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# *CMS NEWS*

Newsletter of the Council for Medical Schemes

Turnaround in financial  
position of schemes  
Fair treatment  
under the spotlight  
Work continues on prescribed  
minimum benefits and chronic cover

# *In this issue*

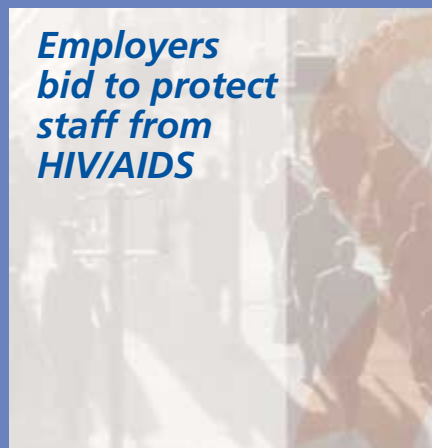
2

*A work in progress:  
Chronic disease  
and prescribed  
minimum benefits*



7

*Employers  
bid to protect  
staff from  
HIV/AIDS*



3

*Cost of benefit  
changes*



9

*Savings accounts &  
solvency - to include  
or not to include*



4

*Financial  
soundness of  
medical schemes*



10

*Belgians in Hatfield*



5

*Regulating risk*



12

*Council gets to  
bottom of complaints*



6

*Fair treatment under  
the spotlight*





**T**he Medical Schemes Act places great reliance on the appropriate governance of medical schemes by independent trustees of schemes. The Act requires that at least fifty percent of board trustees should be elected by fellow members at an annual general meeting. The legislation further places onerous fiduciary duties on trustees, including the duty to act at all times in the best interest of members of the medical scheme, to avoid or declare any conflicts between personal and medical scheme interests, and to act at all times without regard for personal, ulterior and improper motives.

Trustees are also required by legislation to be fit and proper persons. We have regard to a number of factors when assessing the fitness and propriety of those who are to function as trustees, including the honesty, integrity and reputation of such a person. We also, of course, take into account the competence and capability of such persons.

Many trustees are dedicated people with high ethical standards. Many do a fantastic job. Recent research, such as the study on Governance of Medical Schemes in South Africa, conducted for us by the University of Pretoria, also concluded that trustees in South Africa compared favourably with international trends in not-for-profit governance. I have also often, during Council's trustee training workshops, been thoroughly impressed with the level of commitment by many trustees to these largely non-executive responsibilities.

Which is why it is so disappointing that we still have instances such as at Prosano, Telemed and a number of other schemes, where some trustees have, at best, failed to understand the importance of avoiding the appearance of a conflict of interest. At worst, these trustees have been



Photo: Sunday Times

remiss in their fiduciary duties of exercising prudence in the control and use of the resources of the schemes. As a regulator, we cannot stand aside and watch some of these activities unfold. We will take stern action, such as we have taken at Prosano, when trustees breach their duties of good faith and of care towards medical schemes. It is time to step up to the bar!

### **Turnaround in financial position of schemes**

It is still early days. But the signs are there nonetheless. Many medical schemes are showing very visible signs of an encouraging turnaround in their solvency position.

The findings from our analysis of the quarterly statutory returns, required by law to be submitted by medical schemes, show that 2002 has continued the trend of an upswing in the solvency ratio of the industry which was first noted during 2001. These returns show that the average solvency position of open schemes

has increased to 14,11% during 2002 from 13,15% during 2001, an increase of 7,3%. Restricted schemes have also achieved an average solvency of 37,92% during 2002, up from 36,1% during 2001, an increase of 5%. When viewed as a whole, average solvency of schemes during the fourth quarter of 2002 was 21% compared with 20% at December 2001.

These figures are buttressed by growing positive operating results achieved during the last quarter of 2002 as well as the improvements in the net profit position of schemes. An even more encouraging finding of the analysis of these quarterly returns is that those schemes which were very sickly during 2000 (or "in ICU" as we say here) are leading the charge in this continuing recovery. All these factors bode very well for the future sustainability of the industry. While these quarterly returns provide only an early warning system on the operations of schemes, there are many encouraging signs. I congratulate all trustees and administrators for their hard work and diligence. Our own staff deserves congratulations for riding out the storm!

