Centre for Actuarial Research (CARE)

A Research Unit of the University of Cape Town

The Cover Provided for HIV/AIDS Benefits in Medical Schemes in 2002

CARE Monograph Number 10

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Synopsis

In respect of the year 2002, information was obtained for 24 open and 53 restricted medical schemes representing 75% and 94% of open and restricted scheme beneficiaries respectively. These 77 schemes offer a total of 221 options and are associated with 14 separate administrators. In total, this research covers 5,29 million beneficiaries.

The schemes were categorised according to the way in which they provide HIV/AIDS benefits. Disease management programmes are widely used with 78% of schemes linked to either their own programme or another programme. Aid-for-AIDS is the biggest disease management programme with 42% of schemes and 36% of beneficiaries linked to this programme. Most options require benefit registration in order to manage HIV costs more effectively. However, disease management participation is very low with only 0.30% of beneficiaries in the industry making use of HIV/AIDS disease management programmes.

The majority of options are exceeding Prescribed Minimum Benefit requirements. Of the sample, only 15% of options (representing 4% of beneficiaries) restrict HIV/AIDS cover to Prescribed Minimum Benefits. Coverage of Prescribed Minimum Benefits is met through a myriad of different types of cover, with normal hospital cover and chronic medication cover the most widely used. Of concern is the 9% of schemes (representing 4% of beneficiaries) covering Prescribed Minimum Benefits through the member's medical savings account.

Medical schemes are providing extensive coverage of HIV support services including HIV counselling, HIV testing and education and information. 64% of options are offering all three of these support services. 81% of those options that provide access to anti-retroviral medication are also offering both the surveillance of drug effectiveness and counselling for people on drug treatment. Wide coverage of treatment, screening and preventative therapy for HIV-related conditions is also being provided. 84% of beneficiaries have access to screening for tuberculosis; 84% have access to preventative therapy for tuberculosis; 87% have access to preventative therapy for PCP pneumonia and 88% have access to treatment for sexually transmitted diseases.

There has been a significant move towards the use of triple-combination therapy as the optimal anti-retroviral treatment. 90% of beneficiaries have access to triple-therapy treatment and only 9% have no access to anti-retroviral medication at all. Very few schemes are currently offering the sub-optimal mono-therapy "cocktail".

Mother-to-child transmission (MTCT) prevention therapy is also being extensively covered. The combination therapy of AZT and 3TC, (or Combivir), is the most frequently used prophylaxis. 92% of beneficiaries have access to some form of anti-retroviral therapy to reduce mother-to-child transmission. 84% of beneficiaries have access to a caesarean section and 77% have access to mother-to-child transmission counselling. However, only 47% of beneficiaries have access to formula feed.

Post-exposure prophylaxis figures also showed extensive coverage. Currently, 96% of medical scheme beneficiaries have access to this treatment in the case of sexual assault and 94% have access in the case of an occupational injury.

While coverage for HIV/AIDS benefits is high, the question of whether the benefits are adequate is a separate issue. This requires investigation of benefit structures at a micro-level. This monograph provides a first indication of the type of benefit structure and the size of benefits in each benefit category.

The regular monetary limit was the most common mechanism used with respect to all HIV-associated claims. Varying degrees of members' medical savings accounts were utilised with the highest usage appearing in the HIV consultation limit. Capitation, networks and ex-gratia benefits were minimally used. Event based limits were predominantly used with regards to hospitalisation, mother-to-child transmission and post-exposure prophylaxis benefits. Hospitalisation benefits accounted for the largest percentage of unlimited benefits.

The benefit structures were also analysed according to the most common cost management mechanisms utilised. Co-payments were seen to be used preferentially to levies, with some schemes using a co-payment as much as 50% of cost price. However no more than 14% of schemes used either a co-payment or a levy for any limit. The most common tariffs used were the Board of Healthcare Funders (BHF) tariff for pathology, hospitalisation and consultation benefits, and cost price for anti-retroviral medication, other medication, mother-to-child transmission treatment and post-exposure prophylaxis.

In all, trustees are to be congratulated on having succeeded in providing comprehensive access to benefits for HIV/AIDS. The disturbing evidence of the low participation rates in the various disease management programmes points to the inadequate marketing of these programmes and the lack of members' awareness of these services.

It is difficult for members to compare scheme benefits when joining a scheme. Effort should be made to ensure some standardisation across all medical schemes. In line with all the national and international guidelines, the Council for Medical Schemes should facilitate schemes to adopt a guideline on anti-retroviral therapy that stipulates triple therapy as the minimum standard.

It is of concern to note that 9% of options make use of the illegal practice of funding Prescribed Minimum Benefits from savings accounts. We recommend that the Council for Medical Schemes immediately issue a circular warning all schemes that this practice is unacceptable and unlawful. We strongly support the amendment in the Proposed 2002 Regulations that specifically makes the use of savings accounts to fund PMB conditions unlawful.

Based on the survey findings, the authors recommend in the strongest possible terms that the Minister of Health extends the proposed Prescribed Minimum Benefits for HIV/AIDS, as set out in the draft Regulations of 30 April 2002.

In respect of extending the PMBs to include anti-retroviral therapy, we recommend that further modeling needs to be carried out to predict the impact of the epidemic over time on individual schemes. The Minister of Health should promulgate the extension of PMBs to include anti-retroviral treatment, but allow exemptions to schemes that have demonstrable problems in the absence of a risk equalization mechanism. The Minister of Health is urged to pursue the introduction of a risk equalisation mechanism between schemes at the earliest possible opportunity.

Anti-retroviral coverage is adequate in the main but could quickly be exhausted unless prices are reduced to generic levels. The cost to members of anti-retroviral benefits needs further investigation and standardisation to ensure sustainability and access.

Medical schemes should actively seek broader coalitions amongst one another and with organisations like *Treatment Action Campaign* to lobby collectively for a reduction in treatment and monitoring costs.

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1. Introduction

1.1 Background

The HIV/AIDS epidemic has become a highly contentious issue in South Africa. With South Africa shouldering the burden of the highest number of people with HIV in the world, nearly 5 million people or 1 in 9 of the population (Department of Health, 2001), there has been much criticism of the government's perceived lack of coherent action. With hundreds of new infections every day, both the public and private sectors are now finding it increasingly difficult to ignore the serious impact of the virus and are slowly electing to become more proactive in the country's HIV crisis.

Over the past decade , since the extent of the effect of the virus has been widely understood, the government, non-governmental and private corporations have begun campaigns and initiatives to educate, support and treat the people. The last year has seen civil organisations like *Treatment Action Campaign* (TAC) take the government to court over the provision of anti-retroviral medication in all state-run institutions to prevent mother-to-child transmission of the disease (TAC and others v Minister of Health and others, 2002). Government is now shifting in attitude towards dealing with the pandemic and anti-retroviral medication may soon be widely distributed in the public sector. Other court actions have seen price reductions in anti-retroviral medication resulting in greater accessibility to these expensive drugs.

The private healthcare sector, however, lacks transparency and consolidated information has not been available on the extent of HIV benefits being offered. This monograph serves primarily to provide more information on the design of HIV/AIDS benefits in open and restricted medical schemes in South Africa in 2002.

Medical schemes, be they open, restricted or exempt, are under a legal and constitutional obligation to provide access to quality and affordable health care services on a non-discriminatory basis.

Over the last few years, most medical schemes have accepted responsibility for their members with HIV/AIDS. In addition to legislated Prescribed Minimum Benefits, members with HIV/AIDS are often covered through disease management programmes that provide a comprehensive response to the disease. Furthermore, since the reduction in drug prices in 2001, many schemes have undergone substantial benefit design changes.

However, not all schemes provide such benefits, thereby denying members coverage. Therefore, remedies are required to ensure the equitable treatment of people with the disease across all medical schemes.

Some commentators have argued that the HIV/AIDS epidemic will have a negative impact on the viability and future existence of medical schemes in South Africa. It is therefore fundamental that the nature of benefits currently being offered by schemes is widely understood so as to provide a clear basis for decisions regarding the future coverage for HIV/AIDS.

Attempts to cost the impact of proposed Prescribed Minimum Benefits for HIV/AIDS conditions (see Section 1.2) are also dependent on more accurate information on the benefits already being covered by medical schemes.

Reliable information on the nature of benefits offered by medical schemes will assist organisations like *Treatment Action Campaign* in negotiating further price reductions. Areas for focus are the drug costs, pressing for reduced charges for diagnostic and monitoring tests, and for reductions in the cost of treatment for hospitalisation for HIV/AIDS-related conditions.

1.2 Applicable Legislation

The Medical Schemes Act (Act 131 of 1998), effective from January 2000, regulates medical scheme coverage for certain defined health conditions in terms of Prescribed Minimum Benefits (PMBs). The PMBs are defined in Annexure A to the Regulations made in terms of the Act, as published on 20 October 1999 (the 1999 Regulations).

The aim of the legislation is to prevent schemes that did not provide these minimum benefits from abandoning members to the public sector, thereby exhausting public hospital facilities. The minimum benefits must be covered in at least one network of hospitals, which may include public sector hospitals. Schemes may not impose financial limits on members for the cost of diagnosis, treatment or care for the conditions covered by Prescribed Minimum Benefits.

The Prescribed Minimum Benefits for HIV/AIDS currently include only the treatment and management of opportunistic infections and localised malignancies (Department of Health, 1999). No other anti-retroviral medication or treatment to prevent mother-to-child transmission is required. The PMBs and explanatory text that applies to HIV/AIDS benefits is reproduced in full in Appendix A.

Proposed amendments to the Prescribed Minimum Benefits were published in the Government Gazette of 30 April 2002. These proposals (the Proposed 2002 Regulations) are open for comment for three months prior to a determination being made by the Minister of Health and the final publication of the revised Regulations. The proposal extends the PMBs to include a further package of benefits in respect of HIV/AIDS-related conditions, and includes treatment to prevent mother-to-child transmission and in the case of sexual assault. At the same time, it is proposed that the PMBs be extended to cover chronic medicine benefits and medical management in respect of a list of 29 defined conditions. These are set out in full in Appendix B.

The Act requires community rating, thus schemes are prohibited from using age or health status as rating factors and may only use income and number of dependants in differentiating contributions. In addition, the Act requires guaranteed acceptance under which schemes are prohibited from underwriting members on entrance to the scheme, thus limiting discrimination on the basis of any medical condition, including HIV status. Medical schemes may not preclude any member the right to join any benefit option (Medical Schemes Act 1998, section 24 (2)(e)).

However if individual members move from one scheme to another, under circumstances other than a change of employment, waiting periods of up to three months or pre-existing condition exclusions of up to twelve months may be imposed within strictly defined parameters, as set out in the Medical Schemes Amendment Act of 2001. Waiting periods may only apply to Prescribed Minimum Benefits if the beneficiaries making application were not covered by another medical scheme in the 90 days preceding application.

1.3 Objectives

The main objective of this monograph is to provide a comprehensive analysis of the structure of HIV/AIDS benefits in open and restricted medical schemes for 2002. Of major importance will be the extent to which Prescribed Minimum Benefits have been exceeded, in order to evaluate the potential impact of the Proposed 2002 Regulations which expand coverage for HIV/AIDS conditions.

1.4 Data

A comprehensive questionnaire (see Appendix C) was sent to the principal officers of all the open, restricted and exempt schemes in operation in South Africa in 2001. Contact was made with all the known HIV/AIDS disease management programme managers to encourage the participation of their schemes in the survey.

Questionnaires were mailed to 168 schemes on 12 February 2002, using a list combined from the Government Gazette, Vol. 429, No. 22117, and the Council for Medical Schemes website. Extensive telephonic and electronic correspondence was undertaken to attempt to increase the response rate. In some cases schemes no longer existed and a total of 77 completed replies was received before the cut-off date at the end of April 2002. The degree of coverage this represents is discussed in Section 2.

A small number of schemes refused to complete the questionnaire. Attempts were made to source their benefits structures directly from the Council for Medical Schemes but available scheme rules proved too difficult to interpret and were in some cases either vague or ambiguous.

Exempt schemes were subsequently excluded from the analysis as insufficient information was obtained to produce a reliable comparison. These schemes are exempt from the provision of Prescribed Minimum Benefits and their benefit structures are typically based on primary care provided by staff or panel doctors.

In addition to the survey questionnaire, printed marketing material and the internet were utilised to obtain clarity on benefits offered by schemes. Data was not collected on disease management programmes.

1.5 Comparison with Previous Research

Previous research conducted at the University of Cape Town by Mayur Lodhia (2001) was a useful guide and reference, and its section on general employee benefits will remain helpful for future researchers. However, this monograph differs from previous research in the following ways:

- Previous research was based on scheme benefits as opposed to option benefits. This leads to inaccuracy as certain schemes have options that offer Prescribed Minimum Benefits only and others that offer complete HIV benefits. For example, the OmniHealth Omnicare option offers Prescribed Minimum Benefits only, while their Omnitop option offers full HIV benefits including anti-retroviral medication, treatment to prevent mother-to-child transmission and post-exposure prophylaxis.

- Previous research was based on scheme rules with marketing material being available for only some schemes. This monograph is based on information supplied directly by schemes, supplemented by marketing material. The information is thus more accurate and more reliable.

- At the time of writing, the Registrar has only made available data in respect number of beneficiaries by option for 2000. The number of beneficiaries in this research came from each individual scheme directly and is the latest data available for 2002.

1.6 Acknowledgements

The authors would like to thank the following people for their time, support and assistance in obtaining relevant information:

- Nathan Geffen, National Manager of the *Treatment Action Campaign*
- Stephen Laverack, Aid-for-AIDS representative at Medscheme
- Shivani Ranchod
- All the principal officers of the schemes that participated in the questionnaire
- The managers of HIV/AIDS disease management programmes
- The Research staff of the Council for Medical Schemes.

2. Coverage of the Survey

Information on numbers of beneficiaries and benefit structures was obtained for 24 open and 53 restricted medical schemes. These 77 schemes offer a total of 221 options and are associated with 14 separate administrators. In the few cases where beneficiary numbers were not supplied, the latest figure from the scheme's Statutory Return to the Registrar was used. It is estimated that the 77 schemes together cover some 5,290,030 beneficiaries.

The question of whether this represents adequate coverage of the industry was gauged using the latest available data from the Council for Medical Schemes, which is in respect of the year 2000. Since then, there has been further consolidation of schemes and growth of certain schemes. While acknowledging that the use of 2000 data to gauge the extent of reporting in 2002 is far from ideal, there is no other reliable source of data.

The table below shows the degree of coverage for the survey as a whole. Further breakdowns into open and restricted schemes and by size, are given in the graphs which follow. Note that the survey reports on open and restricted schemes, excluding the exempted schemes.

***TABLE 1:* Estimate of Survey Coverage**

	Number reporting in 2002 Research	Number from Registrar's Statutory Returns 2000	Estimated Percentage Coverage
Schemes	77	144	53%
Options	221	407	54%
Beneficiaries	5,290,030	6,579,986	80%
Principal Members (Families)	Insufficient respondents provided information, thus comparison not available.		

2.1 Coverage by Scheme Type and Size

A more detailed way of examining coverage is to consider coverage by scheme type and size. Much of the analysis that follows later uses the same categorisation.

Scheme type is either "open" or "restricted", as set out in the Medical Schemes Act. In general, restricted schemes are employment based and thus restricted to employees and retirees of a specific company or group. Open schemes must allow anyone to become a member.

The criteria for "small", "medium" and "large" schemes are defined by the Council for Medical Schemes in the Registrar's Report for 2000 and shown in the table below. "Ultra small schemes" is a category defined by CARE as those schemes with less than 2500 principal members.

***TABLE 2:* Scheme Size Criteria**

Ultra small	Small	Medium	Large
Less than 2500 principal members	2500 or more principal members but less than 6000 principal members	6000 or more principal members but less than 30000 beneficiaries	30000 or more beneficiaries

The number of schemes gives the number of points of leverage in decisions about benefits. Information was obtained for 51% of the open schemes and 55% of the restricted schemes. Notably, the study covers 83% of large restricted schemes and 70% of large open schemes.

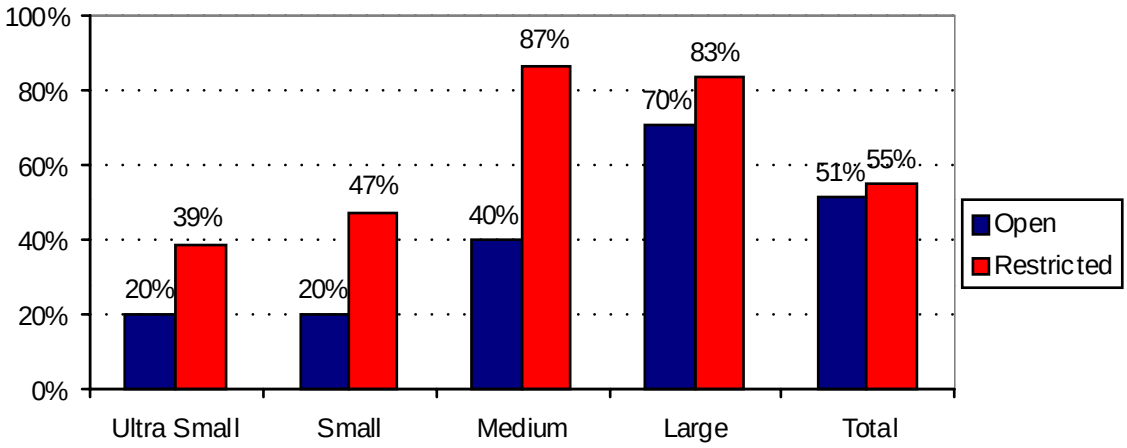

***FIGURE 1*: Percentage of schemes covered in the survey**

A more important analysis is the number of options covered, as this indicates the number of structures affected. The survey covers 52% of open scheme options and 58% of restricted scheme options in the market in 2000. The research covers 109% of large, restricted scheme options, indicating an increase in the number of large, restricted scheme options since 2000.

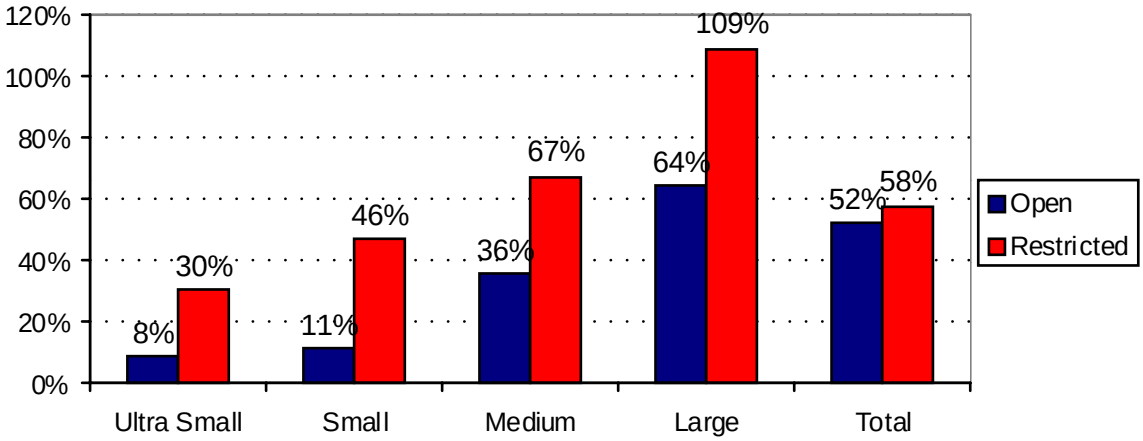

***FIGURE 2*: Percentage of options covered in the survey**

The most important criterion is the number of beneficiaries covered, as this indicates the number of people affected. The survey covers 75% of open scheme beneficiaries and 94% of restricted scheme beneficiaries.

The research has coverage of 122% of the large restricted scheme beneficiaries, indicating a substantial increase in large restricted scheme membership since 2000.

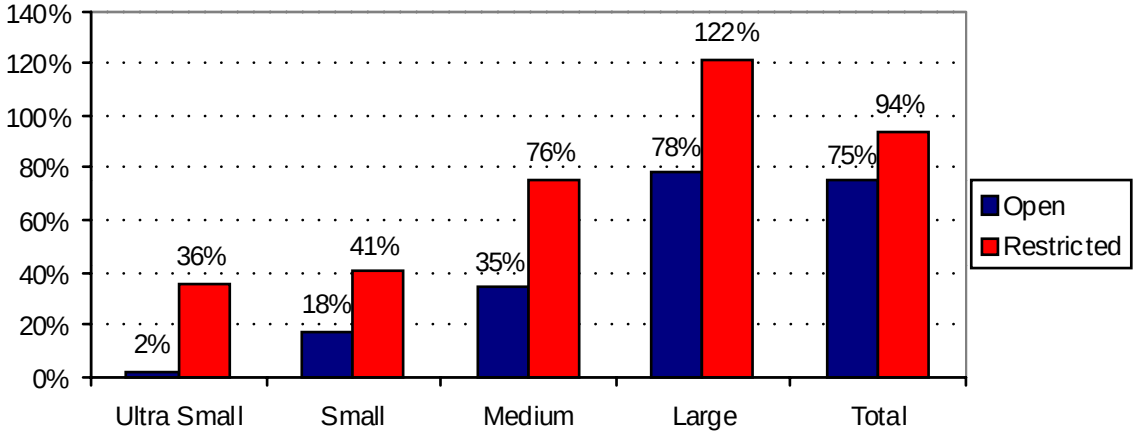

***FIGURE 3*: Percentage of beneficiaries covered in the survey**

The number of schemes and the number of options covered is over half, but is not as extensive as may be desired. However since the beneficiary coverage is so extensive, the data sample was accepted as a fair representation of the South African open and restricted medical scheme market in 2002.

