Health Quality Assessment (HQA), a Section 21 company, has provided a health quality assessment tool for medical scheme management, which allows trustees to measure access to and *quality* of healthcare delivered in medical schemes. It enables trustees to compare options within medical schemes and to obtain a ranking.

HQA also allows trustees to measure performance of networks, for instance by DSPs, in terms of providing good *health outcomes*. Measuring health outcomes will avoid situations where service providers are incentivised not to provide treatment. HQA will also make it possible to measure health outcomes under different forms of managed care, such as capitation or per diem, or traditional fee-for-services schemes with benefit limits for non-PMB conditions.

Measuring health outcomes increases incentives for service providers to provide accurate diagnostic codes. It would also improve the collection of treatment data by

managed care providers. Outcomes are measured by a number of different criteria, including age and gender among others but excluding value judgements, and results are statistically analysed and curve-fitted to indicate whether options provide good health outcomes or not. Obviously there is a high degree of confidentiality.

HQA's Board includes representatives from BHF, CMS, the Consumer Union and medical schemes and administrators. A document outlining the process, data requirements and costs is available on the BHF website on www.bhfglobal.com. For further information or to participate in the initiative, contact Emile Stipp on estipp@deloitte.co.za or Thiru Appasamy on stats@bhfglobal.com.

Report back on a seminar held on the 23rd February on the Risk Equalisation Fund, Benefit Design and Risk Based Capital Models.

The Risk Equalisation Fund is seen as an essential step towards the eventual implementation of Social Health Insurance in South Africa. It is intended as a measure to enforce competition between medical schemes on the basis of efficiency and not according to the risk profile of their members. Initially, it will apply only to the package of PMBs, a basic package of 271 diagnostic treatment pairs (hospital-type conditions) and 25 chronic conditions for which medical schemes must provide compulsory cover at full cost for diagnosis, treatment and care.

2005 and 2006 will be "shadow years" in this process, which will test the operation of the REF without actual flow of money taking place. The shadow years will also permit schemes to discount the effect of the REF in pricing for the benefit year starting 2007. Schemes which successfully reduce the cost of delivery of healthcare retain that benefit for their own members.

BHF recently held a seminar on REF which covered current status, risk-based capital, benefit design and medical savings.

Risk-based capital

Initially, medical schemes were expected to have a 25% "insolvency margin", i.e. funds in excess of 25% of gross contributions, as a guarantee that excessive claims would not drive them into bankruptcy. While this might have a certain relevance for smaller schemes, it is impractical and unnecessary for the larger schemes. This is where the concept of "risk-based capital" was introduced.

Risk-based capital sets a minimum required level of capital, given certain asset and liability requirements, to limit the risk of the capital being depleted – i.e. the risk of insolvency. The major risk faced by medical schemes is with claims, in other words, whether there is sufficient money to fulfil outstanding claims at any point in time.

In estimating claims provisions, one needs to determine what drives claims and the answers are simple: the number of beneficiaries, their profile and the benefit structure as well as the variability of the claims. A formula was introduced which uses a number of factors to determine the minimum capital requirement to cover possible risks and ensure that sufficient capital was available to meet requirements.

Benefit design

The REF benefit package is the most important matter to consider over coming months. If we get it right and it is affordable, tax re-structuring can occur at the same time as REF implementation with mandatory membership, and in this way, the stability of the risk pool will be ensured and SHI will become a successful reality. If the cost is too high and not mandatory, members will leave schemes and the potential consequences could be that high-income individuals will save large amounts of cash to cover possible hospitalisation costs, the demand for insurance vehicles may become higher and individuals may "capitate" themselves with their GPs.

Issues to consider for benefit design requirements for the REF are multiple. Since the PMB package is diagnosis-based, and does not cover all diagnoses, schemes have to offer cover in excess of PMBs, and also primary care benefits, on a standardised basis. This raises cost and coding issues. High costs are not conducive to membership retention. But if the PMB package is cheaper, but less extensive, beneficiaries will suffer. A balance must be found between a comprehensive package in the context of tax reform and cost.

Coding using ICD 10 could give rise to abuse of "PMB codes" for a variety of other conditions to the detriment of the whole PMB concept. Coding should be finalised at the time of finalising standard benefits to ensure that cover can be priced adequately.