**T. Patrick Masobe**  
**Registrar of Medical Schemes**



# *A work in progress: Chronic disease and prescribed minimum benefits*

*Cover for several chronic diseases is to fall under the Prescribed Minimum Benefits (PMBs) from January 2004.*

**T**his means medical schemes will not be able to refuse to cover these conditions, nor limit the amounts spent covering the conditions. This will apply throughout all options on all schemes.

The move was necessitated by the fact that schemes were increasingly forcing members with certain chronic conditions to buy more expensive options. This was achieved by ensuring that chronic condition coverage was either provided, or extended, in the more expensive options available. Many schemes, however, were simply not covering some conditions, forcing members to use state hospitals, which in turn, would not be reimbursed for the service. Inevitably, older and sicker members were those hit by the situation.

Schemes will have the option of placing members in state hospitals – but only if the rules reflect that schemes have contracted with these hospitals as a “designated provider” through which patients will receive their care. If the hospitals have improved facilities for private patients, this is where they will be placed. If the specified care is not available, or queues are too long at the facility, members will be able to go to a private hospital where the care is available and schemes will have to cover the costs.

If a member chooses to go to a hospital which is not a designated provider, she will be able to go there, and the scheme will reimburse the member the amount a designated provider would have charged. The member would have to pay the difference.



## **What will differ from the previous situation?**

Many members have found themselves in state hospitals for conditions covered by the prescribed minimum benefit regulations, with no protection as to the quality of care – or even if the care would be provided at all. These hospitals in turn, have provided the care, without being paid by the schemes, to members who should be covered for the treatment. Many schemes have provided patients with the bare minimum treatment in facilities which leave a lot to be desired.

The new regulations, which will come into force next year, seek to eliminate these practices. Members should then be treated in facilities which will provide adequate care and about which they have prior knowledge, as there will be contracts between schemes and facilities. Members should have access through their scheme’s rules to the facilities they can use and knowledge about

the standards of care they should expect. Members who have chosen to use a private hospital instead of a designated provider will be able to have a portion of the costs reimbursed – the amount the scheme would have paid if it was paying the hospital with which it had a contract. In the past, schemes refused to reimburse any portion of members’ costs under those circumstances.

## **What still has to be done?**

This provides an outline of what members could expect – but the proverbial devil will lie in the detail.

The list of chronic diseases will be accompanied by “protocols”, or a suggested treatment plan. The Council has sought the advice of experts to draw up optimal, safe and cost effective treatment for each of the conditions. These will be in the form of guidelines for schemes.

Some issues have yet to be fully explored and decided upon by schemes and a range of providers. Ideally, members would have some input via their trustees, but that is unlikely in the early stages.

Among these outstanding issues are whether or not patients in state hospitals – even those with two-tier facilities – will be restricted to the hospital’s essential drugs list. Aside from which drugs are available, the next question is whether the drugs will be supplied to patients at the cut-price rate (which the state pays) or at the much more expensive rate charged by drug companies and pharmacies to the private sector.

A question few have asked – but which is likely to prompt questions at some stage – is the role the member’s



own doctor or specialist would play in certain hospitals. It is unlikely in certain circumstances for instance, that the member's doctor will be the treating doctor in a state hospital.

There are bound to be a range of queries and disputes over what is deemed to be suitable treatment – and views on this will most likely vary along the lines of who has a stake in which part of the treatment. For instance, doctors who may be about to lose a patient to a state hospital's system may question the treatment the patient is given. Private hospitals may be disquieted by the possibility of a chunk of their business going to the state's group of two-tier hospitals. Several already argue that public funds have been used to improve the private wards in state facilities. State facilities, they say, will thus compete unfairly with private hospitals, which have been able to avail themselves of only private shareholder funding for the necessary capital expenditure.

Large multinational research-based pharmaceutical companies are already balking at the prospect of medicines that were bought cheaply through the state's tender system might end up being swallowed by private patients in the state's fancier wards. Some generic manufacturers also maintain the differential between state and private markets, and could find themselves in the same situation.

Pre-authorisation systems in medical schemes are likely to be challenged by questions such as what a reasonable wait for a procedure would be at a state hospital; or, when would care be deemed to be inadequate in state hospitals; or when would they have to accept that a patient has correctly chosen to use a private hospital which is not one of the scheme's contracted providers.

All of these issues, and more, are likely to find themselves being aired in the next year as the systems are worked out, and as they are implemented.

