AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

NOVEMBER 2020

Have you received your 2021 Benefit Guide?

We posted your copy of the 2021 Benefit Guide in the first week of November. If you have not received it yet, please call us on 0860 222 633 to ensure we have your correct postal address. In the meantime, access the Benefit Guide on www.angloms.co.za > Info Centre > Find documents and forms. If you consider changing your plan, please speak to us as soon as possible.
Reminder: Should you need to change your plan, please submit the form by 11 December 2020.

Covid-19 impact on the Scheme – update

The impact of the pandemic on the Scheme has been less severe than originally predicted.

So far, approximately 2.6% of all beneficiaries have been infected, about 0.75% of beneficiaries have been admitted to hospital and by far the majority were discharged. A small number required continued home oxygen and post-Covid support. It saddens us to report that the Scheme had Covid-19 related deaths but can report that the rate was less than 0.2% of total beneficiaries. The average age of the deaths was 77.

Our Covid-19 cost per case is somewhat higher than the industry average due to our higher average age but, luckily, Covid costs have been more than offset by a significant decrease in elective procedures and visits this year. Claims are now picking up again, and it is expected that by year-end, the monthly claims will be more-or-less back to normal. For 2021 it is predicted that there will be a greater demand for healthcare, due to procedures having been delayed or postponed in 2020.

As previously confirmed, the Scheme is still able to absorb the Covid-19 costs and provide all necessary benefits.

AGM questions & answers

As promised, we are reporting back on the questions and answers raised at the AGM. This edition covers the last set of questions, raised by Dr Brink, all of which have been paraphrased and answered individually.

"There is an ever-increasing divide between the SRR and the realistic fees currently charged by providers. It is deceptive to describe a benefit as 100% of SRR, when it bears little relation to the actual cost. The actual SRR is not published, so it is increasingly disingenuous to describe benefits as a percentage of a hidden schedule. There are huge discrepancies between the relative value of the SRR for radiologists and pathologists, when compared to anaesthetists, surgeons, physicians and other specialists."
We agree with Dr Brink, there is an increasing divide between the SRR and actual medical costs experienced by members; further, there are large variations between disciplines. Part of this answer has already been given in the October edition of MediBrief. The CPI and medical CPI differential automatically widens the gap if members and pensioners receive CPI-related increases (which schemes tend to follow when increasing their benefits to keep contributions down) and providers use medical CPI as their annual tariff increase.

On referring to tariff variation, again, we agree. We still have providers who charge around the 100% SRR, whereas others charge 400% and more. A few charge way in excess of 1 000% of the SRR.

Competition Law allows each provider to set their own tariff which should be based on their direct costs and on what their market can bear – which is a very important principle. If you, their market, are willing to pay their rate, it is deemed acceptable.

Continues >>

Regarding the comment on the SRR being a hidden schedule, as mentioned, the actual tariff schedule cannot be easily published and even if it were, we doubt the most informed member would be able to navigate it. Unfortunately, there really isn't an easy solution and, if there were, it would be commonly used. There is no deliberate attempt to deceive anybody, which is why we offer the service to give the SRR based on a quotation from a practitioner, and even that comes with a disclaimer.

"The R3 200 co-payment on endoscopic procedures carried out at non-network hospitals is unfair."
Any co-payment should aim to have members receive the most appropriate treatment in the most appropriate facility or by the most appropriate provider at the most appropriate cost. It should aim to reduce unnecessary wastage, be set at a rate that is sufficient to incentivise behavioural change while still having some bearing on the actual costs, and ultimately, improve overall cost efficiencies. The co-payments are regularly discussed and reviewed in the best interest of all members. For 2021 it was decided to not increase the co-payments.

"If the cost of endoscopies is a problem, why does the Scheme not simply publish a Rand limit to the facility payment, regardless of which facility is used?"
If there was one flat co-payment, there would be no incentive for any hospital to compete and offer a lower cost service. Nor would it drive behavioural changes of either the provider or the member. Ideally, one would like day clinics to become far more prevalent and regularly used for day procedures. They should be the members' place of choice for safety and convenience while hospitals should be only accessed when really needed.

"If an endoscopy co-payment is necessary, why not make it reasonable in every case and apply it to all members regardless of which facility is used?"
It would not drive any efficiencies or better outcomes, nor have any impact on the total 'event' cost as already mentioned. Historically, a scheme would simply have used a limit while modern thinking is more focused on the longer-term outcomes and co-payment or risk-sharing strategies aimed at correcting some of the drivers of healthcare inflation.

As with all benefit reductions or restrictions, members are not half as happy as when benefits are increased, even if it is for the long-term good of the Scheme. Cost containment tends to be uncomfortable. We hear you and understand the difficulties and assure you it will be discussed further by the relevant Committees and, no doubt, the Board.

Use day clinics to avoid co-payments

The questions raised at the AGM suggest that we need to remind members to use day clinics wherever possible, to avoid co-payments. A day clinic offers outpatient or same-day procedures, usually less complicated than those requiring hospitalisation. It is a facility which allows for a patient to be discharged on the very same day as the procedure is done.

Your Benefit Guide will inform you as to which procedures should be done in a day clinic or accredited facility. For members on the Standard Care Plan and Managed Care Plan, endoscopies (such as gastroscopy, colonoscopy, sigmoidoscopy and proctoscopy) and cataract procedures will incur a co-payment of R3 200 if performed in a hospital. For cataract surgery, a co-payment of R1 000 will apply if performed in a hospital. Standard Care Plan members please also remember to use the facilities on your plan's hospital network to avoid co-payments for non-emergency hospital admissions.

If you are calling the Call Centre for authorisation, the agents will guide you as to which facility to use. You can also use the Provider Search in the member log-in area of the Scheme website to search for day clinics and network hospitals, or find the list of network providers on the relevant benefit page on the website.

In the case of medical emergencies (as per the Medical Scheme's Act definition) please proceed to the closest facility – no co-payment will apply.

Visit www.angloms.co.za to learn more about your Scheme and benefits.
Find all previous MediBrief editions in the Info Centre > Knowledge Library.

Member Queries:

Value Care Plan: 0861 665 665, anglo@primecure.co.za
Standard and Managed Care Plan: 0860 222 633, member@angloms.co.za
Claims: claims@angloms.co.za