PG GROUP MEDICAL SCHEME

Issue 9

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Dear Member

In this edition we discuss the contribution and medicine benefit changes for 2017, update you on the need to take care of your eyes and, with the end of the year fast approaching, remind you about getting your health screenings done.

We welcome any suggestions that you may have on articles or member benefits you would like published in future newsletters. Please send your suggestions to the Scheme Manager, Aashna Albert, by email to **aalbert@mhg.co.za** or by fax to **0861 64 77 75**.

Until next time, enjoy the read.

Medicine benefit changes for 2017

Over the past two years, the Scheme has seen an upward spiral in medicine costs, which is related to the rising cost of medicine due to the rand/dollar exchange rate, as well as a general trend among some members to claim for more expensive brand-name medicine versus generic or therapeutic alternatives.

As a result, more members exhausted their acute and chronic medicine benefits earlier in the year and had out-of-pocket expenses in the latter part of the year. The Scheme has therefore decided to implement the following changes to the acute and chronic medicine benefits to ensure that members' benefits last longer.

Reference pricing on acute and chronic medicine benefits

Reference pricing is a maximum price that the Scheme will pay for a group of medicines in the same therapeutic class. If you choose to claim for a medicine that is more expensive than the reference price, you will have to pay the difference in the price of the chosen medicine and the reference price.

When the reference price is determined, the Scheme always ensures that there is a choice of clinically appropriate medicines available at or below the reference price. The reference price structure is regularly reviewed by considering various factors, such as new medicines that have become available, the discontinuation or enhancement of medicines, clinical literature and price changes.

Example A

Doctor prescribes an antibiotic and the member refuses to use the cheaper generic alternative

Medicine:
Zithromax tablets

Cost: R174.55

Reference pricing is applied – (R108.48) paid by the Scheme directly to the pharmacy Member must pay the difference of R66.07 to the pharmacy

Example B

Doctor prescribes an antibiotic and the member agrees to use the cheaper generic alternative

Medicine:
Augmentin tablets

Cost: R108.48

As the medicine cost falls within the reference price, the claim is paid in full

Continued overleaf →

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Maximum medical aid pricing (MMAP) on acute medicine

The MMAP is a reference price model that serves as a guide to medical schemes to determine the maximum price that they will pay for any pharmaceutical product. In practice this means that if you choose a more expensive brand-name medicine when there is a generic equivalent available on the market, the Scheme will only pay the price of the generic equivalent and you will be liable for payment of the difference in cost.

The MMAP is currently applied to medicine that is authorised on the chronic medicine benefit. With effect from 1 January 2017, it will also be applied to claims for acute medicine.

Aute Exclusion List

The acute medicine exclusion list is a list of acute medicines that will only be considered for payment following pre-authorisation on the chronic medicine benefit. The object of the acute medicine exclusion list is to protect your acute/ routine medicine benefits through the exclusion of certain medicine from payment for a number of reasons.

The list has been designed to assist you in managing your acute medicine benefit more effectively. Medicines that are excluded from payment for a number of reasons include:

- medicines that are more expensive when compared to equally effective and cheaper alternatives;
- relatively more expensive medicines that are generally not considered as a first option in the treatment of certain chronic conditions; and
- newly registered medicines that are still under review.

As more cost-effective alternatives are available, medicines on this list will be reimbursed upon registration on the chronic medicine benefit, subject to certain reimbursement criteria and protocols.

Note: Medicines that are not on the list that are paid for in cash will not be reimbursed from members' savings accounts.

Factors contributing to contribution increases in 2017

The Scheme will introduce an 8% contribution increase in 2017.