## Cost of benefit changes

Chronic cover limits, which were worth R13 428 in 2002, dropped to R12 563 in 2003, according to a survey of benefit changes carried out by the Council for Medical Schemes.

The cover for chronic conditions ranged from R1 700 per family per year to R54 000 per family per year across all the options evaluated.

Because the sample was limited and the detail in the survey insufficient to draw firm conclusions in several areas, it has been recommended that contribution increases be more closely monitored and carried out annually.

Although the monetary limits dropped, there were only seven out of 69 benefit options – 10% – which failed to provide any cover for chronic conditions at all.

The survey was conducted among schemes submitting rule amendments for benefit changes for the Registrar's approval. In the provision of chronic benefits, most was delivered through preferred provider organisations or through managed care routes.

By next year, the benefits for chronic conditions will be radically altered by the inclusion of 25 chronic diseases which will become part of the package of minimum benefits.

Schemes used levies and co-payments as a way of minimising the use of chronic benefits, with members expected to pay a portion of the cost. Some 16% of the schemes used levies ranging from 15% to 30% of drug scripts and in two schemes a levy of R25 per script was used.

The overall increase in contributions to registered medical schemes was 14%, with those for dependants (adults and children) ranging between 16% and 15%, suggesting increases were steeper for dependants. Increases for child dependant contributions were particularly steep at 17% for members of open schemes.

Although the pace of increases slowed across the spectrum of medical schemes, the slow-down in contribution increases was more marked in restricted schemes. However, when measured against the Consumer Price Index and medical inflation, contribution increases were still high.

Of the 69 benefit options measured, 30 failed to provide any HIV cover beyond the compulsory benefits provided for as prescribed minimum benefits. These were largely delivered through disease management programmes (74,3%). Only 10% were provided through monetary benefits.

Despite the progress of the epidemic in the country, there was a marked decrease in HIV benefits in medical schemes. Schemes offering monetary HIV benefits had the sharpest decrease (down 24%). The price of anti-retroviral medication had dropped during this time.

Most benefit options had unlimited cover for hospitalisation – but this was qualified by sub limits for the various conditions and treatments that the scheme covered in their benefits. The hospital benefits in options offering monetary limits increased by 22% in 2003.



# Financial soundness of medical schemes

A discussion document, “A Review of Factors that Influence the Financial Soundness Of Medical Schemes”, which has been published by the Registrar of Medical Schemes, indicates that the financial soundness of medical schemes is influenced by a number of factors, including the inadequate setting of contributions and the lack of adequate professional supervision when contributions are decided; the manner in which medical scheme reserves are defined and derived, particularly with regard to reserves for claims that have been incurred but not yet recorded (IBNR); and inappropriate investment decisions by medical schemes, resulting in inappropriate asset holding.

The discussion document is the result of almost eighteen months of work by a joint task force set up by the Registrar, made up of staff of the Registrar’s Office, the Actuarial Society of South Africa (ASSA), the Board of Healthcare Funders (BHF), the South African Institute of Chartered Accountants (SAICA) and the Open Medical Schemes Forum. The task force was chaired by Professor Heather McLeod, a member of the Council for Medical Schemes and professor of actuarial science at the University of Cape Town.

The task team also dealt extensively with issues linked to the statutory definition of reserves; the changes to reporting requirements for medical schemes that are below the required reserves; the impact of ‘risk transfer’ through reinsurance and managed health care on the level of required reserves; and the possible introduction of a risk-based capital approach as a basis for the estimation of statutory reserves.

The task force has recommended that consideration be given to the



appointment of a statutory actuary by medical schemes. It has also suggested that ASSA should develop a professional guidance note for the calculation of contributions, and that such guidance should be underwritten by the Registrar and be complied with by all medical schemes.

A further recommendation relates to the calculation of IBNR, required by Section 35(9) of the Medical Schemes Act, to be included in the liabilities of schemes. The estimation of an IBNR may sometimes result in two undesirable effects on reserves. Reserves may be artificially overstated if a scheme has under-reported its IBNR. Alternatively, reserves may be under-reported if the IBNR is higher than warranted. Either way, the process involved in the estimation of IBNR may lead to a perverse situation: schemes that are conservative in the calculation of their IBNR may have inadequate reserves, whereas a scheme that is less conservative and that holds inadequate IBNR may appear to meet the reserve requirement.

