Medicallaw

Prescribed PMBs and medical savings accounts

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The interpretation of prescribed minimum benefit (PMB) regulations, which the Council for Medical Schemes (the Council) has adopted has been, and still is, the subject of much debate. This has predominantly involved Regulations 8(1) and 8(2) relating to the *"pay in full"* and *"designated service provider"* provisions.

Regulation 10(6) is, however, also relevant, perhaps more so to members, and prohibits a medical scheme from paying for the cost of a PMB from a member's savings account. Allowing schemes to do so would detract from the purpose of PMB regulations but the cost of a PMB is different from the voluntary co-payment or deductible, which may be due by a member in respect of that PMB. The Council interprets the Regulation as prohibiting a scheme from paying voluntary co-payments and deductibles in respect of a PMB, which are due by a member, from their medical savings account. This results in the member having to pay for voluntary co-payments and deductibles out of pocket, even though the member has funds available in a medical savings account, and certainly isn't ideal for members.

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The Council's interpretation is largely based on the Appeal Board's decision in *Kara v Gems* and its interpretation of the word "*costs*". In that matter, the essential issue before the Appeal Board was "*whether the Respondent [was] obliged to pay the Appellant's fee in full or whether it [was] only obliged to pay him in accordance with its prescribed tariff in terms of its Rules*". Central to this issue was the interpretation of Regulation 8(1), which requires schemes to "*pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions*". The Appeal Board gave the word "*cost*" its dictionary meaning and found that the "*costs of the treatment therefore means the amount which the member has to legitimately pay to acquire the necessary medical services*". Instead of focusing on what the scheme has to pay, the Council has focused on what the member has to pay the provider and applied this to Regulation 10(6).

This is incorrect because the context in which the word "*costs*" is used in Regulation 8(1) is different from Regulation 10(6), and perhaps more so because the words "*prescribed minimum benefit condition*" and PMB have different meanings. Regulation 8(1) clearly states that a "*medical scheme must pay in full…the diagnosis, treatment and care costs of the prescribed minimum benefit conditions*". Regulation 10(6) refers to the "*costs of a prescribed minimum benefit*"; it does not refer to what a medical scheme must pay or "*the diagnosis, treatment and care*". The word "*costs*" in Regulation 10(6) must be considered, therefore, in the context in which it is used, and not only by relying on the decision in *Kara v Gems*.

The term "*prescribed minimum benefit condition*" used in Regulation 8, and "*prescribed minimum benefit*" used in Regulation 10(6) have different meanings and are defined as:

> **"'prescribed minimum benefits'** means 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'** means a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition."

Section 29(1)(o) of the Medical Schemes Act requires that provision must be made in the rules of a scheme for the scope and level of minimum benefits that are prescribed for beneficiaries. A "*prescribed minimum benefit*" therefore refers to the benefit the member is entitled to under the rules of a scheme, taking into account Regulation 8 and the managed health care principles the scheme applies. "*Prescribed minimum benefit condition*" on the other hand means a condition set out in annexure A or an emergency medical condition.

The term "*costs*" in Regulation 8(1) relates to what a member has to pay the provider for the treatment of a condition set out in annexure A or an emergency medical condition, while in Regulation 10(6) the term "*costs*" refers to the benefit a scheme must pay. Put simply, the focus in Regulation 8(1) is on what the member has to pay the provider, while the focus in Regulation 10(6) is on what the scheme has to fund.

Based on this interpretation, voluntary co-payments and deductibles do not form part of the benefit offered by a scheme, and are not payable by the scheme. As a result they do not fall within the ambit of Regulation 10(6) and schemes should not be prohibited from paying these amounts on behalf of members from medical savings accounts.

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