AMS ANGLO MEDICAL SCHEME

MEDIBRIEF

SEPTEMBER 2020

Q&A from the AGM

In last month's edition we reported back on the AGM, indicating that we would publish questions raised by members in the upcoming issues of MediBrief as they may be relevant to many other members of the Scheme.

Today we are addressing Mr Penhall's question:
"A great number of the members of the Standard Care Plan are pensioners whose contributions are not subsidised and thus cannot afford the Managed Care Plan. I request that this sector of membership be carefully considered as our income is not increasing at the rate the annual membership fees are going up. I appreciate that medical expenses are increasing at an unbelievable rate. When looking into the future from a pensioner's aspect it is bleak, your consideration will be appreciated."

This question raises three key aspects that are, at times, fiercely debated around the Boardroom table.

Firstly, the aspect of Scheme contribution subsidisation by employers.
The Scheme has no influence over employer subsidisation policies or any changes to these policies. Historically, 100% subsidisation on retirement was normal; today 0% subsidisation is the norm. Consequently, the Scheme has a range of pensioners whose contributions are subsidised anywhere between 0-100%, which has given rise to the current inherent difference in the demographics of the three Plans.

As Mr Penhall points out, today, many pensioners choose the Standard Care Plan (SCP) on the basis of affordability. In response, the Trustees are acutely aware of this fact, as well as the implications on the cost of providing services on SCP, the cost of which directly translates into the contribution required.

The second aspect of the question speaks more to the Scheme's long-term funding policy.
Pensioners, on average, tend to claim 2-3 times more than active employees, largely due to the increased hospitalisation and chronic conditions pensioner members experience. Under normal circumstances, insurance-based products, including medical schemes, require the young and healthy to cross-subsidise the old and sick so as to remain viable. AMS however does not have enough young employees to cross-subsidise the pensioners, which means the current contributions are not enough to cover the actual costs of paying all provider claims and should be significantly higher than other schemes. However, the Scheme "artificially" keeps the contributions at normal rates by using the reserves to meet the shortfall. No other Scheme in the country does this on a predetermined ongoing basis – which is the Scheme's long-term funding policy.

AMS does not actively subsidise a pensioner member on any plan – it may not, the law is very clear – all members must be treated fairly, and no individual member or group of members may be given any form of preferential status. If there is a claims shortfall at the end of the month, money is taken from the reserves to pay claims.

Regarding Mr Penhall's question, the third aspect is the most vexing of the lot. The Scheme and Board are painfully aware of the fact that pension increases barely match CPI, yet medical inflation runs at CPI plus 3%, or more.
Even salaries are not keeping up with medical inflation. The reasons here are three-fold, very simply: member expectation, provider expectation and new technology.

To illustrate the point, and we have used these examples before, in the past a stomach ulcer was possibly diagnosed using a simple black and white x-ray after a patient had swallowed copious amounts of barium meal. This intervention was carried out once, maybe twice, in a patient's lifetime, but certainly not frequently. Today, technology has advanced significantly and a gastroscope is done under anaesthetic routinely, as part of preventative care once a member reaches 40-50 years old to check for cancer and other abnormalities, including ulcers. This means the frequency and the cost have each increased by probably 3-4 times, maybe more. The fact that doctors earn significantly more doing a scope, does not detract from the fact that it is much better medicine and we live a lot longer. Further, not too many doctors or members would settle for anything less. Consequently, members expect more, doctors expect more, and it costs much more, none of which is reflected in the CPI basket of goods. And this is but one example – hence, medical CPI is much higher than the normal household CPI.

We can assure Mr Penhall and all members: the Scheme does everything it can to try to curb unnecessary costs whilst trying to ensure market-related benefits. Measures include using provider networks, aggressively negotiating rates through DH and at times, "cost-sharing" with members through co-payment structures or providers in capitated agreements.

Virtual year-end presentations

Considering the increase in participation in our virtual AGM this year, and the continued need to avoid people gathering in big groups, the Scheme has decided to conduct the year-end presentations as virtual meetings this year. Members that can't attend the year-end presentations will find information about the 2021 changes in the October MediBrief and can download the year-end presentation and/or recording after the meeting.

Year-end presentations for employees

As usual, you will be informed by your employer when and how you can attend the presentation.

Pensioner presentations

Our Client Liaison Officers (CLOs) will be presenting the year-end changes on the below dates. Pensioner members may attend any of the three sessions, regardless of which province they live in.

Tuesday 10 November 2020 at 10h00
Presenter: Sanjay Omnath, CLO in Gauteng, Mpumalanga and Limpopo – SanjayO@angloms.co.za

Wednesday 11 November 2020 at 10h00
Presenter: Megan Collins, CLO in KwaZulu-Natal – MeganC@angloms.co.za

Thursday 12 November 2020 at 10h00
Presenter: Shereen Ashraff, CLO in the Eastern and Western Cape – ShereenA@angloms.co.za

Please email the relevant CLO if you would like to attend his/her session, indicating your name, membership number and email address. Please RSVP as soon as you can, but no later than 30 October 2020. The meetings are, due to technical capacity, limited to 250 members, but we will ensure that all members that would like to attend will find a suitable day/time slot. A few days before the presentation, we will send you the link to the meeting and a guide on how to access it. All you need is a device with internet connection, a web browser and approximately 1GB of data.

What can you expect at these meetings?

As in previous years, the CLOs will touch on the Scheme's results in 2020, present changes, including benefits and contributions for the year 2021, take you through important information about your benefits and attend to general questions regarding Scheme membership and benefits.

Some traditions have to be upheld! Pensioner members attending the virtual year-end presentations can, as always, stand the chance of winning a grocery voucher.

Scheme funding for COVID-19 tests

Even though media is reporting on a reduction in positive cases and testing, you might still need a COVID-19 test for some time.

Requirement for funding: screening and referral by a doctor
You always need to be screened by a doctor and get a referral to a pathology laboratory for the test to be paid by the Scheme. Whether the result is negative or positive, the test will be paid by the Scheme and not from your normal day-to-day benefits. The benefit limit for negative tests is one test a year. If the test is positive, it will be funded as a Prescribed Minimum Benefit (PMB).

Self-referral to a pathology laboratory
If you self-refer (without a referral by your doctor) to a registered pathology laboratory like Ampath, Lancet, Pathcare, etc., the Scheme will not fund the test. The Medical Savings Account can be used on the Managed Care Plan if performed by a registered pathology laboratory. Members on the Standard Care Plan will have to pay for these tests from their own pocket.

Drive-through testing
This service might be offered by a registered pathology group or a pharmacy group. As above, if you have not been screened by a doctor and did not obtain referral to go to a pathology group with a practice number, the test will not be paid. The Scheme can only pay claims, as per Scheme Rules, if the service provider can bill with a valid tariff code.

Home testing
If your doctor refers you for a test and you opt for a nursing practice to perform a test at home, the test will be paid, as long as the test is performed by a registered pathology practice.

Pre-admission testing
Before patients can be admitted for elective (planned) surgery, they need to be tested for COVID-19. You still need a referral from a doctor and to use a registered pathology laboratory for the test. The Scheme will cover one pre-admission test per year.

Before you go to a pathology laboratory, whether for a COVID-19 test or other pathology, call and ask if you can make an appointment instead of queueing with other patients.

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