While the authors do not have insight into the benefits structures, option or beneficiary numbers of the schemes that did not reply to the questionnaire, it is anticipated that these schemes have poorer coverage of HIV/AIDS-related conditions than the schemes who did reply.

3. HIV/AIDS Benefit Management

The 77 schemes analysed were divided into 4 categories according to the HIV/AIDS benefits provided and the way in which these are managed:

- Schemes that provide no additional HIV benefits apart from Prescribed Minimum Benefits,
- Schemes that are not managed by any disease management programme,
- Schemes that are managed by the Aid-for-AIDS disease management programme, a programme regarded as the benchmark in the industry by *Treatment Action Campaign*,
- Schemes that are managed by another disease management programme (DMP), including their own programme.

Figure 4 below shows that only 9.1% of schemes are offering no benefits other than Prescribed Minimum Benefits. This translates to 7 schemes.

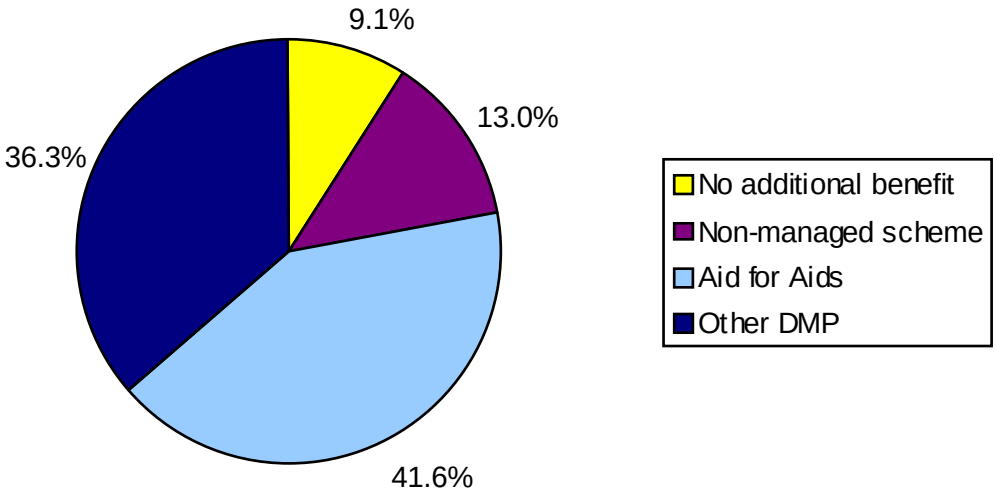

***FIGURE 4*: Categories of HIV/AIDS benefits (by schemes)**

Note that 13.0% of schemes have no specialised disease management programme in place, despite offering benefits in excess of the Prescribed Minimum Benefits.

The largest grouping at 41.6% is schemes that are linked to the Aid-for-AIDS disease management programme. Note however that schemes that did not supply data are more likely to fall into the categories of no additional benefit or no disease management programme.

When beneficiary numbers are associated with the schemes in Figure 4, a different picture is presented. Figure 5, on the following page, shows a reduced degree of influence of schemes linked to Aid-for-AIDS. It is gratifying to note that only 2.5% of beneficiaries belong to schemes that offer no additional benefits.

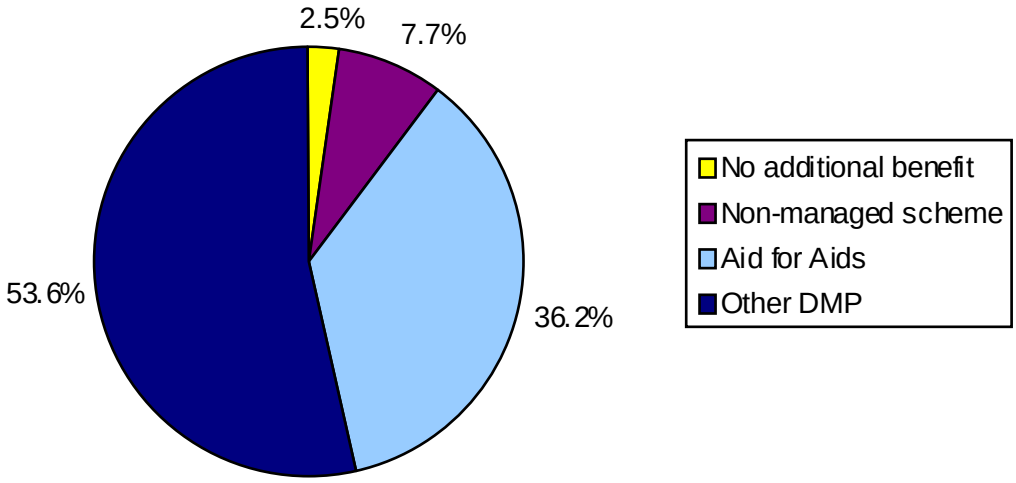

***FIGURE 5*: Categories of HIV/AIDS benefits (beneficiaries in schemes)**

3.1 Features of Chronic Disease Benefit Design

Treatment of members with chronic diseases is a major cost for medical schemes. Thus, a number of mechanisms are used by schemes to manage these costs, including:

- Negotiated tariffs
- Levies and co-payments
- Drug lists or formularies
- Disease management programme registration
- Capitation and networks.

Tariffs are used as a benchmark for cost control. Some schemes pay the industry tariff in full, while other schemes only pay a percentage of the tariff. Any cost over and above the tariff is required to be met by the member.

Levies and co-payments act as a means to prevent the excess utilisation of medical schemes by members. The member will be responsible for a defined portion of each payment thus supposedly deterring the member from excessive claiming behaviour. This has greater impact on lower income members, who may struggle to meet the co-payments from their monthly disposable income.

Drug lists or formularies are used to manage costs. They restrict the member by providing a list of drugs that the provider may choose from for specific conditions. These drug lists usually contain generic drugs and will often exclude anti-retroviral medication, immune system boosters and prophylactics.

Capitation fees are paid directly to medical providers so that they become responsible for the provision of defined health services to the schemes' members. Networks are used to contract collectively with healthcare providers in an effort to reduce costs.

Disease management registration ensures a more comprehensive management of benefits, and leads to better data collection on those lives and their drug utilisation behaviour, thereby optimising cost effectiveness. It may also act as an avenue for interventionist action on the part of the schemes. Disease management programmes provide clinicians with information on current best practice for the treatment of each disease, within the parameters adopted by the scheme.

3.2 Disease Management Programmes for HIV/AIDS

Disease management programmes were introduced in order to provide a comprehensive management approach for beneficiaries of contracted medical schemes. In the case of HIV/AIDS, systems have been created within these programmes to ensure client confidentiality.

Medscheme's Aid-for-AIDS disease management programme is widely regarded as the industry standard. The main objectives of the programme are as follows:

- provide managed access to anti-retroviral therapy
- facilitate access to benefits for the treatment of post-exposure prophylaxis (in the event of occupational injury or sexual assault)
- provide therapy for the prevention of mother-to-child transmission
- offer expert advice to the primary care physician of the member's choice
- provide a comprehensive education and awareness programme to members and employee groups
- assist with medication-related problems and lifestyle issues by means of nurse counsellors (Aid for AIDS, 1998).

Disease management programmes can potentially improve cost effectiveness. Specialist case management and treatment protocols have been found by Aid-for-AIDS to significantly reduce hospitalisation, outpatient and other medication costs.

To the knowledge of the authors there are currently seven disease management programmes in operation in South Africa, with one new programme having begun marketing in 2002 (alphabetically) :

- Accesshealth SA (new programme).
- Aid-for-AIDS
- Calibre Clinical Consultants
- Discovery Health
- Lifesense
- MX Health
- Newmed
- Qualsa (to be merged with Newmed in 2002).

Figures 6 and 7 show that 78% of schemes are linked to a disease management program. These 78% of schemes represent 89% of the beneficiaries in open and restricted medical schemes.

The most widely used disease management program is Aid-for-AIDS, with 42% of schemes linked to their programme. 18% of schemes have their own disease management programme, and each of the remaining programmes is linked to less than 5% of the schemes.

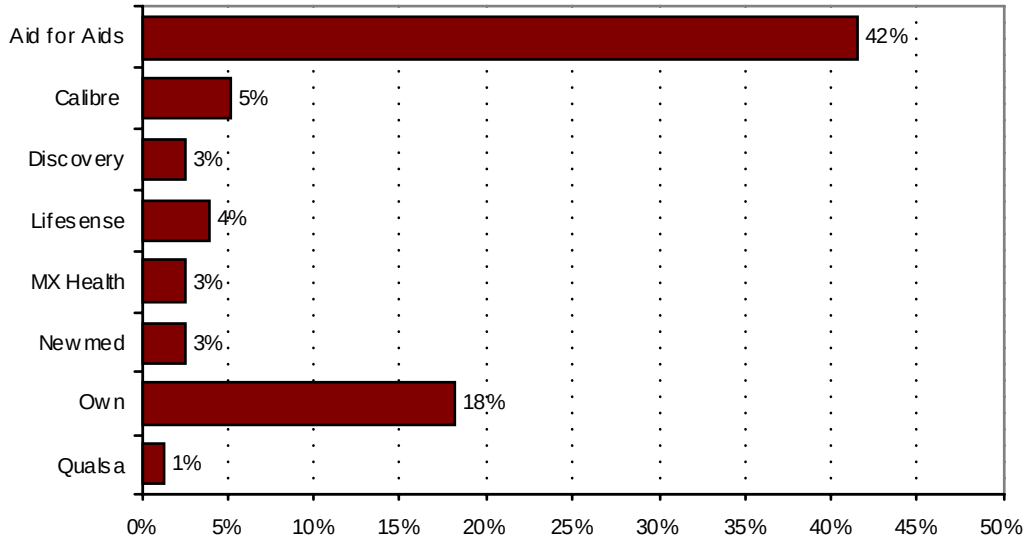

***FIGURE 6*: Schemes linked to each disease management programme**

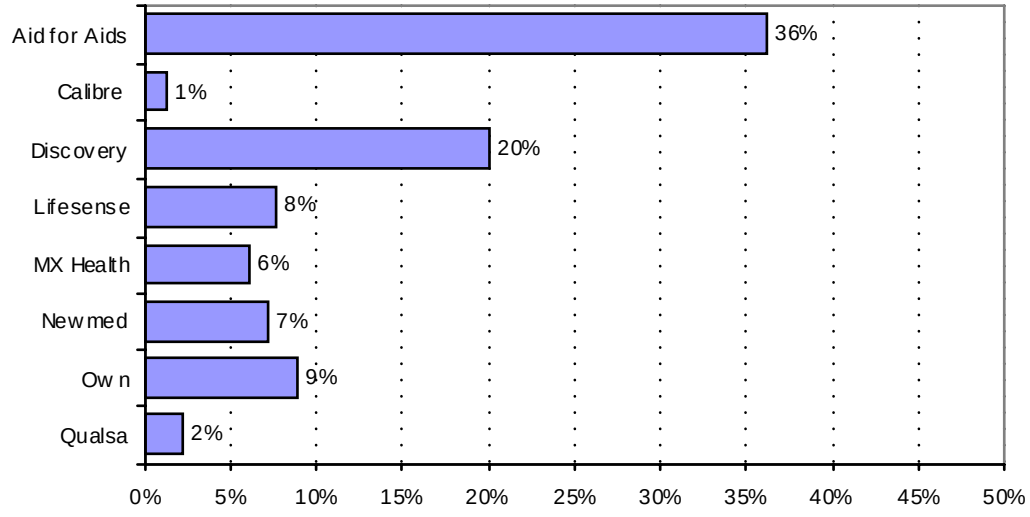

***FIGURE 7:* Beneficiaries linked to each disease management programme**

From Figure 7, Aid-for-AIDS is the biggest single disease management programme with 36% of the beneficiaries. Discovery Health's programme represents 20% of the beneficiaries, the second biggest share.

It is shown below in Figure 8 that all the options on schemes linked to the major disease management programmes require registration for the programme. Those schemes that have developed their own version of a disease management programme only require benefit registration on 66% of options.

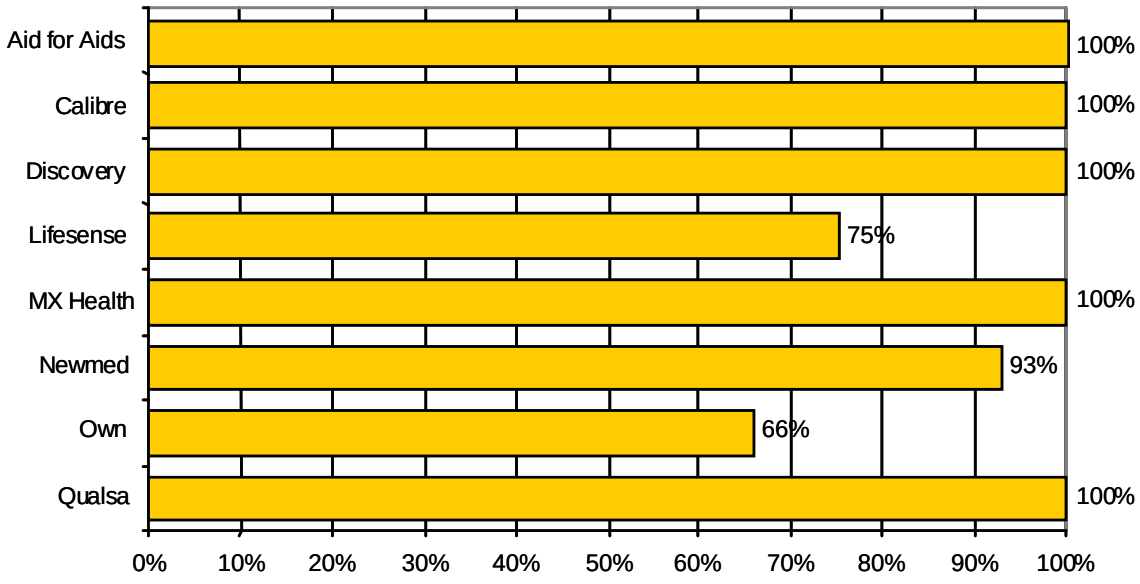

FIGURE 8: **Options of schemes linked to disease management programmes requiring registration**

Overall, 86% of options make use of a disease management programme to manage HIV/AIDS benefits.

3.3 Participation of Beneficiaries in HIV/AIDS Disease Management Programmes

One of the most remarkable results of this research was the very low participation rate of beneficiaries in the HIV/AIDS disease management programmes, given South Africa's high HIV prevalence rates.

This was gauged by comparing, in aggregate, the number of beneficiaries per option registered with the programme compared to the total number of beneficiaries in each of those options that provided this information.

Many schemes refused to provide this information and information was provided for all schemes using the Aid-for-AIDS programme in totality. Results by scheme have been kept confidential.

The graph below shows the number of beneficiaries with access to disease management programmes who have registered for those programmes.

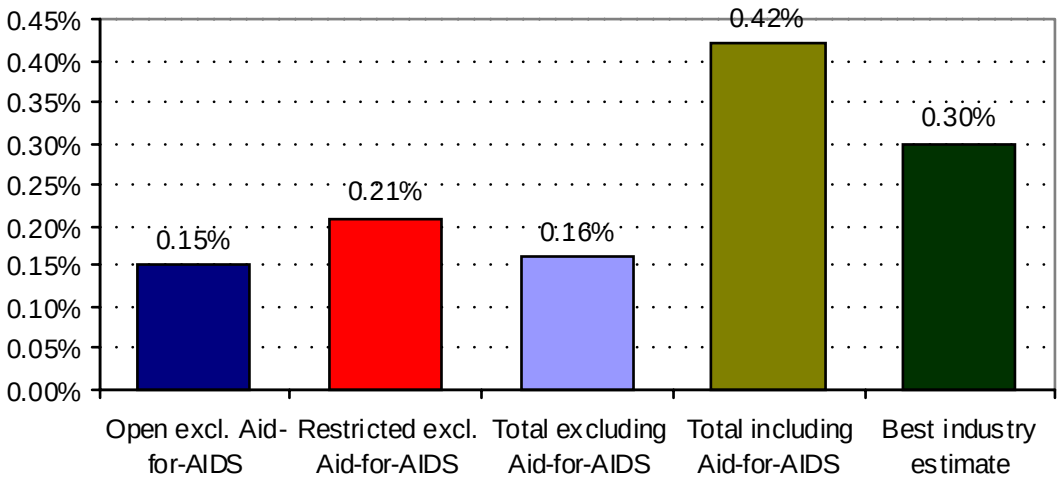

FIGURE 9: **Beneficiaries participating in disease management programmes**

Excluding Aid-for-AIDS, only 0.16% of beneficiaries that have access to disease management programmes are actually registered with the programmes. This is a disturbingly small proportion.

The leading role played by Aid-for-AIDS in the industry is evidenced by the large number of beneficiaries they have enrolled on the programme and thus their experience of clinically managing the condition. Aid-for-AIDS manages 79% of all beneficiaries reported registered on disease management programmes. In total, including Aid-for-AIDS, 0.42% of beneficiaries that have access to programmes are registered on those programmes.

The total number of beneficiaries reported in this survey as being on programmes in early 2002 is 17 745, which is 0.42% of beneficiaries of the schemes reporting on this issue. Other industry evidence suggests an overall number of 22 500 beneficiaries are registered on programmes, which would be 0.30% of beneficiaries in the industry as a whole. This latter number is considered to be the best estimate for the industry.

Although there is no published data on the prevalence of HIV/AIDS within medical schemes, the percentage of beneficiaries participating in schemes' disease management programmes is unquestionably low. The restricted scheme's participation rates are slightly higher than that of open schemes.

The proportion of beneficiaries of medical schemes who may be HIV positive is estimated by CARE researchers, from other research work, to be of the order of 5%. Thus the finding that, in total, only 0.30% of all beneficiaries in the industry are using HIV/AIDS disease management programmes, is a serious problem.

It is of grave concern that members may have access to the services, treatments and therapies that medical schemes are offering, yet are not coming forward.

Research on SASOL, a diversified fuel, chemical and related manufacturing company with more than 26 000 employees in South Africa and a company-wide HIV sero-prevalence rate of 15%, indicates a very low take up of the Aid-for-AIDS programme. Only one quarter of the expected HIV-positive employees have accessed the voluntary counselling and testing offered by the programme and only one third of those who have tested positive have registered for the Aid-for-AIDS programme. (Dickinson: 2002, pp.8-10,40-41,49-50) This reinforces the findings of this research on the low registration and uptake of treatment programmes.

The authors suggest the following reasons for the low uptake of available treatment programmes, but stress that these require further investigation:

- **Inadequate information**
  Lack of information and inadequate marketing by medical schemes and disease management programmes of HIV and ARV benefits may account for some of the low uptake.

- **Stigma and discrimination**
  Fear of stigma, discrimination and possible employment-related repercussions may constitute a significant barrier to accessing HIV/AIDS medical benefits and anti-retroviral therapy. Where medical scheme access is employment-related, fears of unlawful disclosure, stigma and discrimination could be stronger.

- **Scientific confusion**
  Public confusion over the safety and efficacy of anti-retroviral therapy following the "scientific" debates of the HIV denialists may be a factor.

- **Costs**
  Research on the level of co-payments for medicines and diagnostics or perceived costs of accessing ARV therapy will indicate whether this constitutes a barrier to treatment.

- **Delayed uptake**
  Many people with HIV/AIDS may delay access until they become significantly or terminally ill. Evidence presented by Dr Leon Regensberg and Michael Hislop of Aid-for-AIDS indicates that people wait until there is a significant health crisis before registering on the programme. Information on the benefits of early diagnosis, regular monitoring and appropriate anti-retroviral interventions will assist in this regard.

These problems could be overcome through research and a pro-active campaign to market HIV/AIDS benefits. Although this might cost the schemes more money initially, the savings that will accrue from decreased morbidity and HIV prevention may be significant.

4. Coverage of Current Prescribed Minimum Benefits

The role of Prescribed Minimum Benefits and the applicable legislation is described in Section 1.2, with relevant extracts from the legislation provided in Appendix A.

Currently, the only HIV benefit included in Prescribed Minimum Benefits is the treatment and management of opportunistic infections and localised malignancies consistent with prevailing medical practice in a public hospital. Opportunistic infections include Pneumocystis carinii pneumonia (PCP), tuberculosis and oral thrush (Department of Health, 2000).

4.1 Options that provide only Prescribed Minimum Benefits

Figure 10 below shows that 14.9% of options provide Prescribed Minimum Benefits only. These options represent only 3.9% of beneficiaries and 3.0% of families respectively. This implies that most of the options that offer Prescribed Minimum Benefits are relatively small. The families in question are also relatively larger families.