It is proposed to remedy this situation through the development of a professional note on the calculation of IBNR, to be drafted by ASSA and

SAICA and agreed to by the Registrar. Alternatively, it has been suggested that it may be desirable to develop a specific formula for the calculation of IBNR, and that schemes that deviate from such a formula should be required to indicate both the extent of, and the reasons for, deviations.

The task force has been unable to agree on whether or not medical schemes that have entered into reinsurance and managed health care agreements with third parties should be allowed to hold lower reserves. The Registrar remains unconvinced that this would be a prudent approach until inappropriate risk transfer through reinsurance has been dealt with. In addition, the regulation of managed health care would have to mature considerably. These entities would also have to hold their own reserves before changes could be contemplated with regard to lowering the reserve requirements.

The consultation document also identifies the need for more work on a possible risk-based capital formula for South Africa. Current formulas were developed in settings that are quite different from South Africa. The formula was also developed for organisations and regulatory environments that are distinctly different from our own. Initial discussions with trustees have also shown a reluctance to change to a risk-based capital approach at this time, given the intensity of data requirements and complexity of factors to be considered. The task force has recommended, nonetheless, that work should continue to identify risks faced by medical schemes and to determine the factors that might be used in a formula relevant to our conditions.





# Regulating risk

**R**esearch conducted by the Council that allocates medical schemes to 'impact bands' has found that 18,9% (n=26) schemes fell into the high impact band by virtue of their size, pensioner ratio or both. Almost two thirds of schemes (n=87) were classified as medium impact, with the remaining 16,8% (n=23) of schemes rated in the low impact band.

Council's research has allocated medical schemes to impact bands on the basis of the impact that the failure of a particular scheme is likely to have on the stability of the medical schemes environment and the achievement of the Council's regulatory objectives.

Schemes are classified as high impact if their potential failure is judged to have a substantial impact on the stability of the environment and on the statutory objectives of the Council. The failure of any of these schemes would create enormous difficulties for Council in its attempt to deliver on its objectives of market stability and the protection of beneficiaries. The impact on beneficiaries, potential members, other schemes and market confidence would be significant if these schemes were to fail.

Medium impact schemes are those considered to have a moderate impact on the environment, while low impact schemes are judged to have a relatively minor impact on the environment if they were to fail.

The categorisation of schemes into these impact bands was based on two demographic factors: the number of beneficiaries and the proportion of pensioners in a scheme. A medical scheme with a high number of beneficiaries will have a serious impact on the environment if it were to fail. Failure of a medical scheme with a high number of pensioners

(described as beneficiaries who were 65 years or older) would also impact negatively on Council's objective of providing protection to vulnerable groups

Schemes with beneficiary numbers greater than 50,000 were assumed to score a 1 (highest score) while those below 6,000 were assumed to score a 0,25 (lowest score) on the impact ranking. Schemes with beneficiary numbers greater than 6000 but less than 49,000 were scored at 0,5. The indicator on the number of beneficiaries (as opposed to the number of pensioners in a scheme) was further weighted at 60% to reflect its greater importance for stability and market confidence.

With regard to pensioners, schemes with high pensioner rates (above 90%) were scored a high 1, those with a pensioner ratio below 10% a low 0,25 while the intermediate group was scored at 0,5. The pensioner ratio indicator was weighted at 40%.

Other findings suggest that open medical schemes accounted for 65% of schemes in the high impact band while restricted schemes accounted for 75% of schemes in the medium impact band and 96% of schemes in the low impact band.

This allocation of schemes into impact bands forms part of the development of Council's risk based regulatory framework.

This framework calls on the Council to identify 'big' problems in the medical schemes environment and develop plans to solve them. The identification of high impact schemes will allow us to focus our resources on those schemes whose failure could have significant consequences for market stability and member protections.

We proposed therefore to provide higher levels of regulatory supervision for those schemes judged to be high impact. This will be done through the development of Risk Assessment Frameworks (RAFs) for all schemes judged to be high impact. An RAF will allow us to develop a refined understanding of the business and control risks within the scheme. We will also develop Risk Mitigation Plans (RMPs) for these schemes. An RMP will propose actions to be taken by the scheme, by trustees and by the Council in order to mitigate the risk identified in the RAF. Schemes that are judged low impact will continue to enjoy only baseline supervision, including monitoring through quarterly and annual reports.