The decision to increase contributions by 8% in 2017 was motivated by the following factors:

- Medical schemes are non-profit organisations, but should be run at or near a break-even basis in order to remain financially sustainable.
- Since 2012 the Scheme's claims ratio averaged over 106%, which highlighted that members claimed more than they paid in contributions. Moreover, 2015 showed a 103.30% claims ratio, indicating that the shortfall in contributions has escalated.
- In general, medical costs have increased by more than consumer price index (CPI) inflation or general salary increases.
- The latest Council for Medical Schemes annual report indicates that medical inflation for all medical schemes in South Africa is around 11%, which is attributed mainly to:
  - high use of medical services: medical scheme members are claiming more than before;
  - supply exceeds demand: medical practitioners and hospitals over-service patients in order to increase profits;
  - increasing burden of diseases: lifestyle-related illnesses such as heart and other chronic diseases are increasing;
  - shortage of medical practitioners and specialists in South Africa: lack of competition results in increased rates;
  - current exchange rate: the weakening rand increases costs, as some medicines and medical devices are imported.
- The Scheme exceeded its budget on medicine, general practitioners, specialists, hospitalisation and radiology in 2015 and 2016. For a number of years, the Scheme's contribution increases have been contained below the industry average. In 2016 member contributions were increased by 8% compared to the industry average of over 10%.
- Large schemes, such as Discovery Health and Momentum Health, have announced contribution increases in excess of 10% for 2017. The Board of Trustees will continue to make every effort to balance the need to provide competitive benefits, keep contributions affordable and ensure the financial sustainability of the Scheme.

As a result of these factors, the Board of Trustees proposes to limit contribution increases to 8% in 2017 and is introducing a number of initiatives, including the introduction of therapeutic reference pricing, out-of-hospital radiology and pathology to be covered at 80% of the Scheme rate, with 20% that is payable from savings.

Members can assist by using generic medicine where appropriate and by being sensitive to the rates healthcare practitioners charge.

Take care of your eyes – diabetes is a leading cause of blindness

Your eyes are your *windows to the world*, so take good care of them. Go for regular eye exams, get enough sleep and, if you use a computer, give your eyes regular breaks. High blood sugar increases the chances of eye problems, so it's especially important for someone with diabetes to have regular eye exams.

People with diabetes are at greater risk for developing serious eye problems, such as cataracts, glaucoma and retinopathy. Diabetic retinopathy develops when clogged vessels prevent enough blood from moving through the eyes' veins, which affects vision. Cataracts are cloudy areas in the lens inside the eye and are a leading cause of blindness. Glaucoma occurs due to increased pressure in the eyeball and causes slow loss of sight.

Did you know? The Scheme covers glaucoma testing (for blindness) under the wellness benefit. Beneficiaries aged between 40 and 49 are covered once every two years, while beneficiaries who are 40 years old and older are covered once per year. Claims are covered at 100% of the Scheme rate.

Screenings covered on the wellness benefit

Regular health screenings can help identify problems before they start. They can also help identify problems early, when your chances for being cured are better. By getting the right health services, screenings and treatment, you are taking steps that improve your chances for living a longer, healthier life. Your age, health, family history, lifestyle choices, i.e. what you eat, how active you are, whether you smoke, and other important factors have an impact on the kind of healthcare you require and how often you require it.

Don't forget to have your preventive screenings done at your nearest Clicks or Dis-Chem pharmacies. If you haven't gone for your screenings, now is the time to make use of this benefit; these tests are not paid for from your medical savings account, but from your insured wellness benefits.

Source: *https://www.cdc.gov/family/checkup/*

Prescribed minimum benefit (PMB) alert

When do co-payments apply to PMBs?

Answer

Co-payments can only be charged when members voluntarily choose not to:

- go to a designated service provider (DSP) for a specific service; or
- use medication that are not within formulary or approved treatments.

Source: *http://www.medicalaid.co.za/medicalaid/pmbsandchronicdiseases.aspx*

Your personal information

We have robust processes in place to protect your personal information at all times. This is why you need to complete a consent form and submit it to the Scheme before we can assist anyone making a Scheme enquiry on your behalf. Contact our call centre on **0860 00 50 37** and request a consent form to be emailed to you or send an email to **info@pggmeds.co.za**. Alternatively, visit **www.pggmeds.co.za** to download a form.

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