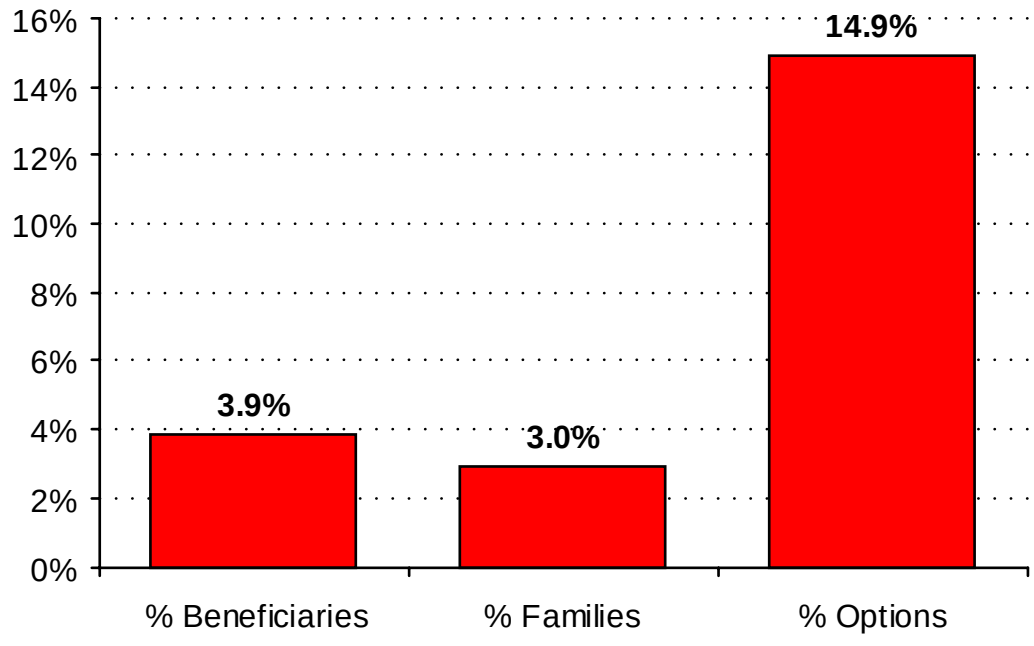

FIGURE 10: **Options that provide only Prescribed Minimum Benefits**

The graph represents 33 options in 17 schemes. These are named in Appendix E.

Also noteworthy is the fact that of those options that provide PMBs only, 24% are restricted scheme options and 76% are open scheme options.

The figure of 4% of beneficiaries with only PMBs differs from the 2.5% of beneficiaries who belong to schemes that offer 'no additional benefit', shown in Figure 5 in Section 3. The reason for this is that in order for a scheme to be classified as offering 'no additional benefit,' every option in that scheme must offer Prescribed Minimum Benefits only. The additional 1.5% of beneficiaries are from those schemes that have options that offer only PMBs as well as options that offer more extensive benefits.

The low numbers of families and beneficiaries that have access only to PMBs is very gratifying. These figures emphasise the medical schemes' efforts to mitigate the effects of HIV and their continued acceptance of responsibility and support for their HIV positive members. Trustees and schemes managers would seem to have realised that a proactive approach to treatment is more cost effective.

4.2 Means of Covering Prescribed Minimum Benefits

All medical schemes in South Africa (with the exception of exempt schemes) are required by law to provide treatment for opportunistic infections as part of Prescribed Minimum Benefits. Anecdotal evidence from schemes, trustees and administrators suggests that the full implementation to meet the requirements of PMB legislation has not yet occurred. Therefore, it is of interest to determine what kinds of cover medical schemes use to provide for opportunistic infections.

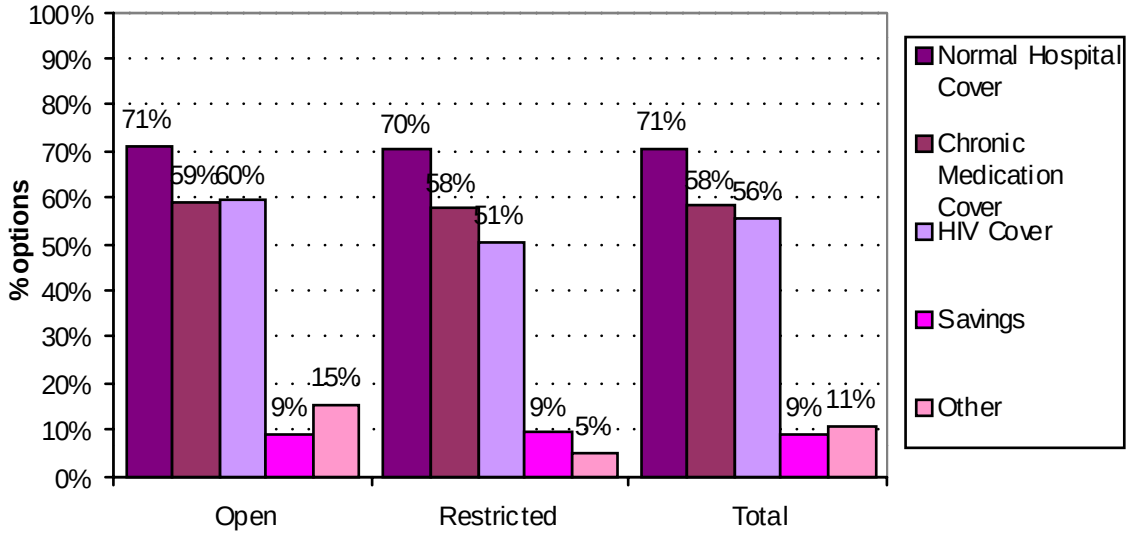

FIGURE 11: **Cover of opportunistic infections by option**

The pattern of opportunistic infection cover for open and restricted scheme options was almost identical, with the majority of options (71% of options in total) providing for opportunistic infections out of normal hospital cover. 58% of options provide for these infections out of chronic medication cover and 56% out of a separate HIV cover. There is an overlap with many schemes using a combination of hospital cover, chronic medication cover and separate HIV cover to meet the Prescribed Minimum Benefits.

Of great concern was the finding that 9% of options were covering opportunistic infections, either partially or completely, from members' medical savings accounts. This can be seen in the figure below. These 20 options from 6 schemes are named in Appendix F. Our understanding is that schemes are required by the Medical Schemes Act to provide cover for PMBs with no limit. The Proposed 2002 Regulations make it explicit that no scheme may use a member's savings account to cover a Prescribed Minimum Benefit condition.

It was even more concerning that of those options that use the members' savings accounts to cover PMBs, only 45% use the savings account in conjunction with some form of pooled cover. In other words, 11 options were paying for opportunistic infections entirely from savings accounts.

An analysis of the options covering PMBs through savings accounts is shown in Figure 12 below. None of the Aid-for-AIDS options do so and the majority are from those schemes offering no additional benefit apart from PMBs.

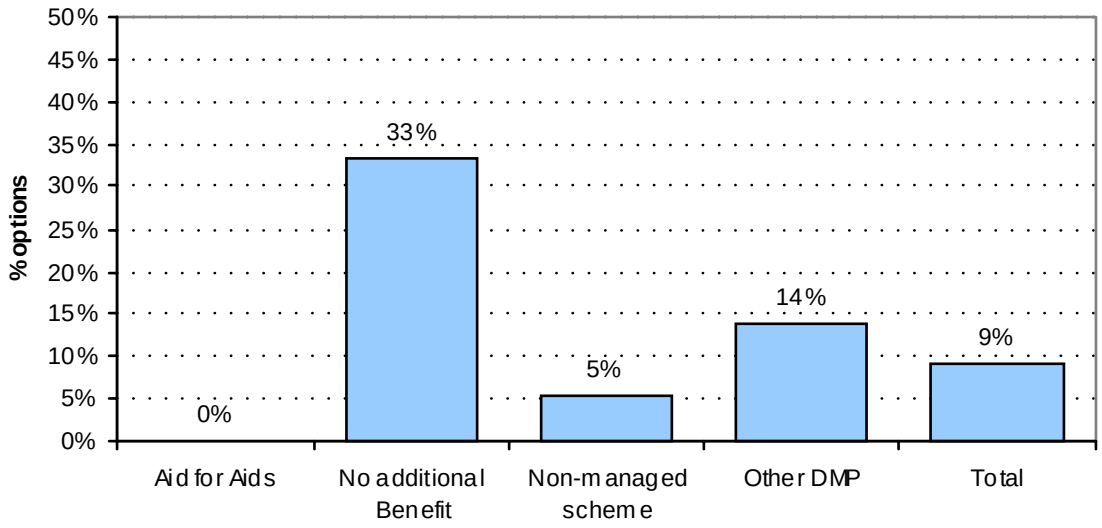

FIGURE 12: **Cover of opportunistic infections by savings accounts**

5. Coverage of Proposed Prescribed Minimum Benefits

The proposed Prescribed Minimum Benefits published for comment include an extended package of benefits on the diagnosis of HIV/AIDS. These include post-exposure prophylaxis for occupational injury and sexual assault and intervention to prevent mother-to-child transmission (Department of Health, Draft Regulations, 2002). The process is described in Section 1.2 and extracts from the proposed legislation are provided in Appendix B.

5.1 Support Services

The inclusion of support services into medical schemes' HIV management programmes is fundamental. Since the disease is fuelled and exacerbated by lack of education and support systems, strong policies on prevention and education can greatly reduce the spread of the disease.

Risk-reduction strategies include correct and appropriate information and education, health and social support services (including counselling, testing and condom distribution) and non-discrimination towards people living with HIV/AIDS.

Government, private corporations and non-governmental bodies have undertaken many initiatives to educate the public against unsafe sex practices and universal precautions in the workplace and schools. Education plays a key role in preventing new infections and reducing the impact of infections that have not been avoided. Education should also include an overview of the disease, the transmission of the virus, identification of the virus through symptoms, and what to do in the event of diagnosis.

The graph below shows that medical schemes, too, have embraced certain support services as core responsibilities.

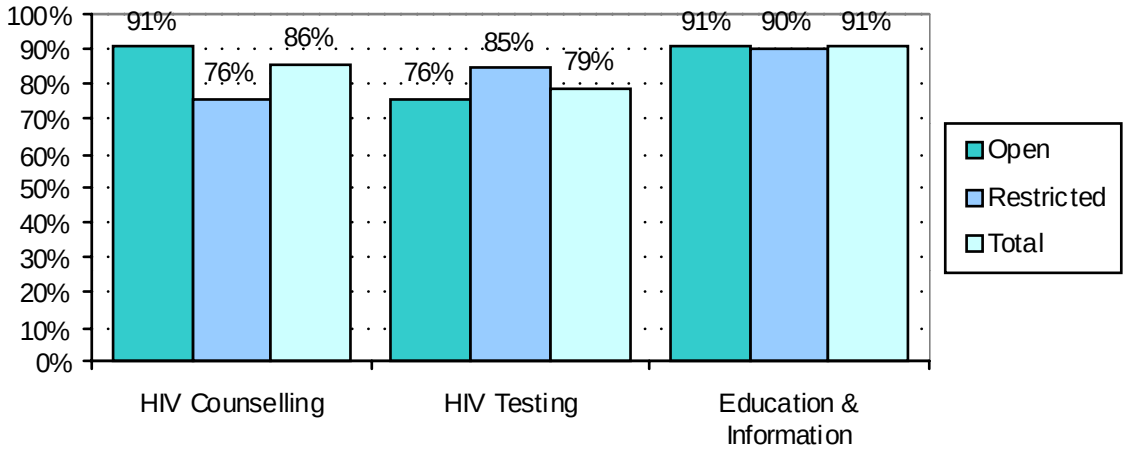

FIGURE 13: **Beneficiaries with access to HIV support services**

Figure 13 shows that the majority of medical scheme options, irrespective of the type of scheme, are offering support services. It is encouraging to note that 91% of beneficiaries have access to education and information and 79% have access to HIV testing. High access to these support services could be due to their low cost nature.

Figure 14 shows the combinations of services offered, with 64% of options providing all three support services. It was found that 13 % of options provide no cover for support services. This translates into 29 options from 13 schemes.

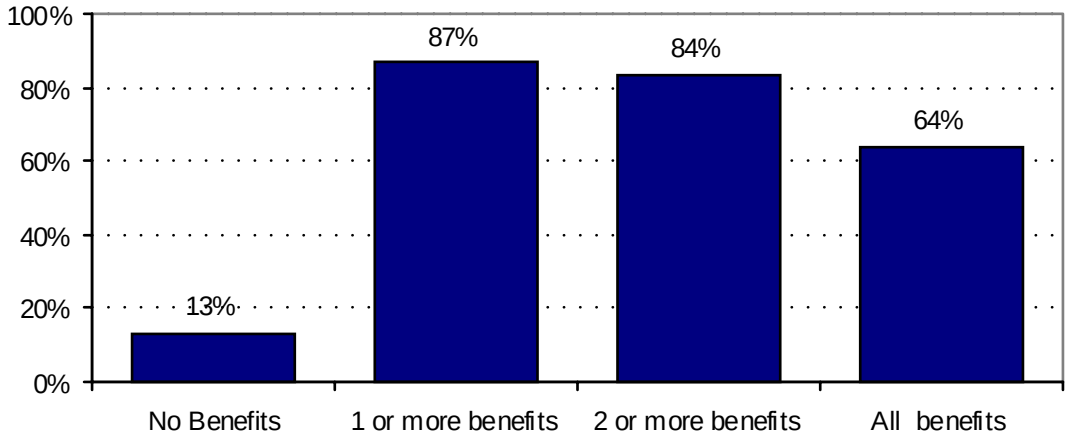

FIGURE 14: **Options providing support service benefits**

The authors contend that universal access to these support services should be provided in terms of Prescribed Minimum Benefits. However, it must be kept in mind that a nearly exclusive emphasis on prevention of the disease, with no access to treatment, is fatal for those already living with the virus.

5.2 Treatment and Preventative Therapy for HIV-related Conditions

The proposed Prescribed Minimum Benefits place emphasis on counselling, testing for HIV and treating people with HIV for opportunistic infections such as PCP pneumonia and tuberculosis. This includes the screening and preventative therapy for these conditions as well as treatment of sexually transmitted diseases (STDs) such as syphilis and gonorrhoea.

The link between HIV and other STDs highlights the importance of treatment of STDs for infected and non-infected people. HIV-negative partners are more susceptible to contracting HIV if they have a STD, and HIV-positive partners are more infective if they have a STD.

The medical schemes were asked to provide details of coverage in four areas of preventative therapy. In summary, across all medical schemes :

- 84% of beneficiaries have access to screening for tuberculosis
- 84% of beneficiaries have access to preventative therapy for tuberculosis
- 87% of beneficiaries have access to preventative therapy for PCP pneumonia
- 88% of beneficiaries have access to treatment for sexually transmitted diseases.

The proportion of beneficiaries with access to these benefits is shown below for different sizes of schemes.

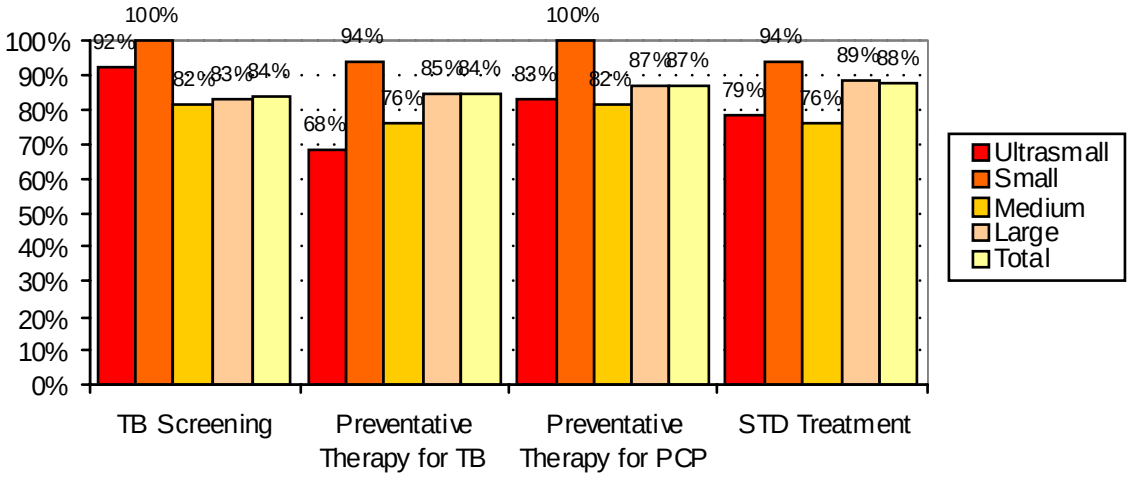

FIGURE 15: **Beneficiaries with access to screening, preventative therapy and treatment for HIV-related conditions**

The number of beneficiaries receiving these preventative therapies and treatments was above 70%, irrespective of the scheme size. The only exception was that only 68% of small scheme beneficiaries have access to preventative therapy for tuberculosis.

These results emphasise medical schemes' awareness of the impact of opportunistic infections on the body's immune system as a result of HIV, and that prevention of these infections lowers susceptibility to the virus. However, the authors contend that universal coverage should already be provided in terms of the current Prescribed Minimum Benefits. The proposed PMBs make the provision of each of these benefits explicit.

5.3 Mother-to-Child Transmission

Mother-to-child transmission (MTCT) is the process whereby an infant contracts HIV from its mother before, during or after birth through contact with the infected mother's blood or through breast-feeding.

Research has shown that combination anti-retroviral therapy, a short course of AZT or a single dose of nevirapine to a pregnant mother and infant just before birth can significantly reduce or nearly eliminate paediatric infection. (Connor, *et al*, 1994; Shaffer, *et al*, 1999; Guay, *et al*, 1999).

In the light of this, the government's decisions to deny prospective mothers access to anti-retrovirals on the grounds that the drugs are toxic, too expensive and management is difficult to implement, received much criticism. This resulted in litigation in the Pretoria High Court, where the *Treatment Action Campaign* was successful in requiring the government to provide access to these anti-retrovirals to HIV-positive mothers and their children to prevent MTCT. (*Treatment Action Campaign and others v Minister of Health and others*. 14 December 2001)

The government appealed to the Constitutional Court. On 5 July 2002, the Constitutional Court found that government policy was unreasonable, inflexible and failed to meet the constitutional requirement to progressively realise access to health care. (Unreported judgment Constitutional Court). The government is now required to lift the restriction on doctors in public facilities to prescribe Nevirapine to women with HIV, train counsellors and develop a comprehensive plan to extend the programme across the country.

Interventions that reduce vertical HIV transmission include substitution of formula feed for breast-milk and administration of anti-retroviral agents to mother and child around the time of birth.

Birth by Caesarean section has been shown to significantly reduce vertical transmission. While it is unclear how feasible elective caesarean sections are in areas with poor resources, they should routinely apply to HIV-positive women in private sector medical schemes.

These interventions can lead to a reduction in HIV-related deaths and prevention of HIV-related future health costs.

Medical schemes were asked which benefits were provided to prevent mother-to-child transmission of the virus. In summary, across all medical schemes :

- 41% of beneficiaries have access to AZT only.
- 56% of beneficiaries have access to AZT and 3TC (also known as Combivir) or any other combination therapy
- 55% of beneficiaries have access to nevirapine
- 84% of beneficiaries have access to a caesarean section
- 47% of beneficiaries have access to formula feed
- 77% of beneficiaries have access to MTCT Counselling

When duplicate drug protocols are removed, it was found that 92% of beneficiaries have access to some form of antiretroviral therapy to prevent mother-to-child transmission. The graph below shows the results by size category of the scheme.

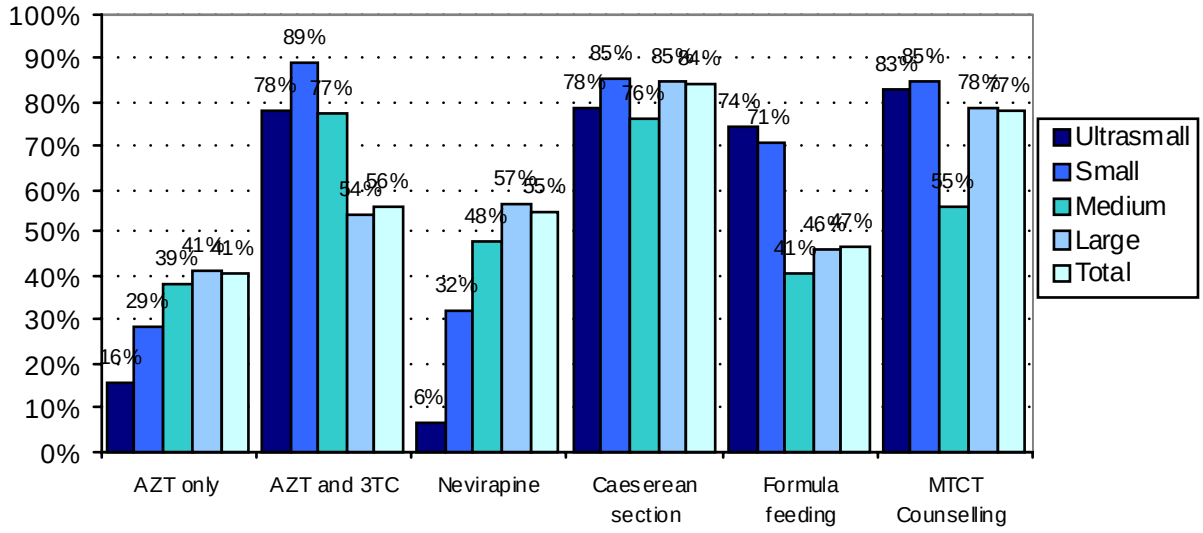

FIGURE 16: **Beneficiaries with access to MTCT therapy**

It can be seen that 56% of beneficiaries have access to Combivir, a drug regimen that is more powerful than AZT (on its own) or nevirapine. Currently, 47% of options (covering 55% of beneficiaries) are providing nevirapine.