In this way we will be able to focus our resources to the areas and schemes whose failure would have greater impact on the stability of the environment we regulate. We will be able to focus on the 'big problems' and propose measures to fix them.

Table 1. Medical schemes by impact band

Impact band	Medical schemes		
	Open	Restricted	Total
High	17	8	26
Medium	22	65	88
Low	1	22	23
Total	40	95	137

# Fair treatment under the spotlight

*"Fairness is what justice really is"*  
Associate Justice Stewart Potter,  
US Supreme Court, 1958



Potter had a point. Justice demands not that everyone has their every need met, but that decisions affecting the rights of people are taken in a manner which is fair, reasonable, equitable and unbiased. Ensuring that decisions by medical schemes are taken fairly was undoubtedly the primary intent of the legislature mandating the Council for Medical Schemes, in terms of section 7 of the Medical Schemes Act, to "protect the interests of beneficiaries at all times".

The Council for Medical Schemes has made significant progress toward ensuring that beneficiaries are treated fairly by their medical schemes. Yet, judging by the large volumes of complaints that continue to pass through our office and our frequent interactions with consumer organisations, many beneficiaries of medical schemes still believe that they are being unfairly treated. Some of these allegations are well founded, but others are not.

Given the centrality of this issue to the mandate of the Council, the fair treatment of beneficiaries has been identified as one of our main thematic concerns during 2003. A project team has been set up to investigate the issue, including representations from the divisions in the Registrar's office which interface most directly with consumers.

Our first goal is to better under-

stand the concepts of fairness and unfairness within the context of the medical schemes environment. In this quest, we are mindful of the fact that fairness is not a static and inflexible concept, but is dependent on the particular context in which it is applied. Yet, we have achieved a measure of objectivity in this determination through looking at how the concepts have been applied by courts, various legal doctrines which have a bearing on the subject, literature that has been written about the concept, and how it has been applied in other jurisdictions.

We then applied the principles, guidelines and criteria derived from this process to a list of alleged unfair practices identified by the analysis of complaints data and focus group discussions in a series of internal and external stakeholders. The objective of this exercise was to make a determination, with as much objectivity as possible, as to whether or not the alleged unfair practices can actually be regarded as unfair. The practices identified as actually unfair are being categorised in terms of severity of impact on consumers, to allow for prioritisation of interventions by the Council.

Having reached this point, we are about to proceed to phase two of the project, which is to develop an understanding of the extent to which identified unfairness is already being ade-

quately addressed, either by the Council or through some other body or process; and what still needs to be done to ensure that consumers are adequately protected against such unfairness. Arising from the process, recommendations will be made to Council in relation to steps that should be taken to improve the protection of consumers against unfair treatment within the medical schemes environment. These recommendations could take various forms, including inter alia:

- promoting the development by the industry of a code of conduct to ensure that fair practices are voluntarily adhered to and maintained;
- developing guidelines for the industry of specific ways in which fairness in treatment of beneficiaries can be enhanced – including possible developments of the model rules;
- supporting consumer bodies in the provision of assistance to aggrieved beneficiaries of medical schemes;
- more effective enforcement of existing statutory protections;
- declaration of undesirable business practices in terms of section 61 of the Medical Schemes Act; or
- development of recommendations to the Minister of Health for the strengthening of the regulatory and statutory framework to render unfair practices unlawful.

Before the finalisation of the project, stakeholders will be given opportunity to comment on the draft report and recommendations. However, should you require further information at this stage, please feel free to contact the project coordinator, Stephen Harrison, by e-mail: [s.harrison@medicalschemes.com](mailto:s.harrison@medicalschemes.com).





# Employers bid to protect staff from HIV/AIDS

**T**he Council for Medical Schemes received a number of requests for approval of an entity that would allow them to cater for the needs of employees who are currently employed, but without medical scheme cover, to be insured at least for HIV and AIDS.

These are often lower-income workers who cannot afford the expensive drug treatment required when caring for HIV/AIDS. In certain instances, this could also be extended to medicals scheme members, with certain provisos.

This issue received added impetus after several employer groups announced they would start providing HIV cover, including anti-retroviral medicines, to their employees.