The Supplementary Benefit Package is another thorny problem. It is unclear whether SBPs will be equalised or not. If not, the benefits of equalisation will be lost, since members will have to buy SBPs in any event, and then on a risk basis. If equalised, REF will have to carry a high burden which has increased tax implications on current members. And if savings accounts cannot be used for SBPs then it is hard to see the need for them.

Option downgrading will remain an issue. Members with greater healthcare needs will choose higher SBPs which will give rise to a cost spiral for SBPs accompanied by downgrading.

Questions remain concerning primary care benefits and savings, the latter of which will play a clearly reduced role.

There are countless potential consequences of REF benefit design. While design itself should become easier to understand, it is moot whether members really know to which benefits they will be entitled under REF. Benefits may look the same on the surface, but benefit entitlement between different schemes or even options may be very different indeed and it is probable that members will become aware of these differences only if they become ill.

Trustees will be required to focus more on managed care arrangements, with increased emphasis on risk transfer, preferably through risk-adjusted capitation, for which the environment is not really prepared as yet. However, should there be a significant move to such risk transfer, the role of current managed care organisations will change. Health outcomes will assume a new importance as will the quality of healthcare. There will be third-party handling of member complaints, among other new developments.

It is consequently important that certain legislative priorities be settled now. For instance, solvency requirements for managed care risk takers must be determined timeously as must solvency offsets for schemes transferring risk.

Medical savings accounts

All healthcare funding is underpinned by three main principles: demand is high, resources are limited so rationing and prioritisation are necessary. The question is, who decides the funding? Supply-side control hands that power to healthcare providers. Demand-side control leaves patients with the decision. Both lead to different funding models.

Medical savings accounts (MSAs) offer numerous benefits. They allow prioritisation by choice, eliminate the need for micro-management by the funder, reduce fraud and create a deeper awareness in both provider and patient of the cost implications of treatments. So in the currently regulatory framework, MSAs work well. They are limited to 25% of contributions and guarantee open access. At the same time, PMBs are funded not from savings but from the risk pool.

However, in December 2004, Council ruled that variability within MSAs is inconsistent with S29(1)(n) in the Medical Schemes Act which prohibits the variation of contributions by factors other than plan type, income and number of dependants. This means that all members within an option must all have the same level of Medical Savings, be that 10%, or 15% or 25%.

Those members who are compelled to increase their medical savings contributions might well decide to opt out of the scheme for financial reasons. This will increase costs and risks to medical schemes. Should

however, medical schemes savings be decreased to a lower percentage, there could well be large premium reductions, but also a large drop in benefit entitlements and an increase in out-of-pocket expenses with a concomitant undermining of the role of the scheme itself.

It was consequently suggested that the CMS address the legislative issues in S29 (1)(n) since it would appear

that its apparent applicability to MSAs is an accidental one, since MSAs sit outside the risk pool it is intended to protect. Further, it was recommended that PMBs should be used to accommodate specific concerns around MSAs, while an integrated approach should be adopted to benefit design issues.

Uniform Patient Fee Schedule

Public hospitals are not entitled to charge VAT. The VAT-exclusive amount in the document on the CMS website, www.medicalschemes.com, should be used.

Not all provinces have implemented the UPFS as detailed in the BHF Member Communiqué MC.Biii.147. Free State, Mpumalanga, Limpopo and Northern Cape are still pending.

The latest UPFS price list and user guide from the National Department of Health can be obtained from BHF.

The Newcastle Provincial Hospital has changed from a level 1 district hospital to a level 2 regional hospital and its practice number changed from 056 **001** 5601029 to 056 **002** 5601029 with effect from 9 December 2004.

Updated ICD-10 CD's

The Board of Healthcare Funders has once again made available a CD containing a very basic search engine for ICD-10 (version 2, 2005), which is an update of the previous CD distributed in 2003. This CD contains the full list of codes expanded to the 5th digit level where appropriate, thus the list has almost trebled in size. This file was developed by DXS Systems (Pty) Ltd from a base file provided by Discovery Health.

To assist Practice Management software developers, Hospital Information Systems developers, and the IT

divisions of funders, administrators and claims bureaux, the ICD-10 (version 2, 2005) CD contains a flat file of all ICD-10 codes for direct download and importation into software systems. This file is available in Excel format (on the main menu), or in a .txt file (pipe-delimited basic flat file) in the Exports folder.

To order your copies of this cd, please contact the PCNS Client Services Department on 0861302010. Cd's are R30 each.

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