In total, 73% of options (covering 83% of beneficiaries) provide caesarean section with 70% of large scheme options offering this benefit.

However, only 47% of options (46% of beneficiaries) have access to formula feed, another benefit that could reduce transmission of the virus. Only 46% of the large scheme beneficiaries and 41% of the medium scheme beneficiaries have access to formula feed, figures that are relatively low bearing in mind that formula feed is medically indicated for women with HIV.

Mother-to-child transmission counselling is widely provided with 77% of beneficiaries in total with access to this service. It is also surprising to see that 90% of the small scheme options provide this service, while only 63% of the large schemes do so.

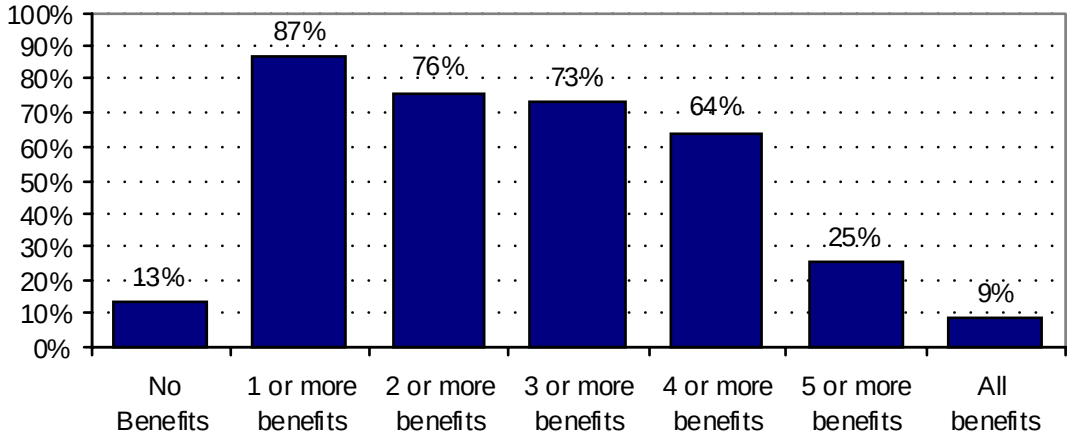

FIGURE 17: **Options providing mother-to-child transmission benefits**

In summary, Figure 17 highlights the fact that the private sector has taken heed of the dangers of mother-to-child transmission. 73% of all scheme options are offering three or more of the treatments to prevent vertical transmission of the virus.

It was found that 13% of options (representing 7% of beneficiaries) are offering no mother-to-child transmission benefits at all. These 29 options are contained in 17 schemes. Thus the extension of PMBs in this area will represent a relatively small change for the medical scheme environment.

Mother-to-child transmission prevention benefits should be made available to all beneficiaries, in line with the decision of the courts, in particular the decision of the Constitutional Court.

5.4 Post-exposure Prophylaxis

Post-exposure prophylaxis (PEP) is the provision of anti-retroviral medication to those who may have been exposed to the HIV virus in order to prevent infection. It is most often provided in the cases of:

- Sexual assault
- Occupation injury (such as a needle-stick injury) or
- Any other sexual exposure to HIV (such as any willing sexual activity)

The government recently announced that rape victims are to be provided with anti-retroviral medication at all public health institutions. This treatment will be accompanied with counselling and testing for HIV, pregnancy and sexually transmitted diseases.

The graph below shows the response by medical schemes to providing benefits in this area.

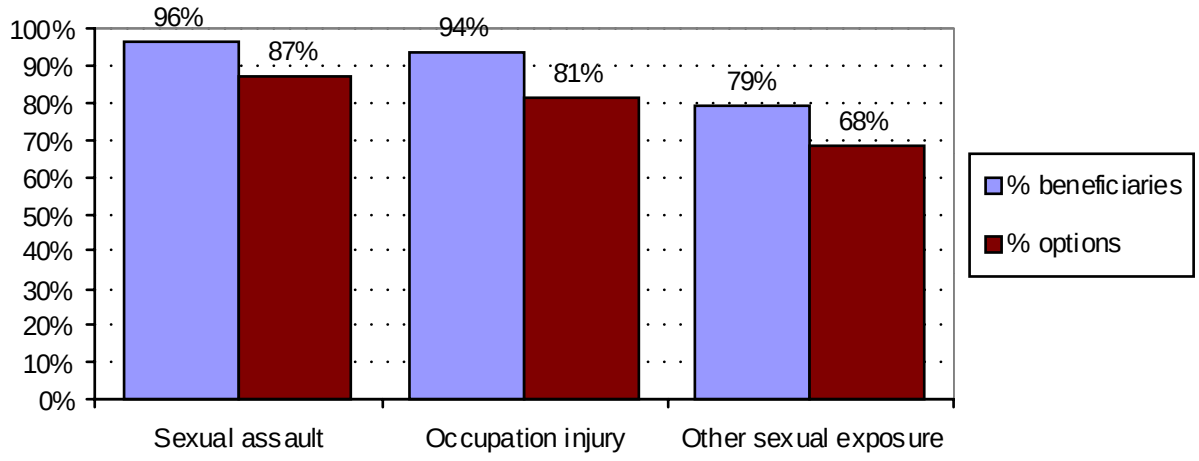

***FIGURE 18:* Access to post-exposure prophylaxis**

Medical schemes, have taken full responsibility for the provision of post-exposure prophylactics with 96% and 94% of beneficiaries with access to these treatments in the cases of sexual assault and occupational injury respectively.

The results were lower in the case of other sexual exposure to HIV with only 68% of options and 79% of beneficiaries with access to treatment under these circumstances.

The extension of PMBs in this area is essential and now forms part of the minimum package offered by government following the Cabinet statement of 17 April 2002. In this context, we recommend that the medical schemes follow the Sunninghill Clinic protocol on sexual assault to achieve the best and most cost-effective management.

6. Coverage of Anti-Retroviral Therapy

Anti-retroviral therapy is central to the management of HIV/AIDS. Since 1996, the use of combination therapy has reduced morbidity and mortality dramatically in Europe and North America (Palella *et al*, 1998) while the introduction of universal anti-retroviral access in Brazil has led to savings in hospitalisation costs (Ministry of Health, Brazil, 2001). These drugs are expensive and largely unaffordable in developing countries such as South Africa.

The absence of practical government action to reduce medicine prices has led organisations such as the *Treatment Action Campaign* and *Medicins Sans Frontiers* to import anti-retroviral medication and treatment for opportunistic infections in defiance of patent laws into our country from other developing countries such as Brazil and Thailand, where generic medication is manufactured. In addition, the Doha Declaration of November 2001, which clarifies that patent laws should not be an obstacle to public health requirements, has been ignored by government (Nathan Geffen, TAC, personal communication, 2002).

Anti-retroviral medication can be divided into two main classes of drugs: protease inhibitors (PI) and reverse transcriptase inhibitors (RTI). Protease inhibitors are newer and more expensive, while reverse transcriptase inhibitors (such as AZT and 3TC) have been widely available and have lower prices.

Over the last two years, the prices of anti-retrovirals in South Africa have been substantially reduced leading to an increase in accessibility to those who previously could not afford them, even with private sector medical scheme cover.

Treatment began in the form of a one-drug regimen, referred to as “mono-therapy.” Further research indicated that a combination of three drugs, loosely referred to as “triple-therapy cocktails” or HAART (highly active anti-retroviral therapy), is optimal. In fact, mono-therapy and dual-therapy have been shown to cause a build up of resistance to anti-retroviral medication, resulting in triple-therapy becoming less effective. The triple regimen is very powerful and can reduce the viral load to undetectable levels. Dual therapy results in sub-optimal therapy (Bredell Consensus Statement, 2001).

The utilisation of these drugs is limited by their cost and possible development of resistance. For the first 7-12 years, anti-retroviral therapy may not be necessary. Clinical monitoring is essential to ensure that treatment starts when the immune system cannot cope and a person with HIV/AIDS starts developing AIDS-related illnesses. At this stage, lifelong treatment with anti-retroviral medicines becomes essential. The majority of scheme members with HIV/AIDS will not need anti-retroviral therapy immediately or for a number of years.

Figure 19 below shows the proportion of options offering different treatment protocols for antiretroviral therapy. In 2002, 73% of options provided access to anti-retroviral therapy. This translates to access for 92% of beneficiaries in Figure 20.

It should be noted that access to benefits does not guarantee that the size of the benefit is sufficient to provide cover for the full year. This aspect of benefit design is dealt with in more detail in Section 7.

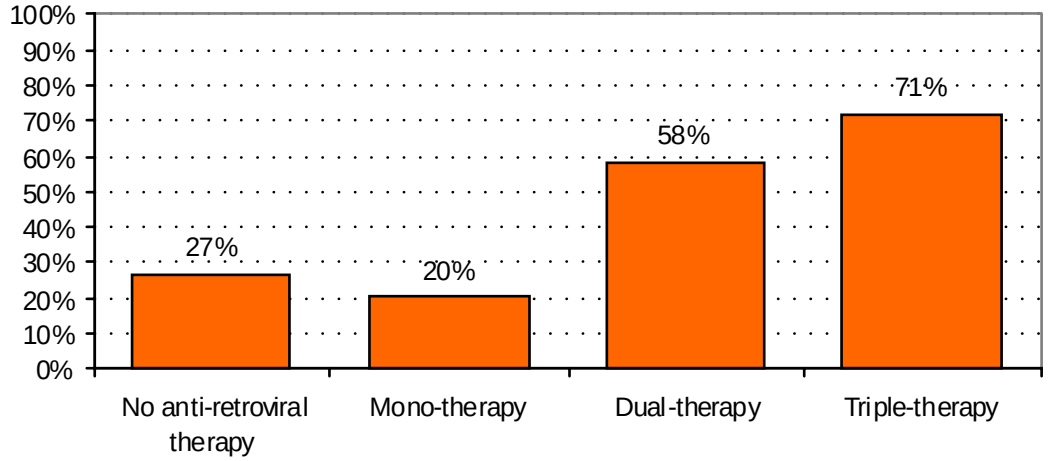

FIGURE 19: **Options that provide access to anti-retroviral therapy**

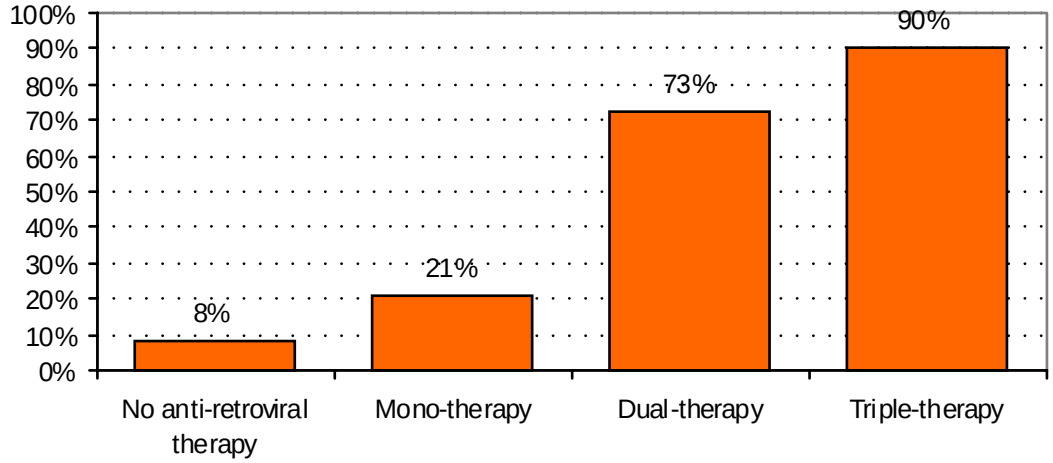

FIGURE 20: **Beneficiaries with access to anti-retroviral therapy**

The research has shown that there is a clear preference for triple-therapy, with 71% of options (translating into 90% of beneficiaries) following best treatment protocols and providing access to the triple-therapy "cocktail". 58% of options provide the sub-optimal "dual-therapy" option and only 20% still offer mono-therapy.

However, a considerable proportion of options, 27%, currently offer no anti-retroviral treatment to their members. These options are from the smaller schemes and represent only 8% of beneficiaries.

The graph below show that 33% of "non-managed scheme" options are in this category, followed by 27% in the "other disease management programme" category.

These figures do not take into account those options that offer anti-retroviral medication fully from the member's medical savings account.

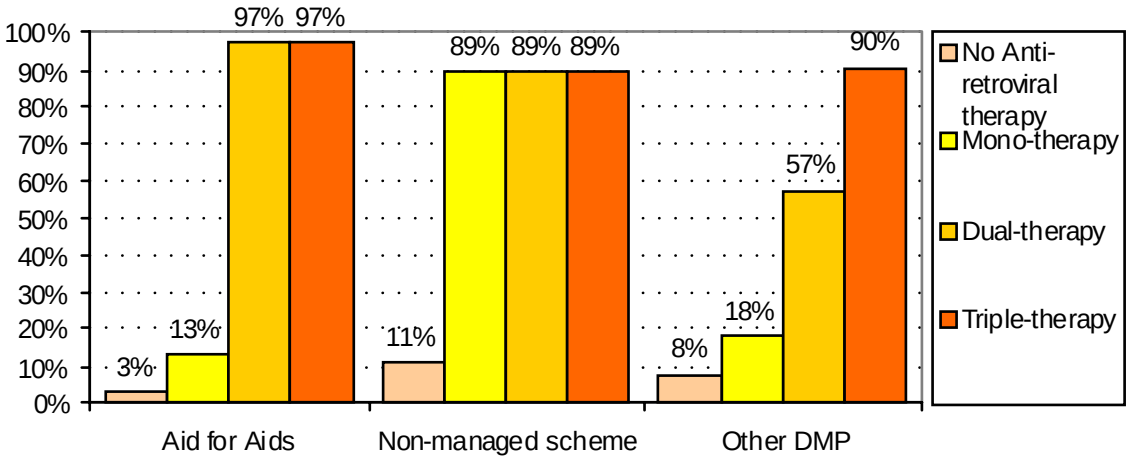

FIGURE 21: **Beneficiaries with access to anti-retroviral therapy by scheme categorisation**

Figure 21 provides more detail on the provision of anti-retroviral medication by scheme category. The following results were obtained:

- The beneficiaries belonging to Aid-for-AIDS-linked schemes, the category that represents the largest number of schemes, largely have access to dual-therapy or triple-therapy. Only 3% of beneficiaries belonging to Aid-for-AIDS-linked schemes have no access to anti-retroviral medication.
- 89% of all "non-managed" scheme beneficiaries have access to mono, dual or triple-therapy, depending on the patient's doctor's recommendations. The "non-managed" schemes are the only category of schemes still providing mono-therapy on a large scale.
- Beneficiaries of schemes that are linked to "other disease management programmes" (the category representing the greatest number of beneficiaries) primarily have access to triple-therapy (90%). 18% of these beneficiaries have access to mono-therapy and only 8% have no access to anti-retroviral medication.

For individual clinical benefit, public health reasons and cost-effectiveness, it is essential that mono-therapy be immediately discontinued and dual therapy also phased out as soon as possible. Mono-therapy leads to increased resistance, therapeutic failure and chronic side-effects. Although dual-therapy provides more sustainable benefits than mono-therapy, it also lacks the durable therapeutic value of triple-therapy.

An anti-retroviral therapy guideline facilitated by the Council for Medical Schemes, based on the HIV Clinicians Society Guidelines, the Bredell Consensus Statement and the World Health Organisation Guidelines for a Public Health Approach (WHO 2002), is the minimum requirement for public health reasons and the best individual clinical outcomes. It is desirable from a public health perspective and to save the lives of people with HIV/AIDS that triple anti-retroviral therapy forms a part of the PMBs. The WHO has also included all anti-retroviral drugs on its latest Essential Drugs List.

6.1 Support Services for ART

Medical scheme costs involved in providing anti-retroviral therapy, other than the drugs themselves, include diagnostics, drug monitoring, treatment of any potential side effects and counselling for people on drug treatment. Support for individuals or through support groups is a necessary component of anti-retroviral therapy.

Research at Somerset Hospital in Cape Town has shown a higher than 80% adherence profile among all racial and socio-economic groups on anti-retroviral therapy. The MSF Khayelitsha pilot programme reports similarly high adherence rates and they are borne out by clinical results. A majority of patients who started ARV therapy in the MSF project had fewer than 48/ml CD4+ T-cells (average healthy 800-1200/ml CD4+ cells) and an HIV viral load higher than 170, 000 copies per cubic millilitre. After six months of therapy more than 90% of the patients on anti-retrovirals had an undetectable viral load and had gained more than 135.5/ml CD4+ cells, thus beginning the reconstitution of their immune systems. (MSF/Department of Public Health and Primary Health Care UCT 2002)

Figure 22, below, shows the extent of support services for anti-retroviral therapy in medical schemes.

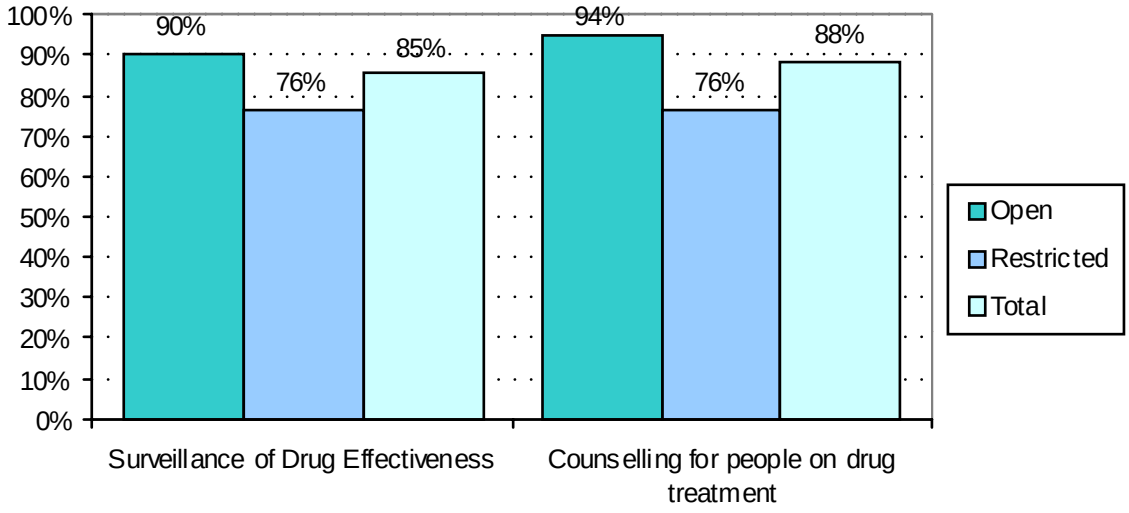

FIGURE 22: **Beneficiaries with access to both anti-retroviral therapy and HIV support services**

Figure 22 shows that 85% of beneficiaries that have access to any form of anti-retroviral therapy (including therapy to prevent mother-to-child transmission and post-exposure prophylaxis), also have access to surveillance of drug effectiveness, a crucial stage in the management of drug treatment. 88% of these beneficiaries are also receiving counselling once on drug treatment.

The figures are slightly lower for restricted schemes than for open schemes. This is surprising since it would be expected that employers would be most concerned with the efficient use of anti-retroviral treatment for their employees.

It is noticeable from the figure below that 81% of beneficiaries, who have access to anti-retroviral medication, also have access to the surveillance of the effectiveness of these drug treatments and counselling. Only 15% of beneficiaries have no access to these benefits.

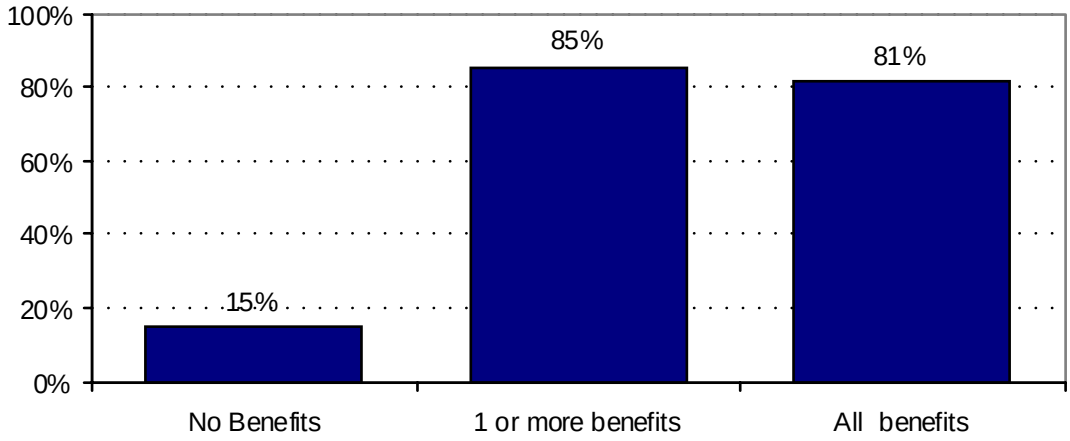

FIGURE 23: **Beneficiaries with access to both anti-retroviral therapy and HIV support services**

The inclusion of support services for those on anti-retroviral medication is essential to the cost-effective use of these drugs. Patient adherence to drug regimens is critical to beneficial clinical outcomes.