The major obstacle to simply providing the cover and charging a contribution for the supply of the drugs is the Medical Schemes Act itself, and several groups then approached the Council to seek a way forward.

A focus group discussion was held with various stakeholders including medical schemes, administrators, managed care organisations and health insurance companies at the Council's offices, to explore possible alternatives to HIV cover.

## **Several models were discussed.**

Typically, an employer organisation would seek to form a separate HIV fund to cater for the HIV needs of all the employees who are employed but uninsured. In this model, cover would not be extended to the employee's dependants.

Insured employees would receive their HIV benefits through their medical scheme either as part of the prescribed minimum benefits or as enhanced benefits.

In another model, an independent party would start an HIV fund to cater for groups of companies, again with employees who were not covered by medical schemes. In this model, dependants would be included. The service would be rendered through a managed care company or by the company itself through a defined method of financing and delivery.

A third model would see an independent party starting a fund to serve all the company's employees irrespective of whether or not they belonged to a medical scheme. Again, this would be delivered with the assistance of a managed care company or by the company.

In a fourth model, an independent party, or an employer, would start an HIV fund contracted to a managed care organisation. The fund would cater for employed but uninsured employees on medical schemes who would then access the benefits through their medical scheme.

## ***A medical scheme undertakes a liability in return for a premium or contribution:***

- a)** to make provision for the obtaining of any relevant health service
- b)** to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and
- c)** where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with the medical scheme.

*continued on page 8*

The Council for Medical Schemes does not have a policy-making function, but must rather “control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy” (section 7(b) of the Medical Schemes Act [“MSA”]).

The Council for Medical Schemes therefore does not have the power to develop an alternative framework for the regulation of HIV-specific products. To the extent that such products emerge within the market, they must function within the ambit of the Medical Schemes Act.

There may, however, be exceptional circumstances in particular instances which would justify limited exemptions being granted to HIV-specific products – but these would need to be considered on a case by case basis.

For the reasons outlined above, Council refrained from developing a “framework” for exemptions. Certain principles were agreed on, however, which would guide Council’s deliberations on any particular application for exemption for an HIV-specific product.

HIV-specific products typically conduct the business of a medical scheme by accepting premiums or contributions in return for undertaking the liability to make provision for (a) obtaining treatment for HIV, (b) defraying expenditure incurred in connection with HIV treatment, or (c)

rendering the HIV treatment themselves or making provision for it through agreement with another service provider.

There is no question therefore of the applicability of the Medical Schemes Act to these products, and that if they were to operate, exemptions from specific provisions of the Act would be required in terms of section 8(h) on demonstration of exceptional circumstances. This in turn depends on the merits of each case.

Some employers who are at present unable to extend medical scheme cover to lower income employees in the company, might see themselves as qualifying for an exemption.

Some of these employers, despite the constraints on their ability to supply a full medical scheme service to all employees, would nevertheless like to give access to HIV positive employees for treatment when they need it. While these employees may be receiving treatment for opportunistic infections in state hospitals, it is the provision of anti-retroviral therapy that employers would ideally like to provide.

Under these limited circumstances, the medical scheme could potentially apply for the registration of an additional benefit option with specific exemptions (such as exemptions from prescribed minimum benefits other than the HIV benefit) to be accessible to employees of the company in question below a particular

income threshold, pending the development of an appropriate low cost alternative.

HIV-specific products would be required to register as medical schemes in terms of the Medical Schemes Act, and Council would not accept an application for exemption from this requirement to register (sections 20 and 24 of the MSA). To do so would circumvent the regulatory framework and would entail either the development of an alternative regulatory framework for these products, which would be assuming the power of the legislature; or the rewriting of the Act itself.

The application of a consistent and uniform legislative framework for such products is necessary to protect consumers in any arena where they would otherwise be vulnerable and open to abuse.

The effect of registration would disallow members of the limited HIV medical scheme from being members of another medical scheme in terms of Section 28 of the MSA.

Section 28 applies to individuals, and therefore Council would lack the authority to grant schemes exemption from this provision.

The Council, with very limited exceptions, believes the development of cost-effective medical schemes with adequate HIV interventions ought to be encouraged.



### ***From the United States***

The Wall Street Journal’s online edition reports that the United States Supreme Court handed down a decision in April which would compel health maintenance organisations (HMOs) to open their networks to doctors who, though outside the HMO network, agree to follow the organisation’s rules.