7. Limits Applied to HIV/AIDS Benefits

In order to manage costs, medical schemes have in many cases imposed financial limits on benefits with regards to HIV/AIDS. In a few cases, they have excluded cover altogether. Although the use of financial limits appears to be discriminatory, if not imposed, many low cost medical schemes would face grave financial risk or would become unaffordable to their target members.

The authors have identified six types of costs associated with HIV:

- Medication costs, including anti-retroviral medication and other medication such as immune boosters
- Consultation costs
- Pathology costs
- Hospitalisation costs
- Mother-to-child transmission costs
- Post-exposure prophylaxis costs for events such as sexual assault, needlestick injury and other sexual exposure to HIV.

The relationship of these costs to various financial limits is given in the chart below:

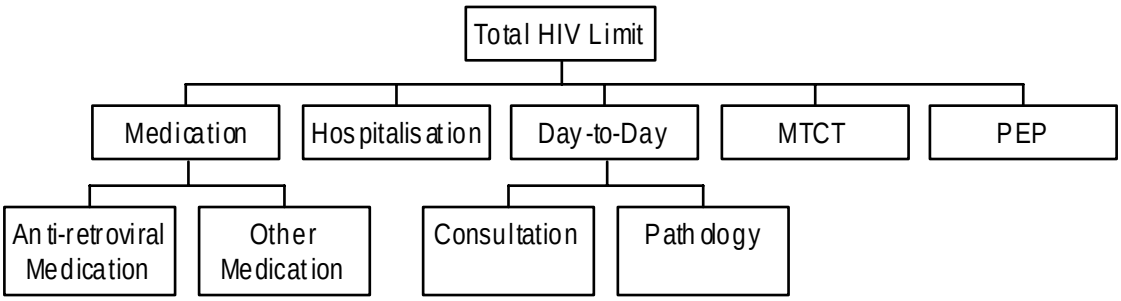

FIGURE 24: **Categorisation of costs and financial limits for HIV/AIDS benefits**

7.1 Medication Limits

7.1.1 Anti-retroviral Medication Limits

Anti-retroviral medication is one of the biggest costs in the treatment of the HIV virus. As such, medical schemes impose different types of limits to manage this benefit.

The chart below gives an indication of how medical schemes provide for this benefit.

The following types of benefits are provided:

- No benefit was provided by the option at all
- The option provides a discretionary benefit on an 'ex gratia' basis
- The option provides for the full amount of the benefit out of the member's medical savings account (MSA)
- The option provides a monetary limit for the benefit, but once this benefit was exhausted, the members MSA was used partially
- The options caps the benefit by using a monetary limit
- The option uses a medication limit as opposed to a monetary limit. For example, a scheme may provide Combivir.
- The option imposes no monetary or any other limit on the benefit.

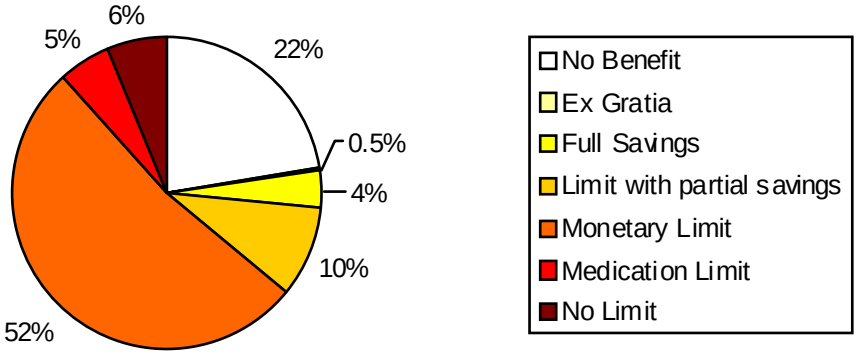

FIGURE 25: **Type of anti-retroviral medication limit (by option)**

It is seen from the chart above that 22% of options still currently provide no anti-retroviral therapy benefit to their members. The majority of options (52%) cap the benefit using a monetary limit. Surprisingly, only 14% of options make partial or full use of the member's MSA.

The benefits subject to monetary limits are structured in different ways. Results indicate that 50% of options provide for anti-retroviral medication out of a limit that was specifically for HIV/AIDS. Furthermore, 15% of options provide for this medication out of chronic medication or chronic illness cover.

To get a clearer understanding of the range of monetary limits, Figure 26 depicts the highest and lowest limits for those schemes that provide a monetary limit for this benefit. Those schemes that have the same monetary limit for all their options will be seen as a single bar. The limits are given per beneficiary and per family where applicable. In order to standardise the per family limit, the limits for a family of four were calculated.

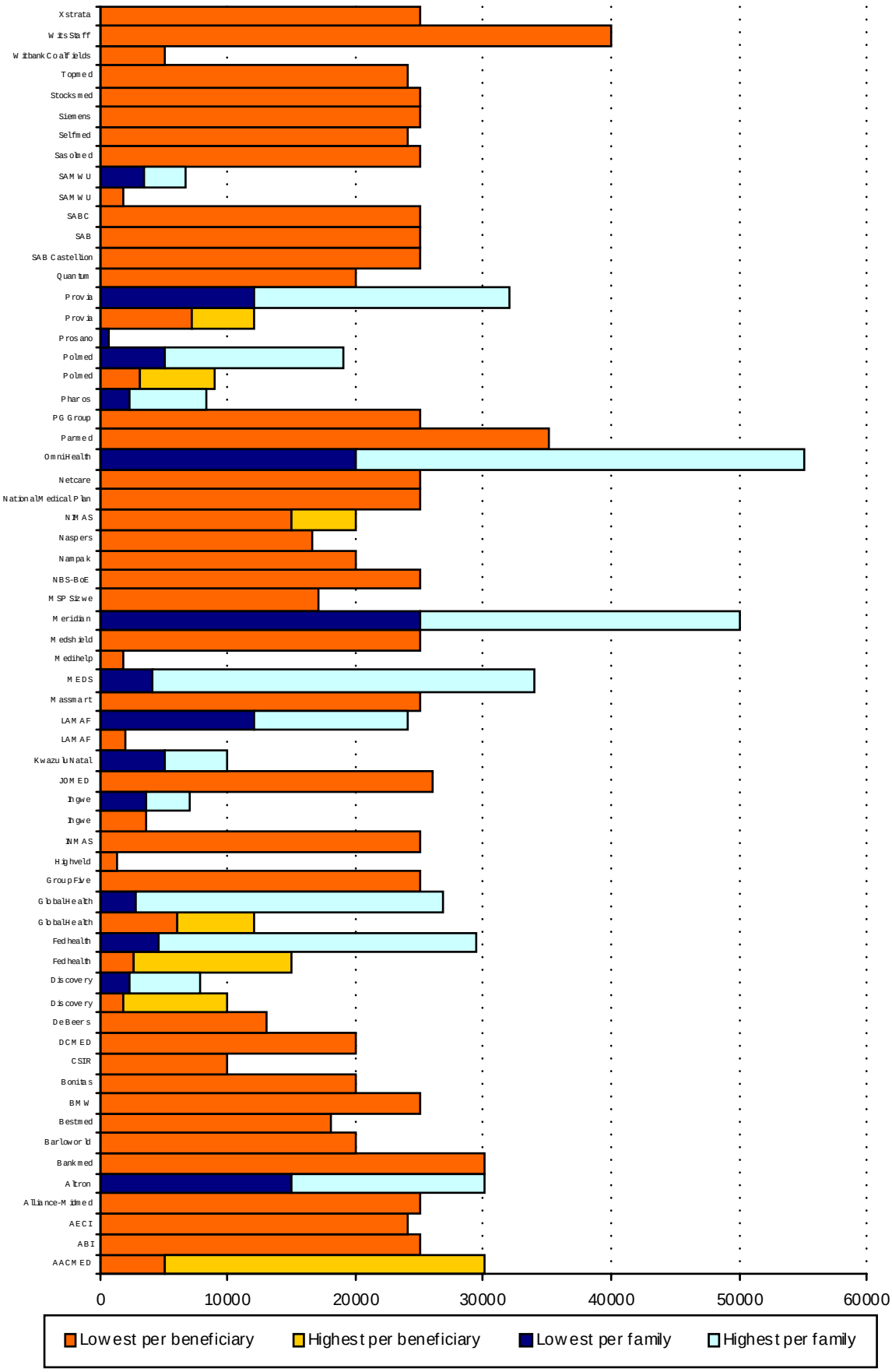

FIGURE 26: **Range of annual anti-retroviral medication monetary limits**

The maximum limit per beneficiary was found to be R40 000 p.a., for the University of the Witwatersrand Medical Scheme. The second highest was R35 000 p.a. for Parmed Medical Scheme. Both these schemes are restricted, administered by Medscheme and are linked to the Aid-for-AIDS disease management programme.

The minimum benefit per beneficiary was found to be R1 300 p.a., for the Highveld Comprehensive option. The second lowest limit was R1 800 p.a., for the Medihelp Sentinel and Dimension range of options.

The average monetary limit per beneficiary was R17 061 p.a.. This equates to R1 422 per month. Three years ago triple combination therapy averaged R4 500 per month. Significant price reductions based on generic comparisons and activist pressure internationally has reduced triple therapy to a range of R700 to R1 800 per month. Brazilian generics used by MSF costs R450 per month.

These prices can be reduced further. Medical schemes face the following dilemma: to increase their average benefit to R2 000 per month or to join the lobbying for generic competition to ensure sustainable programmes in the long term.

7.1.2 Other Medication Limits

Other medication is any form of medication designed to boost the body's immune system, prevent the onset of opportunistic infections and provide a healthier lifestyle for the member. These medications also include nutrients, vitamins as well as medication such as Co-trimoxazole (also known as Bactrim ®, Purbac and Septran).

The illustration below shows the types of other medication limits.

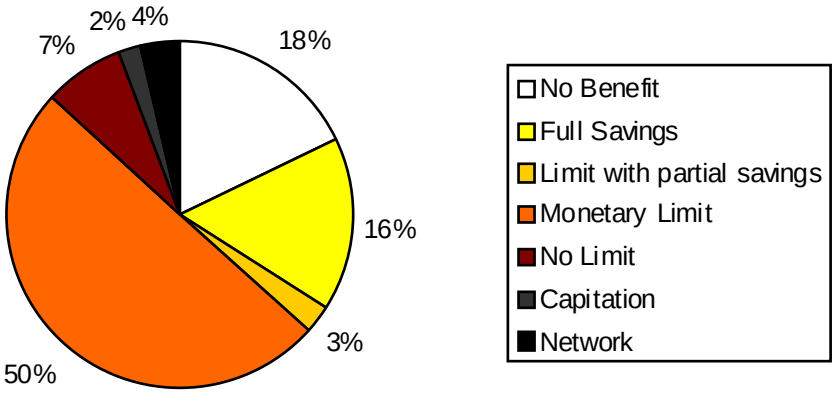

FIGURE 27: **Types of other medication limits (by options)**

The types of "other medication" benefit designs are similar to the categories for anti-retroviral medication benefit design, with the following two additions:

- Capitation, which refers to the pre-determined Rand amount, per covered person, paid directly to a medical provider. The provider is then responsible for the provision of health services for each of the covered persons for an agreed time period.
- Networks, where a group of health care providers or hospitals contract collectively with a medical scheme as preferred providers.

Schemes again mostly use a monetary limit to manage their benefits. However, 18% of options provide no "other medication" benefit at all. 19% of options make full or partial use of the member's savings account and 6% of options make use either of a capitation or a network system.

It was also surprising to see that out of those schemes that provide an "other medication" benefit, 63% of the limits are from a category that was specifically for HIV/AIDS and only 17% fall under acute or chronic medication. In most cases, the anti-retroviral limit also included "other medication". Thus, the range of "other medication" limits was very similar to the range of anti-retroviral medication and will not be provided separately.

As before, the maximum limit was R40 000 p.a., for the University of the Witwatersrand Medical Scheme. The minimum limit was R500 p.a., for the Vulamed Standard option.

The average monetary limit was R16 440 p.a., slightly lower than the average limit for anti-retroviral medication. This was largely because in most cases the anti-retroviral medication limit encompasses "other medication" as well.

7.2 Day-to-Day Limits

7.2.1 Consultation Limits

It is expected that HIV-infected patients would see general practitioners and specialists more often than other members. This is due to two main reasons. Firstly, medical practitioners are needed for monitoring the disease since the decrease in resistance of the immune system due to the HIV virus, will result in frequent opportunistic infections. Secondly, doctors are needed in the management of treatment and the surveillance of drug effectiveness.

43% of options' HIV consultation benefits fell under an overall consultation or day-to-day benefit, while 22% fell under a limit that was specifically for HIV/AIDS.

The types of consultation limits are given below. Additional categories include:

- A visitation limit. For example, the Ingwe Classic option has an annual limit of 15 visits per beneficiary and 45 visits per family p.a.
- A visitation limit using the member's savings account partially once the visitation limit was exhausted.

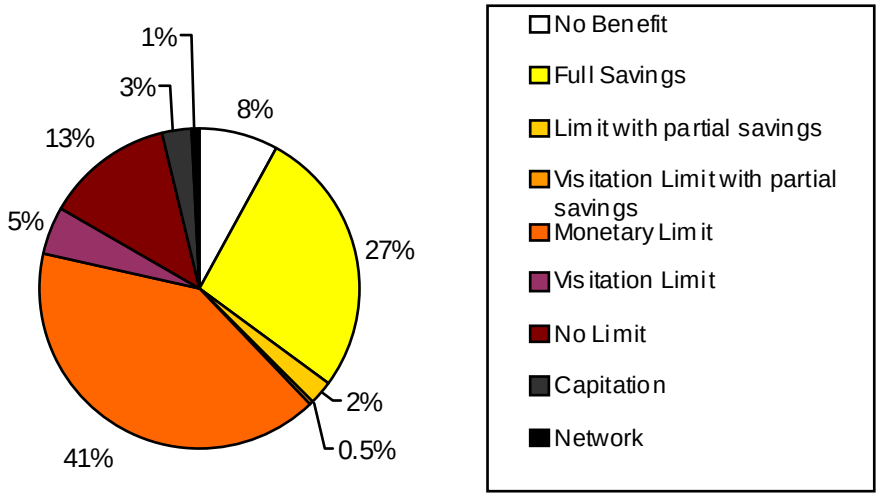

FIGURE 28: **Type of consultation limits (by options)**

These results suggest that a monetary consultation limit was the most popular method of capping this benefit. It was astonishing to observe that 27% of options make full use of the member's savings account for the consultation benefit, particularly since only 4% of options made full use of savings for anti-retroviral medication. A visitation limit was also popular, with 15% of options making use of this type of limit.

Figure 29 shows the range of highest and lowest consultation limits that schemes provide for HIV/AIDS. The green bars indicate that the schemes' consultation limits are part of the overall scheme limit and thus distort the figure. This only applies for the "per family" limits, since overall limits are primarily given per family.

The maximum limit per beneficiary was found to be R35 000 p.a., for the Methealth Openplan Primary and Premier range of options. Openplan manages HIV by phase of disease. For example, in Phase 3 where the member has a CD4 count of 200-250, the limit was R35 000 p.a..

The second highest limit per beneficiary was R30 000 p.a., for the Bankmed Essential range of options. Both Openplan and Bankmed are administered by Metropolitan Health; Bankmed is linked to the Newmed disease management programme and Openplan is linked to Qualsa, which has subsequently been acquired by Newmed.

The minimum benefit per beneficiary was found to be R440 p.a., for the Transmed Essential range of options. The second lowest limit was R525 p.a., for the Topmed Bophelo option. The average monetary limit per beneficiary was R2 921 p.a.. This equates to R243 per month.

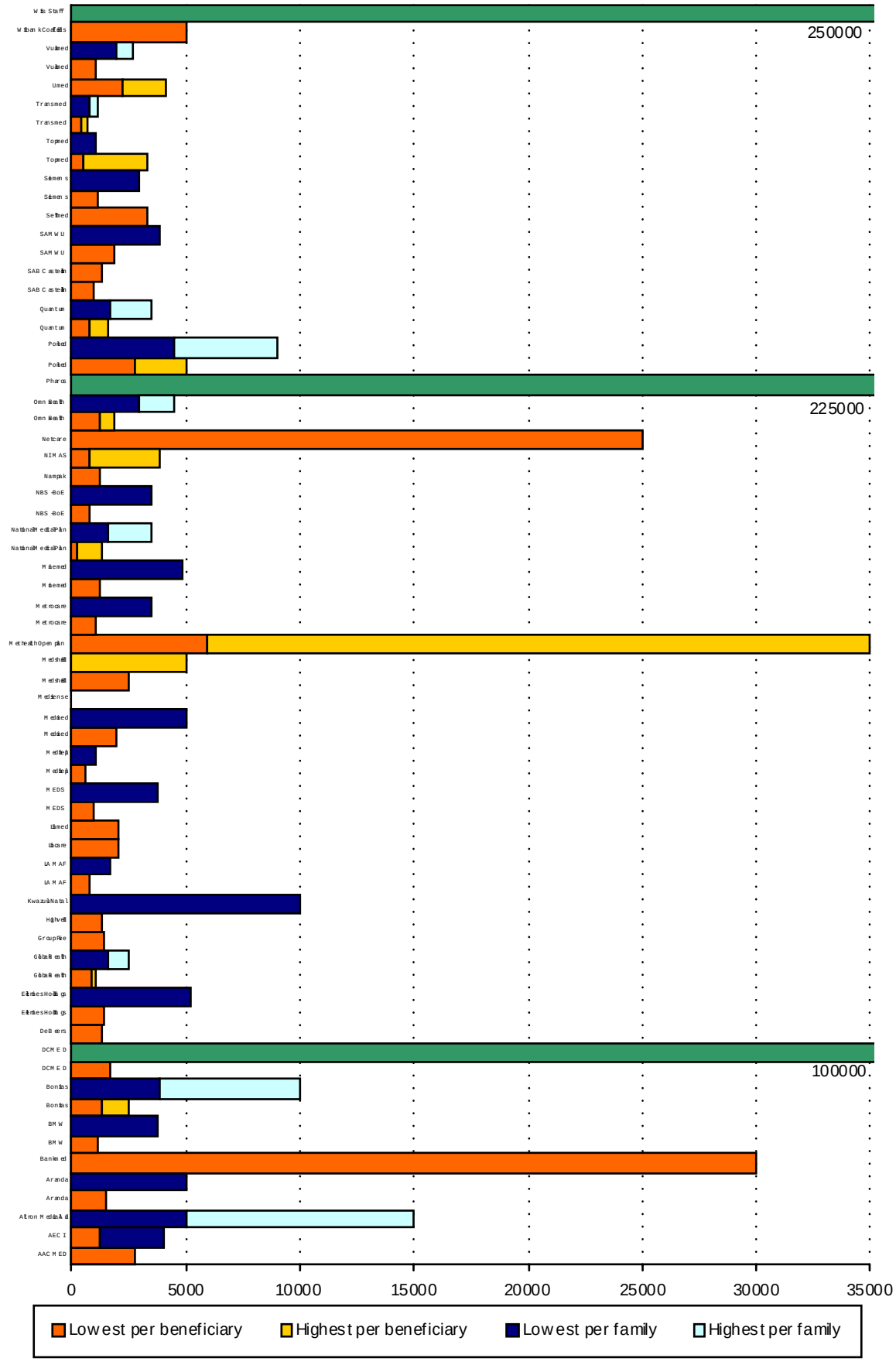

FIGURE 29: **Range of annual HIV consultation monetary limits**

7.2.2 Pathology Limits

Pathology tests combined with the patient's overall health determine when the patient should start anti-retroviral therapy. Pathology tests aid in the monitoring of the disease. Pathology tests for a person with HIV/AIDS are required to:

- diagnose opportunistic infections
- ascertain the effectiveness of drug treatment
- detect the reduction in viral load within the blood
- assess the status of the immune system
- monitor side-effects related to drugs
- monitor the development of possible resistance to the medication.

The main pathology tests are CD4 counts (which determines the level of deterioration of the patient's immune system), viral load tests (which determines the amount of virus in the patient's blood) and HIV antibody diagnostic tests. Combination blood counts and routine pathology tests are also necessary (Department of Health, 2000).

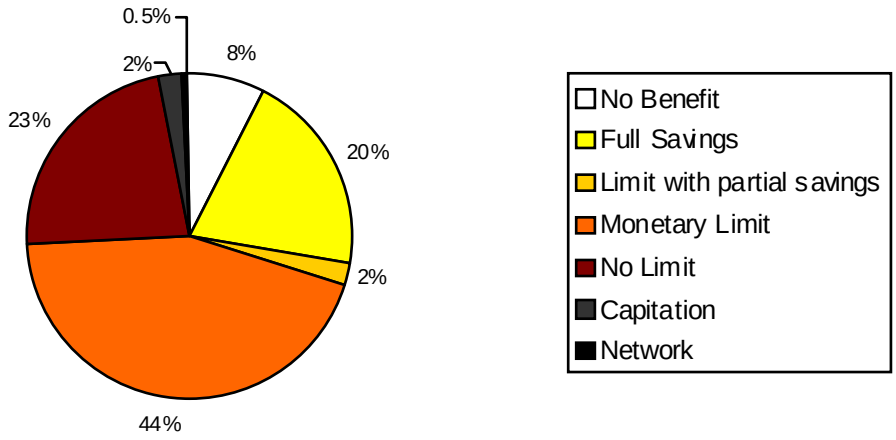

FIGURE 30: **Type of pathology limits (by options)**

Three limit types dominate the benefit designs used by medical schemes for pathology benefits: 23% of options had an unlimited pathology benefit, 44% used a monetary limit and 20% of options used the members' full savings.

33% of these pathology limits fell under a category that was specifically for HIV/AIDS; 24% fell under a separate pathology limit; and 11% of the limits fell under the scheme's overall limit.

39% of limits were given per beneficiary; 42% were given per family; and 19% were given as both a per beneficiary and a per family limit.

As a result of these different design approaches, a comparison of all pathology limits would be distorted. Instead, a graph of the distribution of monetary limits per beneficiary and per family was more appropriate and is shown below.

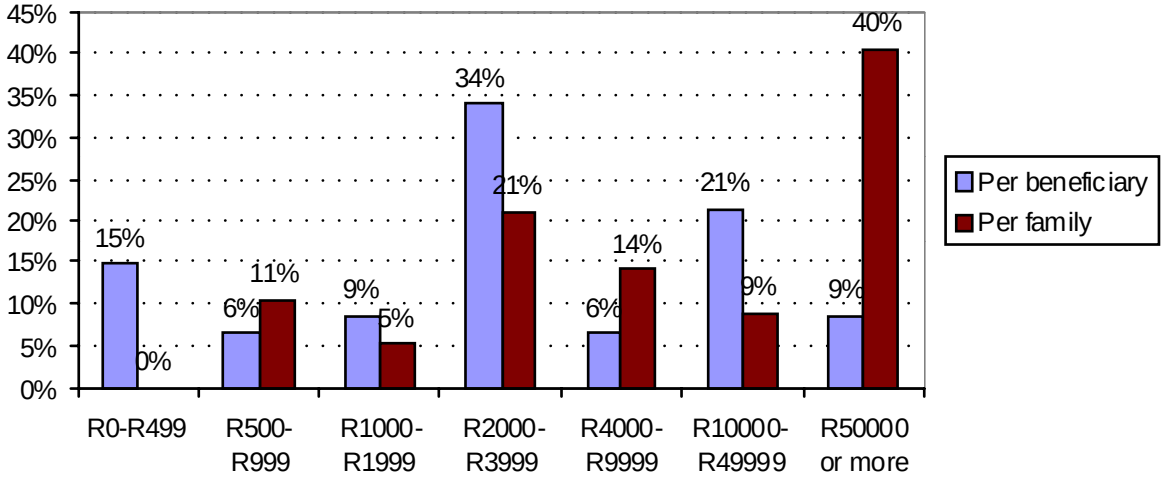

FIGURE 31: **Financial limit ranges for pathology benefits (proportion of options)**

It is noteworthy that the majority of pathology limits peak in the R2 000 - R3 999 per annum monetary range. Although 40% of options for the per family limit are above R50 000 p.a., all of these limits fall under the overall scheme limit category. This explains their relatively high amounts.

The maximum limit per beneficiary was found to be R500 000 p.a., for the National Independent Medical Scheme Premier option. This limit stems from their "Out-of-hospital" category. The highest limit for an option where the limit comes out of a separate pathology limit was R30 000 p.a., for the Bankmed Equilibrium range of options.

The minimum benefit per beneficiary was found to be R320 p.a., for the Transmed Essential range of options. It must be borne in mind that these options are low-cost options and often cannot afford to give their members more expensive and extensive benefits.

The average monetary limit per beneficiary was R29 785 p.a.. This figure was distorted by the National Independent Medical Scheme (NIMAS) range of options. Excluding NIMAS, the average limit per beneficiary was R8 521 p.a.. The real value of the average was actually less than this since many options deduct expenditure for pathology benefits from their overall limit and this tends to overestimate the benefit limit.

Current costs per patient for CD4 count, viral load tests, liver function tests costs approximately R2 400 per patient per year. These prices can be significantly lowered. For instance, a CD4 test currently costs R240 each time. Recently, researchers at the National Health Laboratory Services and Wits University developed a new CD4 test that cost R82.50.

Similarly, researchers point to the cost of the PCR test for babies that cost R450 to test their HIV status accurately at six weeks. They believe that the price can be reduced to less than R80 per test if the patent holders (Roche) agreed to a generic licensing.

Consensus on monitoring costs at a meeting of experts hosted by *Médecins Sans Frontières* and *Treatment Action Campaign* suggested that monitoring prices could be reduced from R2 400 per year to R800 per year in the short-term. (MSF/TAC 2002) Here again, the medical schemes can significantly contain costs by supporting collective efforts to reduce prices.

7.3 Hospitalisation Limits

The Registrar's Report for 2000 identifies hospitalisation costs as a major expenditure category for medical schemes, with total hospital costs accounting for 33.7% of total risk benefits paid. With respect to the treatment and management of HIV/AIDS and opportunistic infections, hospitalisation costs can be a large component of total costs.

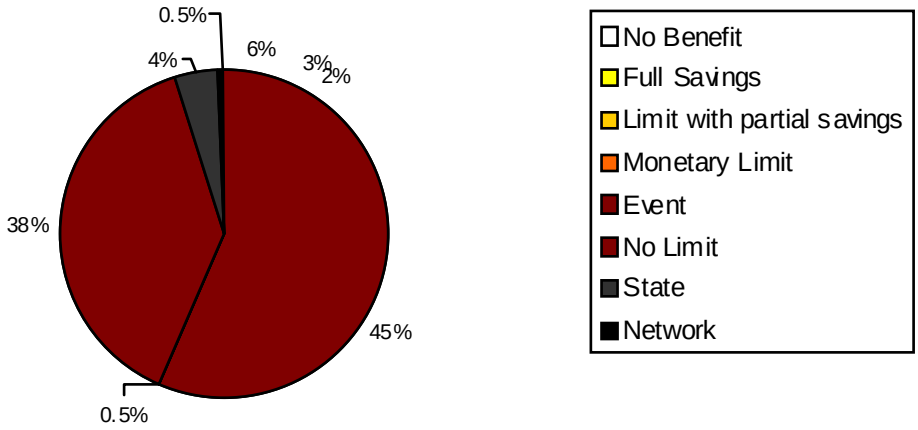

FIGURE 32: **Types of hospitalisation limits (by options)**

The types of hospitalisation limits, as displayed in Figure 32, are similar to those discussed previously. Two new hospitalisation-specific limits include:

- An event limit. For example, the JOMED Medical Scheme has a hospitalisation limit of R200 000 per event.
- A state hospital benefit. For example, Transmed Medical Fund provides hospitalisation only at state hospitals.

The results show that 3% of options use the member's savings account to pay fully for hospitalisation benefits. A further 2% make partial use of the savings accounts to cover hospitalisation costs. This benefit design must be reviewed as hospitalisation in terms of the Prescribed Minimum Benefits may not be paid from savings accounts. This is being made explicit in the Proposed 2002 Regulations (Appendix B).

It is significant to note that 38% of options have an unlimited hospitalisation benefit, which includes hospitalisation for HIV/AIDS. 49% of options gave their HIV-hospitalisation limits out of a more general hospital category and 18% stem from the schemes' overall limit. Only 20% of the hospitalisation limits were specifically for HIV/AIDS.

45% of schemes have a monetary limit, with 60% of these limits given per family. The ranges of hospitalisation limits vary widely, as illustrated on the following page. Since the majority of limits were given per family, only these will be discussed.

The maximum limit per family was found to be R1 500 000 p.a., for the Methealth Openplan Premier Pinnacle option and the Medshield Maxielite option. These limits come out of a general hospitalisation category. The highest limit for an option where the limit comes out of a separate HIV cover was R30 000 p.a., for the Discovery Classic and CSIR Essential range of options.

The minimum benefit per family was found to be R5 000 p.a., for the Free State Medical scheme. However, this limit was only for HIV hospitalisation and the scheme's general hospitalisation limit was higher.

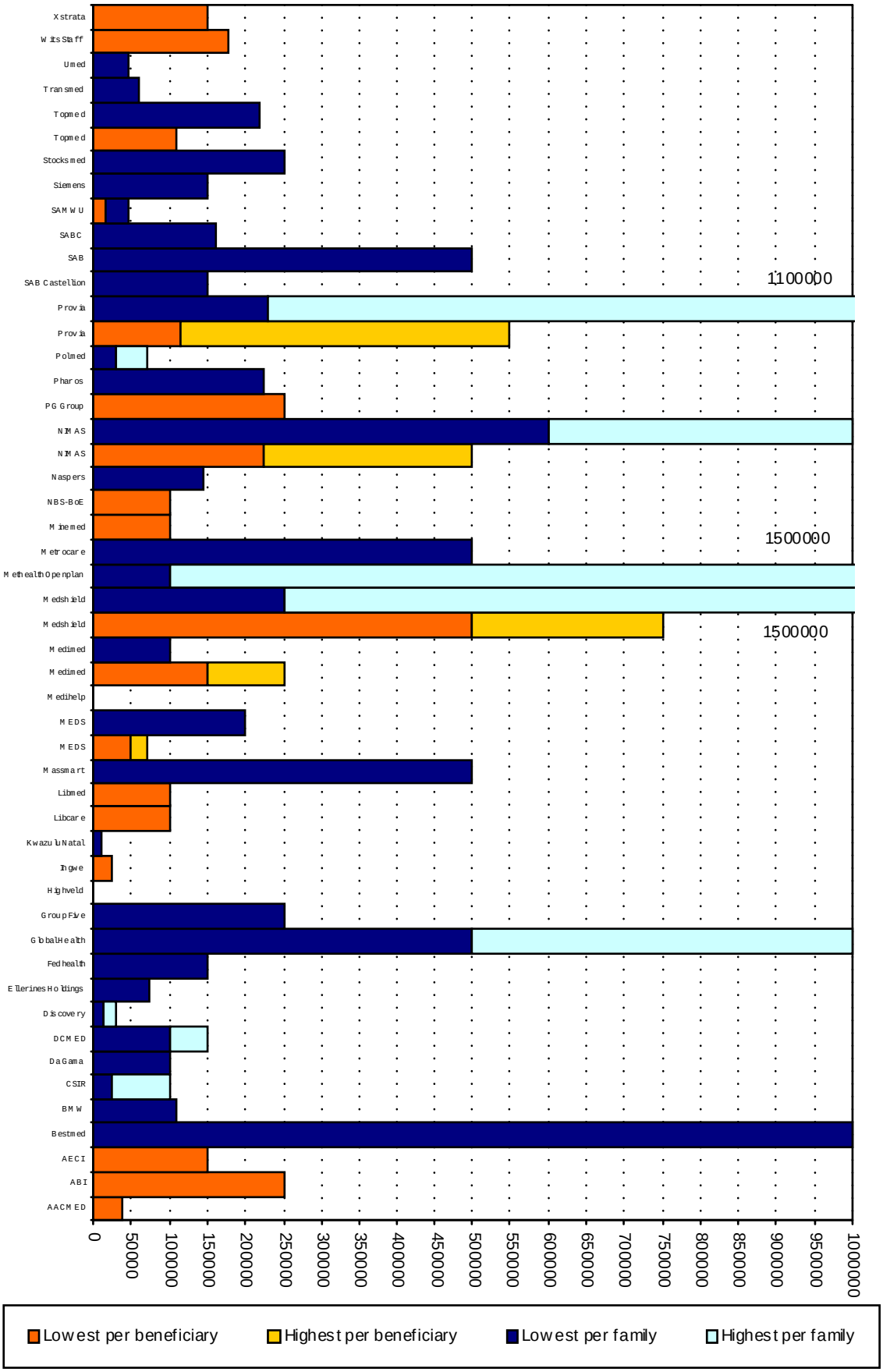

FIGURE 33: **Range of annual HIV hospitalisation monetary limits**

7.4 Mother-to-Child Transmission Limits

Very few medical schemes hold separate limits for mother-to-child transmission (MTCT). Rather, many schemes have separate HIV limits that include MTCT benefits. 82% of limits given for MTCT fall under a category that was specifically for HIV/AIDS and only 6% fall under a chronic medication benefit. This is very high considering that only 50% of anti-retroviral medication limits fall under a category that was specifically for HIV/AIDS.

The chart below illustrates that the most common type of MTCT limit was a monetary limit with 67% of options using this mechanism. 6% of options use an event limit. For example, all of Discovery Health Medical Scheme's options provide a MTCT limit of R1 200 per event. Furthermore, 6% of options have a medication limit. For example, Transmed Medical Fund will provide one Nevirapine tablet, two doctor consultations and two HIV tests as the MTCT benefit.

Also noteworthy is that only 5% of options use the member's medical savings account fully or partially and almost 1% of options will provide treatment on an ex-gratia basis. It was also interesting to observe that only 10% of options provide no benefit for prevention of MTCT which was less than the 18% of options who do not provide more general access to anti-retroviral medication.

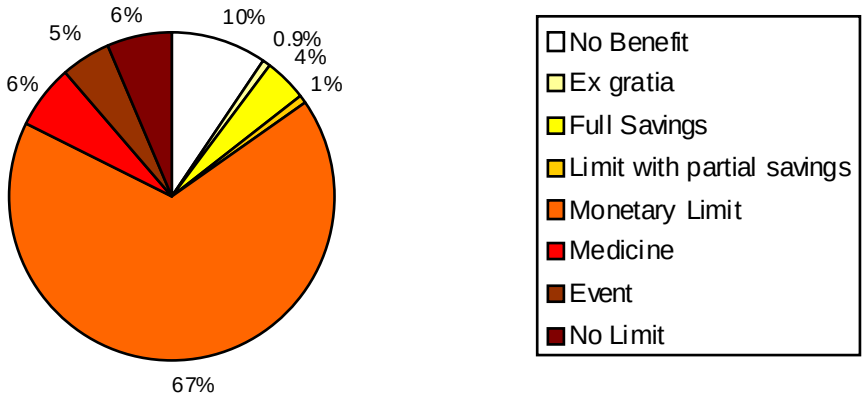

FIGURE 34: **Types of mother-to-child transmission limits (by options)**

Figure 35 on the following page represents the highest and lowest limits for those schemes that provide a monetary limit for mother-to-child transmission. The limits are given per beneficiary and per family where applicable.

Given that 79% of the monetary limits were given per beneficiary, the maximum, minimum and average limits will be discussed per beneficiary.

The maximum limit per beneficiary was found to be R40 000 p.a., for the University of the Witwatersrand Medical Scheme. The second highest per beneficiary limit was R35 000 for Parmed Medical Scheme.

The minimum benefit per beneficiary was found to be R500 p.a., for the Vulamed Standard option. The second lowest limit was R900 p.a., for the Vulamed Advanced option.

The average monetary limit per beneficiary was R15 549 p.a. This is high considering that the average limit for access to anti-retroviral medication was R17 061 p.a.. This could be due to the fact that the MTCT limit was often included in the anti-retroviral limit.

The range of limits per beneficiary and per family is illustrated on the following page.

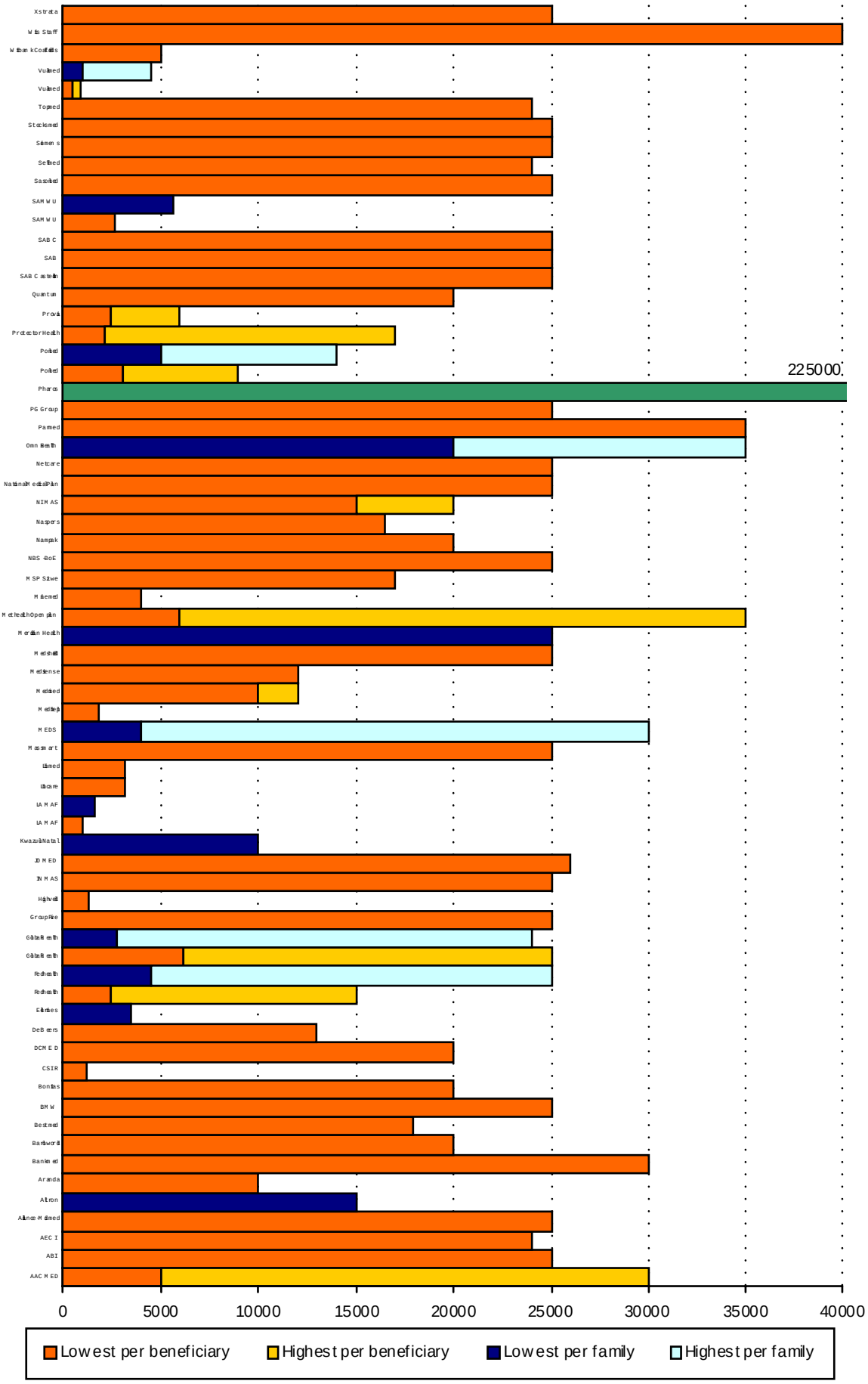

FIGURE 35: Range of annual mother-to-child transmission monetary limits

7.5 Post-exposure Prophylaxis Limits

As demonstrated in Section 5.4 on post-exposure prophylaxis benefits, most medical schemes are already providing anti-retroviral treatment for members who might have been infected by HIV through occupational injury, sexual assault or any other sexual exposure to HIV.

A notable feature is that 86% of schemes use the same limit for mother-to-child transmission as they do for post-exposure prophylaxis. In those 14% of cases where the monetary limit differed, post-exposure prophylaxis usually had a higher limit than treatment to prevent MTCT.

The types of limits for post-exposure prophylaxis are almost identical to that for MTCT treatment. The only distinctions to be made are that a few more options have an unlimited benefit for post-exposure prophylaxis and fewer options use the members' savings fully as compared to MTCT limits.

A further notable feature of post-exposure prophylaxis limits was that 84% of the limits given fell under a category that was specifically for HIV/AIDS. This was the highest percentage out of all the forms of limits discussed thus far.

Once again, the maximum limit per beneficiary was found to be R40 000 p.a., for the University of the Witwatersrand Medical Scheme. The second highest per beneficiary limit was R35 000 p.a., for the Parmed Medical Scheme.

As with mother-to-child transmission, the minimum benefit per beneficiary was found to be R500 p.a., for the Vulamed Standard option. The second lowest limit was R900 p.a., for the Vulamed Advanced option.

The average monetary limit per beneficiary was R15 467 p.a. This was a bit lower than the average limit for MTCT treatment, which was R15 549 p.a.. This is surprising given that those schemes that had different limits for the two treatments usually had a higher limit for post-exposure prophylaxis. However, most of the options that had higher limits have their limits defined per event and thus were not taken into account when calculating the average annual monetary limit.

7.6 Total HIV/AIDS Benefit Limit

The questionnaire attempted to ascertain the total annual HIV/AIDS benefit limit .but the quality of responses was inadequate. Most schemes do not have a total limit that covers all facets of HIV treatment, including hospitalisation, consultation and medication.

It was noticed that many schemes had an HIV limit that included anti-retroviral medication, other medication, treatment to prevent mother-to-child transmission and post-exposure prophylaxis. Most often this limit did not include hospitalisation, consultation and pathology benefits. No analysis has been made of the total HIV benefit limit as the figures received did not accurately reflect this amount.

7.7 Cost Management Mechanisms

Research indicated that a number of mechanisms are used by medical schemes to manage the high costs incurred by HIV/AIDS members. Those most commonly used are tariffs, co-payments and levies. The reasons for their use are discussed in Section 3.1. The graphs below show the extent of use of these mechanisms.

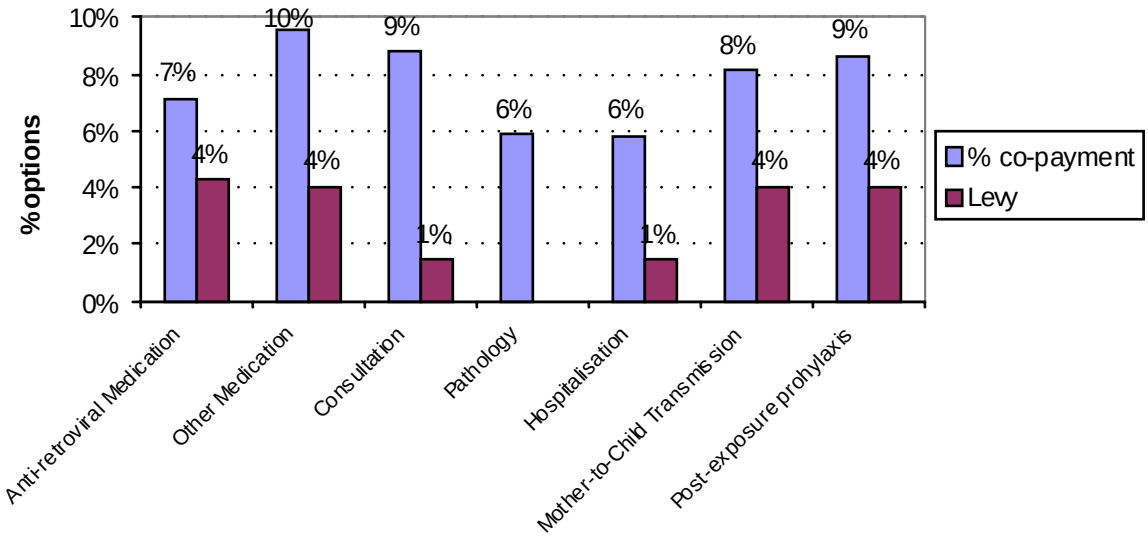

FIGURE 36: **Options using co-payments and levies**

Schemes appear to prefer to use co-payments rather than levies. Noteworthy is the fact that no more than 4% of options are using levies on any of the limits discussed in this chapter.

Many schemes place lower or upper limits on their levies. For example, the SABC Medical Scheme has a minimum levy of R20 and Stocksmed has a maximum levy of R35 on anti-retroviral medication. The highest levy was on the hospitalisation benefit of De Beers Medical Scheme, where a levy of R300 was imposed on the member.

On the other hand, co-payments are primarily used with regards to "other medication," with 10% of schemes using this mechanism. Utilisation of co-payments was lowest with respect to hospitalisation and pathology benefits. No schemes in the sample make use of a levy on pathology benefits.

Co-payments tend to be used far more aggressively than levies. For example, Pharos Medical Scheme has a co-payment of 50% on anti-retroviral medication, and Independent Newspapers Holdings Medical Aid Scheme (INMAS) has a 50% co-payment for their pathology benefit. 93% of those options using a co-payment for anti-retroviral medication impose a co-payment of 20% or more. With respect to post-exposure prophylaxis, 94% of options with a co-payment have a co-payment of 20% or more.

A variety of possible tariffs are available for use by medical schemes. Schemes may also develop their own tariff structure in negotiation with providers, but to date there is little evidence of this. Capitation payments are beginning to be used for some benefits. The authors acknowledge that work needs to be done in this area to get a more complete picture but we provide these preliminary results to assist trustees.

With regards to anti-retroviral medication, other medication, mother-to-child transmission and post-exposure prophylaxis, the three most commonly used tariffs were reported to be the Board of Healthcare Funders (BHF) tariff, the Maximum Medical Aid Price (MMAP) tariff and cost (the scheme pays for the full cost of the treatment). The cost tariff peaked for all these limits.

The mostly commonly used tariff for pathology, consultation and hospitalisation benefits was also the BHF tariff. For example, 92% of pathology limits used the BHF tariff as their benchmark.

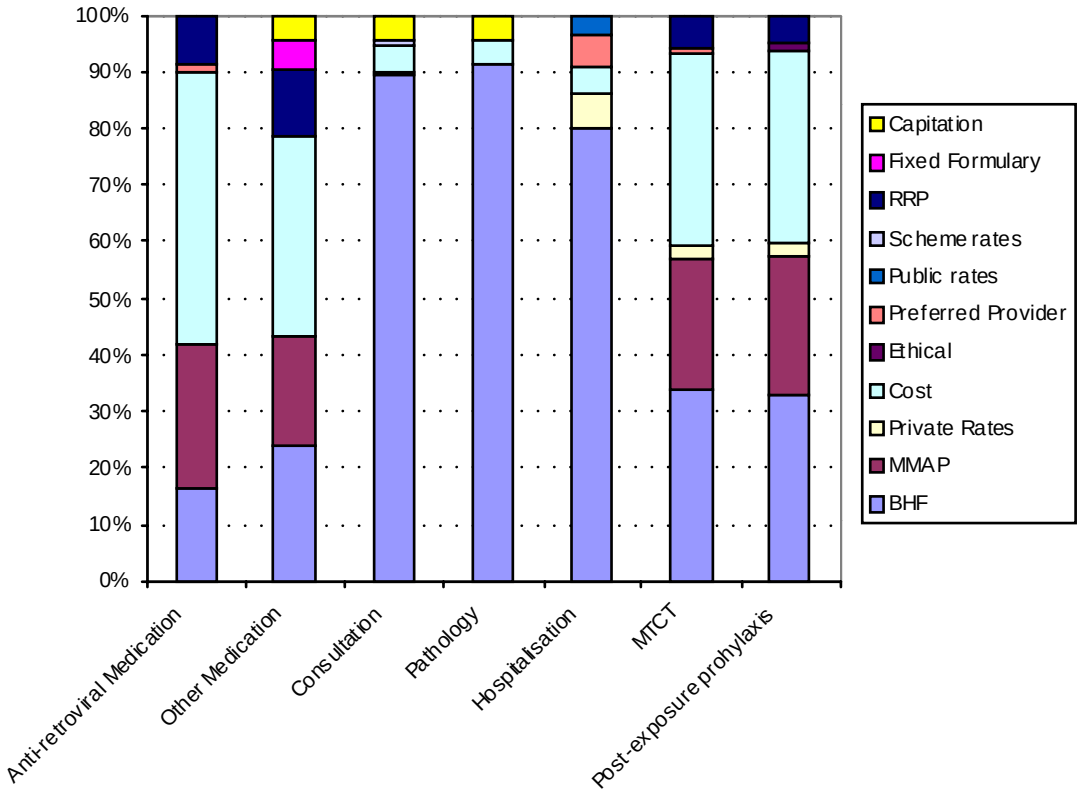

FIGURE 37: **Utilisation of tariff structure (by options)**

8. Conclusions and Recommendations

8.1 Key Survey Findings

8.1.1 Extensive use of disease management programmes

It was found that 78% of schemes are managing HIV/AIDS through a disease management programme, so that 89% of beneficiaries receive their benefits through these programmes. Only 13% of those schemes offering more comprehensive benefits than those prescribed by the Medical Schemes Act have no specialised management system in place. These schemes should consider the benefits of a co-ordinated approach to management of the disease that can be delivered by a disease management programme. In particular, in this fast-changing clinical area, access to research and protocols for the disease are important.

8.1.2 Extensive range of HIV/AIDS benefits and very high levels of access to coverage

All of the results from this research indicate that the majority of medical schemes surveyed are offering an extensive range of HIV/AIDS benefits to their members. Although there is more emphasis on prevention and education than treatment, most medical schemes are offering anti-retroviral medication; treatment to prevent mother-to-child transmission of the virus and post-exposure prophylaxis. The number of beneficiaries covered is particularly noteworthy:

- 96% of beneficiaries have access to benefits greater than Prescribed Minimum Benefits.
- 92% of beneficiaries have access to some form of antiretroviral therapy to prevent mother-to-child Transmission.
- 84% of beneficiaries have access to a caesarean section, 77% of beneficiaries have access to MTCT counselling, although only 47% of beneficiaries have access to formula feed.
- 96% of beneficiaries have access to antiretroviral therapy after sexual assault and 94% after occupational injury.
- 86% of beneficiaries have access to HIV counselling; 79% have access to HIV testing and 91% have access to education and information.
- 84% of beneficiaries have access to screening for tuberculosis and access to preventative therapy for tuberculosis.
- 87% of beneficiaries have access to preventative therapy for PCP pneumonia
- 88% of beneficiaries have access to treatment for sexually transmitted diseases.
- 90% of beneficiaries already have access to triple-combination antiretroviral therapy

In all, trustees are to be congratulated on having succeeded in providing comprehensive access to benefits for HIV/AIDS.

8.1.3 Low disease management programme participation rates

Excluding Aid-for-AIDS, only 0.16% of beneficiaries that have access to disease management programmes are actually registered with the programmes. Including Aid-for-AIDS, 0.42% of beneficiaries that have access to programmes are registered on those programmes. The best estimate for the industry, including schemes who did not respond to the survey, is considered to be 0.30% of beneficiaries.

The disturbing evidence of the low participation rates in the various disease management programmes, despite South Africa's high HIV prevalence rates, points to the inadequate marketing of these programmes and the lack of members' awareness of these services. A number of other factors are also suggested by the authors.

Further initiatives need to be implemented to make members' more cognisant of the programmes' confidentiality, the services these programmes offer to help manage the disease and accurate scientific information on the benefits and risks of anti-retroviral therapy in order to expand programme participation.

8.1.4 Triple-combination anti-retroviral therapy is considered as standard by scientists and by most medical schemes

There is a clear indication that the private healthcare sector allows access to triple-combination therapy as the optimal anti-retroviral treatment. It is promising to see that medical schemes' are considering best practice when providing members with the appropriate treatment.

Nevertheless, anti-retroviral medication still constitutes a small part of the schemes' overall limit and schemes should look for capacity to increase this limited service to their members. 71% of options (representing 90% of beneficiaries) already provide triple-combination anti-retroviral therapy. However, 20% of options are still providing mono-therapy or dual therapy as treatment.

In line with all the national and international guidelines, the Council for Medical Schemes should facilitate schemes to adopt a guideline on anti-retroviral therapy that stipulates triple therapy as the minimum standard.

8.1.5 Relatively few schemes and options not providing benefits

The provision of only Prescribed Minimum Benefits by medical schemes was not as extensive as anticipated.

- 9.1% of schemes have options that offer no other benefits apart from Prescribed Minimum Benefits. These schemes represent 2.5% of beneficiaries.
- In total, 14.9% of options offer these minimum benefits only. These options represent 3.9% of beneficiaries and 3% of principal members.
- 13% of options do not offer HIV testing, counselling or education and information.

- 13% of options offer no treatment to prevent mother-to-child transmission.
- 27% of options (representing 8% of beneficiaries) do not provide general access to anti-retroviral medication.

Although coverage in the survey was some 80% of all beneficiaries in the industry, coverage by schemes was only 53%. While the authors do not have details of the benefit structures of those schemes that did not respond, it is probable that these predominantly smaller schemes have poorer coverage of HIV/AIDS-related conditions than the survey reports.

8.1.6 Use of members' medical savings accounts

Use of members' medical savings accounts in HIV-related instances is not as high as expected. In fact, only 4% of options make full use of the members' savings account to fund anti-retroviral medication.

Further analysis showed that members' savings accounts were used most extensively with regards to consultation and pathology limits. 29% of options made use of either partial or full savings in their consultation limits and 22% of options made partial or full use in their pathology limits. Only 3% of options made full use and 2% partial use of savings accounts in their hospitalisation limits.

It is thus reassuring to see that most medical schemes are accepting responsibility for their members' health and not passing the risk on to the member by forcing coverage through his or her own savings account.

However, it is of concern to note that 9% of options make use of the illegal practice of funding Prescribed Minimum Benefits from savings accounts. We recommend that the Council for Medical Schemes immediately issue a circular warning all schemes that this practice is unacceptable and unlawful. We strongly support the amendment in the Proposed 2002 Regulations that specifically makes the use of savings accounts to fund PMB conditions unlawful.

8.2 HIV benefit structural reform is still needed in many schemes

Regrettably, it is still noticeable that the challenge to abate the virus is not as high on many schemes' agendas as it should be. Many schemes refused to answer the questionnaire on the grounds that they have no members with HIV, that they do not anticipate HIV to be a future problem among their members and that they currently have no HIV benefit system in place.

However, it was encouraging to witness the current reform of certain schemes' HIV structures. Overall, this indicates an increased commitment based on the experience of members requiring treatment and support, as well as an understanding of the impact of the epidemic on society.

8.3 Implications for Proposed Prescribed Minimum Benefits

This research indicated that many schemes' management and principal officers are ill informed to understand the best management and treatment of the disease. It became clear from vague questionnaire responses that some principal officers did not even understand the concept of Prescribed Minimum Benefits. In addition, the fact that medical schemes are voluntarily verifying that they are not providing treatment of conditions where coverage is compulsory, indicates that they are not evading the law, but rather do not understand it. Thus, more interaction between the schemes' disease management programmes and scheme trustees needs to be established.

With regards to the compulsory provision of Prescribed Minimum Benefits, it is encouraging to see that a mere 4% of beneficiaries have access only to the current minimum benefits.

In fact, so extensive is the provision of certain treatments such as post-exposure prophylaxis in the case of sexual assault and occupation injury, as well as anti-retroviral therapy to prevent mother-to-child transmission, that these benefits have already been provided by industry in advance of the proposed extension of PMBs.

The large number of beneficiaries already covered for the proposed PMBs suggests that at an industry level, the PMBs can be legislated with little additional burden on schemes as whole.

We are in a situation where almost all the beneficiaries in the survey are already covered for the PMBs , but where a large number of smaller open schemes have not reported and probably do not provide any HIV benefits. These small schemes can discriminate against HIV-positive beneficiaries and are effectively practicing a form of risk-rating through their benefit design They are currently placed at an unfair advantage in price terms by choosing not to offer certain benefits which are already provided to the majority of beneficiaries.

Accordingly, we recommend in the strongest possible terms that the Minister of Health extends the proposed Prescribed Minimum Benefits for HIV/AIDS, as set out in the draft Regulations of 30 April 2002.

8.4 Further Extension of Prescribed Minimum Benefits

The Minister of Health has asked for assistance in formulating the position on anti-retroviral medication being included in Prescribed Minimum Benefits.

The survey shows that 92% of beneficiaries have access to anti-retroviral therapy and 90% of beneficiaries already have access to triple-combination antiretroviral therapy. However the size of the benefit is shown to be inadequate for a full year's supply of medication in many cases.

It is not possible in the limited time for preparation of comments on the draft Regulations to complete all the modeling work that would be needed to show the long-term impact on individual medical schemes of including anti-retroviral medication in the PMBs.

We are increasingly of the opinion that the financial impact at an industry level is manageable, but it remains to be demonstrated how individual schemes would be affected. The existence of a risk equalisation mechanism between schemes would have led us to make an immediate recommendation to include anti-retroviral treatment in the Prescribed Minimum Benefits. Its absence leads the actuaries to take a more cautious stance.

We recommend that further modeling needs to be urgently carried out to predict the impact of the epidemic over time on individual schemes. The Minister of Health should promulgate the extension of PMBs to include anti-retroviral treatment, but allow exemptions to schemes that have demonstrable problems in the absence of a risk equalization mechanism. The Minister of Health is urged to pursue the introduction of a risk equalisation mechanism between schemes at the earliest possible opportunity.

8.5 Confusion for members in benefit designs

Lack of consistency between all the open and restricted schemes' HIV-associated limits was also noticeable. Limits were given in a range of different ways including a per beneficiary limit, a per family limit, a per beneficiary and a per family limit or a limit according to the number of member dependants. Other limits were given per event, some per month as opposed to per year and some according to the member's medication needs.

It is thus difficult for members to compare scheme benefits when joining a scheme. Effort should be made to ensure some standardisation across all medical schemes.

8.6 Adequacy of benefits

Benefits for prevention, treatment of opportunistic infections and medication are in the main adequate. Prevention coverage through counselling, testing, post-exposure prophylaxis for occupational injury, sexual assault and mother-to-child transmission is mostly adequate throughout the schemes surveyed.

Smaller schemes may need encouragement to ensure compliance, especially since these benefits will constitute part of the PMBs.

Anti-retroviral coverage is also adequate in the main but could quickly be exhausted unless prices are reduced to generic levels. The cost to members of anti-retroviral benefits needs further investigation and standardisation to ensure sustainability and access. Schemes are encouraged to join together with civil society lobby groups to work for the reduction in treatment costs.

8.7 Sustainability of benefits

The main cost-drivers in the treatment of HIV/AIDS include drug costs, diagnostics and monitoring, hospitalisations and support services. The sustainability of medical schemes and the benefits depend on managing HIV/AIDS in a non-discriminatory and cost-effective manner. The use of disease management programmes is an essential step. However, price reductions and active involvement of all medical scheme members in cost-containment are two essential components to ensuring sustainability of benefits and ultimately schemes.

Generic substitution of medicines for opportunistic infections and anti-retrovirals are essential to reduce prices. Anti-retroviral therapy can be reduced to R450 per month, or lower, through the use of generics. This will require the engagement of medical schemes and the Council for Medical Schemes with government and drug companies to ensure non-exclusionary voluntary licences are granted to all generic manufacturers on the basis of a 4-5% royalty.

Similarly, the laboratory costs of diagnostics and monitoring can be reduced significantly through generic substitution or price reductions. These measures are essential because of the scale of the HIV/AIDS epidemic and the high costs of treatment.

Medical schemes should actively seek broader coalitions amongst one another and with organisations like *Treatment Action Campaign* to lobby collectively for a reduction in treatment and monitoring costs.

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Appendix A: Extracts from the Medical Schemes Act and Regulations on Minimum Benefits

ANNEXURE A TO THE REGULATIONS
EXPLANATORY NOTE

The objective of specifying a set of Prescribed Minimum Benefits within these regulations is two-fold:

(i) To avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals.
(ii) To encourage improved efficiency in the allocation of Private and Public health care resources.

The Department of Health recognises that there is constant change in medical practice and available medical technology. It is also aware that this form of regulation is new in South Africa. Consequently, the Department shall monitor the impact, effectiveness and appropriateness of the Prescribed Minimum Benefits provisions.

A review shall be conducted at least every two years by the Department that will involve the Council for Medical Schemes, stakeholders, Provincial health departments and consumer representatives. In addition, the review will focus specifically on development of protocols for the medical management of HIV/AIDS.

These reviews shall provide recommendations for the revision of the Regulations and Annexure A on the basis of:

(i) inconsistencies or flaws in the current regulations;
(ii) the cost-effectiveness of health technologies or interventions;
(iii) consistency with developments in health policy; and
(iv) the impact on medical scheme viability and its affordability to Members.

ANNEXURE A : LIST OF PRESCRIBED MINIMUM BENEFITS

Categories (Diagnosis and Treatment Pairs) constituting the Prescribed Minimum Benefits Package under Section 29(1)(o) of the Medical Schemes Act (listed by Organ-System chapter)

Haematological, Infectious And Miscellaneous Systemic Conditions

Code: 168s
Diagnosis: # HIV-associated disease - first admission or subsequent admissions
Treatment: # medical and surgical management for opportunistic infections / localised malignancies

EXPLANATORY NOTES AND DEFINITIONS TO ANNEXURE A

1) Interventions shall be deemed hospital-based where they require:
- An overnight stay in hospital. or
- The use of an operating theatre together with the administration of a general or regional anaesthetic. or
- The application of other diagnostic or surgical procedures that carry a significant risk of death, and consequently require on-site resuscitation and/or surgical facilities.
or
- The use of equipment, medications or medical professionals not generally found outside of hospitals.

2) Where the **treatment component of a category in Annexure A is stated in general terms** (i.e. "medical management" or "surgical management", it should be interpreted as referring to prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition.

Where significant differences exist between Public and Private sector practices, the interpretation of the Prescribed Minimum Benefits should follow the predominant Public Hospital practice, as outlined in the relevant provincial or national public hospital clinical protocols, where these exist. Where clinical protocols do not exist, disputes should be settled by consultation with provincial health authorities to ascertain prevailing practice.

The following interventions shall however be excluded from the generic medical / surgical management categories unless otherwise specified:
……
vii) Treatments, drugs or devices not yet registered by the relevant authority in the Republic of South Africa.

6) In certain cases, **specified categories shall take precedence** over others present. Such "overriding" categories are preceded by the sign "#" in their descriptions within Annexure A**.**

For example, where someone is suffering from pneumonia and HIV, because the HIV category (168S) is an overriding category, the entitlements guaranteed by the 'pneumonia' category (903D) are overridden.

7) Hospital treatment where the diagnosis is uncertain and/or admission for diagnostic purposes. Urgent admission may be required where a diagnosis has not yet been made. Certain categories of prescribed minimum benefits are described in terms of presenting symptoms, rather than diagnosis, and in these cases, inclusion within the prescribed minimum benefits may be assumed without a definitive diagnosis. In other cases, clinical evidence should be regarded as sufficient where this suggests the existence of a diagnosis that is included within the package.
Medical schemes may, however, require confirmatory evidence of this diagnosis within a reasonable period of time, and where they consistently encounter difficulties with particular providers or provider networks, such problems should be brought to the attention of the Council for Medical Schemes for resolution.

SECTION 29(1)(O) OF THE MEDICAL SCHEMES ACT (as amended in 2001)

RULES OF MEDICAL SCHEME

29. **Matters for which rules shall provide**. (1) The Registrar shall not register a medical scheme under section 24, and no medical scheme shall carry on any business, unless provision is made in its rules for the following matters:

(o) The scope and level of minimum benefits that are to be available to beneficiaries as maybe prescribed.

REGULATION 8: PRESCRIBED MINIMUM BENEFITS

8. (1) From the date of commencement of these regulations, the prescribed minimum benefits that medical schemes must offer in terms of the Act consist of the provision of treatment for all the categories of Diagnosis and Treatment Pairs listed in Annexure A subject to any limitations specified in Annexure A.
(2) Any benefit option that is offered by a medical scheme must reimburse in full, without co-payment or the use of deductibles, the diagnostic, treatment and care costs of the prescribed minimum benefit conditions specified in Annexure A in at least one provider or provider network which must at all times include the public hospital system.
(3) Cover in the public hospital system must include all the costs of diagnosis, treatment and care for the prescribed minimum benefit Diagnosis-Treatment Pairs in Annexure A to a level and entitlement that is not different in terms of quality and intensity to the services provided to publicly funded patients.
(4) Medical schemes may offer enhanced options to their members through additional cover for any specific entitlements: Provided that diagnosis, treatment and care under the prescribed minimum benefits is provided.
(5) The options referred to in sub regulation (4) may include the use of alternative providers or provider networks and could incorporate member co-payments, or enhanced options for other benefits that fall outside of the prescribed minimum benefits or both.
(6) If cover for a prescribed minimum benefit as defined in Annexure A under an enhanced option is exhausted while the patient still requires diagnosis, care or treatment for that prescribed minimum benefit , that patient may be transferred to a lower cost provider or provider network, but the medical scheme must continue to be fully liable for all costs incurred in delivering the prescribed minimum benefit care that is required.
(7) A member or dependant shall not lose his or her entitlement to any prescribed minimum benefit, regardless of any enhanced option they may choose or as a result of any condition associated with that enhanced option.
(8) Medical schemes may employ appropriate interventions aimed at improving the efficiency and effectiveness of health care provision provided that every option offered by a medical scheme must at least provide full cover for prescribed minimum benefits in at least the public hospital system.

(9) These regulations must not be construed to prevent medical schemes from employing techniques such as the designation of preferred providers, requirements for Pre-Authorization and the application of Treatment Protocols: Provided that in the case of Pre-Authorization a medical scheme must not refuse authorization for the delivery in a public hospital of standard treatment for a prescribed minimum benefit as defined in Annexure A.
(10) Every Medical Scheme must make provision in its rules for the reimbursement of the cost of care that is considered to fall within the Prescribed Minimum Benefits prescribed under these Regulations within all the membership options that the medical scheme offers.
(11) Medical schemes must refer to these Regulations in their rules and such reference may not be a full reproduction of these Regulations.
(12) Medical schemes must specify in their rules whether they restrict the provision of the prescribed minimum benefits under specific membership options to a named network of providers.
(13) The Registrar must determine whether a medical scheme's rules are consistent with the provisions of the Act and these Regulations before approving such rules.
(14) Disputes and complaints between a member or a provider and the medical scheme in relation to minimum prescribed benefits must be dealt with in terms of Chapter 10 of the Act.

REGULATION 9: LIMITS ON BENEFITS

9. A medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the prescribed minimum benefits, *pro-rata* to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.

REGULATION 12: PRE-EXISTING SICKNESS CONDITIONS

12. (2) No waiting period may be applied –
(a) to any treatment or diagnostic procedure covered within the prescribed minimum benefits;

[Note this has not yet been repealed, but waiting periods were moved from the Regulations to the Act in the 2001 Amendments. See Section 29A of the Medical Schemes Amendment Act of 2001, for revised details of waiting periods that may be imposed. Exclusion from Prescribed Minimum Benefits for a general waiting period of three months and a condition-specific period of 12 months may be imposed for those who were not in cover in the 90 days before application to a medical scheme.]

Appendix B: Extracts from the 2002 Draft Regulations on Minimum Benefits

'**prescribed minimum benefits'** mean 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;

AMENDMENT TO ANNEXURE A OF THE REGULATIONS

By the substitution for Code 168S of the following:

Code:	168S
Diagnosis:	#HIV-infection
Treatment: [1]	HIV voluntary counselling and testing
	Co-trimoxazole as preventive therapy
	Screening and preventive therapy for TB
	Diagnosis and treatment of sexually transmitted infections
	Pain management in palliative care
	Treatment of common opportunistic infections
	Prevention of mother-to-child transmission of HIV
	Post-exposure prophylaxis following sexual assault.

[1] Note: comment is requested on this formulation of the benefit for HIV, in addition to other possible formulations, such as the wording of the existing benefit; and a treatment making provision for the provision of anti-retroviral therapy when clinically indicated.

By the insertion of the following:

CHRONIC CONDITIONS

Diagnoses:

Addison's Disease
Anti-coagulating therapy
Asthma
Bipolar Mood Disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Cushing's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1 and 2

	Dysrhythmias Chronic Obstructive Pulmonary Disease Epilepsy Glaucoma Haemophilia Hyperlipidaemia Hypertension Hypothyroidism Multiple Sclerosis Osteoarthritis Parkinson's Disease Rheumatoid Arthritis Schizophrenia Systemic Lupus Erythromatosis Ulcerative Colitis
Treatment:	Diagnosis, medical management and medication

IN THE EXPLANATORY NOTES AND DEFINITIONS TO ANNEXURE A

The insertion after note (2) of the following note:

(2A) In respect of treatments denoted as "medical management", note (2) above describes the *standard* of treatment required, namely "prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition". Note (2) does not restrict the setting in which the relevant care should be provided, and should not be construed as preventing the delivery of any prescribed minimum benefit on an outpatient basis or in a setting other than a hospital, where this is clinically most appropriate.

REGULATION 8: PRESCRIBED MINIMUM BENEFITS

(1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

(2) The rules of a medial scheme may, in respect of any benefit option, provide that
- (a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and
- (b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her designated dependant obtains such services from a provider other than a designated service provider, provided that no co-payment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(4) Subject to subregulations (5) and (6) and to section 29(1)(p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts for another drug instead, the scheme may impose a co-payment on the relevant member.

REGULATION 10: PERSONAL MEDICAL SAVINGS ACCOUNTS

(6) The funds in a member's medical savings account shall not be used to pay for the costs of a prescribed minimum benefit.

Appendix C: Questionnaire

HIV/AIDS Benefits Questionnaire 2002

TAC
TREATMENT ACTION CAMPAIGN

The Centre for Actuarial Research (CARE)

A Research Unit of the University of Cape Town

Thank you for taking the time to complete this questionnaire. TAC and CARE would appreciate it if you would complete the following 12 questions regarding the scheme's HIV/AIDS benefit structures for **2002**. Please send the scheme's benefit structures for 2002 along with this questionnaire.

After you have completed the questionnaire, please send it to the researcher by 15 March 2002. If you wish to fill it in electronically, e-mail the researcher to send you an electronic copy.
If you are unable to answer any specific question, please state why. If you have any queries, contact the researcher, Andrew Stein, whose details are given at the end.

Name of medical scheme: _____ Scheme code: _____

Name of administrator: _____ Open / Restricted / Exempt scheme: _____

Details of person submitting questionnaire:

Name : _____ Position within scheme: _____

Telephone number: (____) _____ Fax number: (____)_____

e-mail address: _____

1. **Below, fill in the details for all the options the scheme offers for 2002.**

Option Name	Number of families as at 1 January 2002	Number of beneficiaries as at 1 January 2002
Option Number 1:		
Option Number 2:		
Option Number 3:		
Option Number 4:		
Option Number 5:		
Option Number 6:		
Option Number 7:		
Option Number 8:		
Option Number 9:		
Option Number 10:		
Option Number 11:		
Option Number 12:		

2a. **If the scheme is linked to a disease management programme, please place a cross in this box.** ☐

If not, please skip to question 3.

2b. **Who manages the program?**

own scheme program	
Aid for AIDS	
Calibre Clinical Consultants	
CareAssist	
Lifesense	
MX Health	
Newmed	
Qaddsi	

Option Number	1	2	3	4	5	6	7	8	9	10	11	12
2c. **Insert a cross under those options where the member specifically needs to register to qualify for this program.**												

2d. **Fill in the number of beneficiaries registered for HIV/AIDS benefits in each option as at 1 January 2002**

1	2	3	4	5	6

7	8	9	10	11	12

2

For questions 3-8, please cross all the boxes applicable to each option.

3. **Which of the following support services are provided?**	1	2	3	4	5	6	7	8	9	10	11	12
HIV counselling												
HIV testing												
Education & information												
Surveillance of drug effectiveness												
Counselling for people on drug treatment												

4. **Which of the following does the scheme provide?**	1	2	3	4	5	6	7	8	9	10	11	12
Screening for Tuberculosis (TB)												
Preventative therapy for Tuberculosis (TB)												
Preventative therapy for PCP Pneumonia												
Treatment for Sexually Transmitted Diseases (STDs)												

5. **Does the scheme provide treatment for opportunistic infections out of**	1	2	3	4	5	6	7	8	9	10	11	12
Normal Hospital Cover												
Chronic Medication Cover												
HIV Benefit Cover												
Other: specify												

6. **Which of the following does the scheme provide to prevent Mother-to-Child Transmission (MTCT)?**	1	2	3	4	5	6	7	8	9	10	11	12
AZT only												
AZT and 3TC or other combination therapy												
Nevirapine												
Caesarian section												
Formula Feeding												
MTCT Counselling												

7. **Does the scheme provide anti-retroviral medication as post-exposure prophylaxis for:**	1	2	3	4	5	6	7	8	9	10	11	12
Sexual assault												
Occupational injury												
Other sexual exposure to HIV												

8. **Which of the following anti-retroviral "cocktails" does the scheme provide for the treatment of HIV?**	1	2	3	4	5	6	7	8	9	10	11	12
No anti-retrovirals are provided												
Mono-Therapy												
Dual-Therapy												
Triple-Therapy												

9. **Please place a cross under those options which offer Prescribed Minimum Benefits only**	1	2	3	4	5	6	7	8	9	10	11	12

3

10. **Please specify for each sub-limit, whether the limit is specifically for HIV/AIDS or whether the limit falls under a more general limit which also applies to non-HIV members.**

If the limit is "specifically for HIV/AIDS", then please place a cross in that box and provide the Rand amount per family and per beneficiary for this limit for each option.
If the limit falls under "another category", then please state the name of the category this limit falls under and provide the overall Rand limit for this category per family and per beneficiary for each option.

Please specify what tariff benefits are paid at by selecting a tariff from the list given below.
scheme or administrator-negotiated tariff
Board of Healthcare Funders (BHF)
Hospital Association of South Africa (HASA)
Maximum Medical Aid Price (MMAP)
South African Medical Association (SAMA)
Other: please specify

Then indicate the percentage copayment and levy paid by the member for each option.

Lastly, specify how each sub-limit is funded from a medical savings account or similar arrangement for each option from the list given below.
No savings account therefore not applicable
Not at all
Partially with benefit limited to funds in savings account
Fully

10a. Anti-retroviral medication

Limit is specifically for HIV/AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10b. Other medication (including nutrients and vitamins)

Limit is specifically for HIV/AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10c. Consultation

Limit is specifically for HIV/AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10d. Pathology

Limit is specifically for HIV/AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10e. Hospitalization

Limit is specifically for HIV/AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10f. **Mother-to-Child Transmission**

Limit is specifically for HIV /AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10g. **Post-exposure prophylaxis**

Limit is specifically for HIV /AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

10h. **Total HIV benefit limit**

Limit is specifically for HIV /AIDS ☐ Limit falls under another category (please specify) ☐

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

6

11. **What is the overall chronic disease benefit per annum for each option?**

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											
Tariff used												
% copayment												
Levy (R)	R											
Use of savings												

12. **What is the total overall limit per annum for each option?**

	1	2	3	4	5	6	7	8	9	10	11	12
Per family	R											
Per beneficiary	R											

When faxing or e-mailing this questionnaire, please attach the scheme's 2002 benefit structures or post them to the underlying address:

Andrew Stein
Centre for Actuarial Research
University of Cape Town
Private Bag
Rondebosch
7701 SOUTH AFRICA

Cell number: (083) 680-8885
Fax number: (021) 689-7580
e-mail address: astein@iafrica.com
CARE office number: (021) 650-2475

T

Appendix D: Medical Schemes who supplied information

Name of Scheme	Administrator	Options Covered
Anglo American Corporation Medical Scheme (AACMED)	Sovereign Health	Primary Care Option
		Managed Care Option
		PrimeCure Option
ABI	Medscheme	
AECI	Medscheme	AECI Healthcare 100% plan
Alliance-Midmed	Medscheme	
Altron Medical Aid	Allcare	Option 1
		Option 2
Aranda	Providence	
Bankmed	Metropolitan Health	Equilibrium Health Plan
		Equilibrium Plus
		Prime Health Plan
Barloworld Medical Scheme	Medscheme	Barmed
Bestmed	Self	Millenium Comprehensive
		Millenium Standard
		Topcare
		Blue Print Healthplan
		Bonus Plus
BMW	Medscheme	
Bonitas	Medscheme	Elite
		Standard
		Primary
		Bonsave
Chamber of Mines Medical Aid Society	Self	
Chartered Accountants Medical Aid Fund	Self	Vital
		Vital Plus
		Vital Double Plus
		Ecomed Catastrophe
		Ecomed Comprehensive
		C.A. Alliance
CSIR	Discovery Health	Essential Core
		Essential Core Plus
		Essential Comprehensive Plus
		Classic Core Plus
		Classic Comprehensive Plus
Da Gama Medical Scheme	Metropolitan Health	

Daimler Chrysler (DCMED)	Medscheme	Plan A
		Plan B
De Beers Benefit Society	Self	
Discovery	Discovery Health	Classic Comprehensive Max
		Classic Comprehensive Standard
		Classic Core Max
		Classic Core Standard
		Coastal Core
		Essential Comprehensive Max
		Essential Comprehensive Standard
		Essential Core Max
		Essential Core Standard
		Foundation Core
		Foundation Plus
Ellerines Holdings Medical Scheme	Medscheme	
Fedhealth	Medscheme	Maxima High
		Maxima Medium
		Maxima Low
		Ultimax
		Ultima 300
		Ultima 200
		Ultima Core
Free State Medical Scheme	Self	
Global Health	Amanzi Health Administrators	Silver
		Gold
		Platinum
Group Five Medical Scheme	Medscheme	
Highveld Medical Scheme	Mpumalanga Managed Care	Comprehensive
Independent Newspapers Holdings	Medscheme	
Ingwe Health Plan	Self	Ingwe Capitation
		Ingwe Classic
		Ingwe Hospital
JOMED Medical Scheme	Self	
Kwazulu Natal Medical Aid Scheme	Private Health Administrators	Comprehensive
LAMAF Medical Scheme	Self	Diamond
		Silver
Libcare	Medscheme	
Libmed	Medscheme	
Massmart Health Plan	Medscheme	
Medcor	Medihelp	

Medical Expenses Distribution (MEDS)	Medscheme	Gemini
		Managed Care
		Synergy 80%
		Synergy Basic
		Synergy Network
Medihelp	Medihelp	Sentinel 100
		Sentinel 80
		Sentinel Basic
		Dimension 100
		Dimension Life
		Dimension Core
		Nucleus Vital
Medimed	Providence	Medisave Max
		Medisave Standard
		Managed Care
		Coca-Cola Sabco (CCS)
Medisense	Discovery Health	
Medshield	Medscheme	Maxielite
		Medibase
		Mediplus
		Hospiplus
		Medibonus
Meridian Health	Sovereign	Traditional Comprehensive
		Traditional Limited
		Nu Gen Comprehensive
		Nu Gen Core
		Carecross
Methealth Openplan Medical Scheme	Metropolitan Health	Primary Clinic
		Primary Doctor
		Primary Classic
		Principal Elite
		Premier Classic
		Premier Select
		Premier Elite
		Premier Pinnacle
Metrocare	Medscheme	
Minemed	Providence	
MSP Sizwe		Affordable
		Full Budget
		Super 100
		Ecipamed
		Primary Care
NBS-BoE Group Medical Scheme	Medscheme	

Nampak	Sovereign	Standard
		Extended
Naspers	Self	N-Option
National Independent Medical Scheme	Self	Quantum Option
		Optimum Option
		Premium Option
National Medical Plan	Sovereign	Gold
		Comprehensive
		Economy
		Incentive Plan
		Incentive PlusPlan
		PrimeCure
Netcare Medical Scheme	Sovereign	
OmniHealth	Medscheme	Omnisave
		Omnicare
		Omnibonus
		Omnicore
		Omnitop
		Omniplus
Parmed	Medscheme	
PG Group Medical Scheme	Sovereign	
Pharos Medical Plan	Private Health Administrators	Rainbow Option
		Creation Option
		Footprint
Polmed	Metropolitan Health	Higher Plan
		Lower Plan
Profmed	Providence	Comprehensive
		Select
		Hospital
Prosano	Sigma	ProClassic
		ProVider
Protector Health	Protector Group Fund Managers	Primary
		Primary Plus
		HMO
		HMO Plus
		Family Care
		Familycare Plus
		Flexicare
		Flexicare Plus

Provia	Liberty Healthcare	Platinum Plan
		Platinum with Threshold
		Gold Plan
		Gold with Threshold Plan
		Silver Plan
		Silvercure
		Essence Plan
		Essence Network Plan
		Essence with Threshold
		Elite Plan
		Elite with Threshold
Quantum Medical Aid Society	Medscheme	Primary Plan
		Primary Plan with Buy Up
South African Breweries Castellion	Medscheme	
South African Breweries	Medscheme	
SABC Medical Aid Scheme	Medscheme	
SAMWU National Medical Scheme	Self	
Sasolmed	Medscheme	
Selfmed	Medscheme	Selfmed Afrisure
		Selfmed MedXXI
		Selfmed MedXXI Chronic
		Selfmed MedXXI Chronic Comp
		Selfmed MedXXI Chronic Exec
		Selfmed MedXXI Comprehensive
		Selfmed MedXXI Exec
		Selfmed 80%
Siemens	Medscheme	
Southern Sun Group Medical Scheme	Discovery Health	Classic Comprehensive
		Classic Core
Stocksmed	Medscheme	
Telemed		Basic PMB Plan
		Managed Standard Plan
		Standard Plan
Topmed	Medscheme	Topmed 100%
		Topmed 80%
		Topmed Incentive Comp
		Topmed Exec
		Topmed Incentive Savings
		Topmed Limited
		Topmed Bophelo
		Topmed Bophelo Network

Transmed Medical Fund	Metropolitan Health	State and Network
		State and Own Choice
		Ubuntu
		Batho
		Private Cover and Savings Account
		Essential and Network
		Essential and Network and Top Up
		Essential
		Essential and Top Up
		Standard
		Standard and Top Up
Umed	Self	Option 1
		Option 2
Visimed	Old Mutual	Jupiter
		Mars
		Venus
		Mercury
Vulamed	Medscheme	Standard
		Advanced
Witbank Coalfields Medical Aid Scheme	Mpumalanga Managed Care	Comprehensive
Wits Staff Medical Scheme	Medscheme	
Xstrata	Medscheme	

Appendix E: Options Providing Only Prescribed Minimum Benefits

Name of Scheme/Option	Type
AACMED PrimeCure	Restricted
Bankmed Prime Health Plan	Restricted
Bestmed Millenium Standard	Open
Bestmed Blue Print Healthplan	Open
Bestmed Bonus Plus	Open
Da Gama	Restricted
Ellerines Holdings	Restricted
Fedhealth Maxima Low	Open
Fedhealth Ultima 200	Open
Libcare	Restricted
Libmed	Restricted
MEDS Synergy Basic	Open
MEDS Synergy Network	Open
Meridian Carecross	Restricted
Metrocare	Restricted
NMP PrimeCure	Open
OmniHealth Omnicare	Open
Provia Silver Plan	Open
Provia Silvercure	Open
Provia Essence Plan	Open
Provia Essence Network Plan	Open
Provia Essence with Threshold	Open
Provia Elite Plan	Open
Provia Elite with Threshold	Open
Telemed Basic PMB Plan	Open
Telemed Managed Standard Plan	Open
Telemed Standard Plan	Open
Topmed Bophelo	Open
Topmed Bophelo Network	Open
Visimed Jupiter	Open
Visimed Mars	Open
Visimed Venus	Open
Visimed Mercury	Open

Appendix F: Options Funding Opportunistic Infections from Medical Savings Accounts

Name of Scheme/Option	Type
Bankmed Equilibrium Health Plan	Restricted
Bankmed Equilibrium Plus	Restricted
Bankmed Prime Health Plan	Restricted
Bestmed Millenium Standard	Open
Bestmed Bonus Plus	Open
Chamber of Mines Medical Aid Society	Restricted
CSIR Essential Core	Restricted
CSIR Essential Core Plus	Restricted
CSIR Essential Comprehensive Plus	Restricted
CSIR Classic Core Plus	Restricted
CSIR Classic Comprehensive Plus	Restricted
Provia Platinum with Threshold	Open
Provia Gold with Threshold Plan	Open
Provia Essence Network Plan	Open
Provia Essence with Threshold	Open
Provia Elite with Threshold	Open
Visimed Jupiter	Open
Visimed Mars	Open
Visimed Venus	Open
Visimed Mercury	Open