The decision comes after a number of medical insurance companies had challenged the growing number of American state laws which force the companies to accept “any willing provider”, consequently giving members greater choice in selecting medical care.

The journal also reports that the biggest health insurer in the state of Illinois, Blue Cross and Blue Shield, has decided to pay pharmacists US\$1 every time they persuade a customer to switch from a brand name drug to a generic.

The report says that Blue Cross and Blue Shield believed that patients could save between \$40 and \$50 per prescription, and that large pharmacies could make as much as between \$5000 and \$10,000 every three months.



# Savings accounts & solvency - to include or not to include

**T**he Medical Schemes Act of 1998 and its Regulations came into effect in 2000.

This Act was ground-breaking in many respects, especially in its pursuit of social policies. The main policy objectives that it sought to achieve were social solidarity, community rating, and cross-subsidisation between the young and healthy on the one hand and the old and infirm on the other. Also, contributions were not to be related to the health status of a person, which means that medical schemes cannot practice risk-rating.

The Act also sought to ensure that medical schemes were financially sound and there are a number of provisions in the law that address this objective. One of the most significant of these is the "solvency" requirement.

Although this particular requirement has resulted in a lot of - sometimes heated - discussion, it is important to note that it forms the cornerstone of the financial supervision of medical schemes.

One particular area of debate is: Why not exclude savings accounts from the requirement to hold statutory reserves?

**Chapter 7 of the Act, deals with financial matters. Section 35 (3) requires medical schemes to hold assets the aggregate value of which shall not only meet all liabilities as and when they become due, but an excess reserve the extent of which is determined in the Regulations. Regulation 29 then determines these excess reserves to be held to be at least 25% of gross annual contributions. There are phasing-in provisions with the level of 25% to be met by 31 December 2004 and thereafter. The phasing-in provisions also now apply to newly registered schemes.**

Schemes are therefore required to maintain a specified minimum amount of accumulated funds, that is, assets should exceed liabilities by a statutorily determined amount (hence

"the solvency requirement").

A requirement of this nature is in line with other regulated industries both locally and internationally. No credible argument against the requirement per se has been forthcoming.

The main purpose of the requirement is to act as a cushion should a scheme experience unexpected high levels of expenditure. Sudden variations in the levels of claims may result in much higher expenditure than the contributions can meet. This may result in shortfalls. The Act seeks to ensure that schemes have enough reserves to withstand such shocks until corrective action can be taken. This in turn ensures that scheme members continue to be covered.

**Regulation 29 (3) reads as follows: "A medical scheme must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than ...". Essentially, this means that in calculating the minimum reserves to be maintained, the denominator must include not only risk contributions, but savings contributions as well. The savings balance held is not included (as a reserve) in the numerator.**

*It has been argued that the current approach is overly conservative and creates a disincentive for schemes to offer savings accounts. Savings accounts are distinguishable from risk pools in that a savings account does not carry the same risk as the risk pool. This is quite obvious, because a member's benefits are limited to the amount contributed to a savings account.*

**The risks that a scheme faces in so far as the savings accounts are concerned, are limited to the following:**

- **Bad Debts.** This relates to the risk of bad debts on savings advances. It is argued that only a few schemes face this risk, and the risk reduces as the year progresses any-

way. This risk should be addressed through appropriate provisions for bad debts in the income statement.

- **Investment risk.** This relates to the risk if savings balances are in equities and there is an experience of a reduction in value. It is argued that this risk should be more appropriately addressed through a restriction of savings balances to cash or through a reduced reserve requirement more commensurate with this risk.
- **Fraud and Mismanagement.** The risk that the scheme will incur financial losses through fraud or mismanagement of the savings accounts does not warrant the current approach. It is argued that this risk is better addressed through appropriate service level agreements with administrators, with penalty clauses for losses incurred, for instance.

The exclusionist camp argues that the statutory requirements should be calculated on the basis of risk contributions only. This would have the effect of reducing the amount of reserves required to be held by a medical scheme

These arguments have some merit. However, the conservative approach charge should be viewed against the background of the current solvency approach.

The basis for the current requirement stems from the Campagne Report of 1957<sup>1</sup>. This report stated the following:

- The minimum solvency requirement should be an alarm bell mechanism to warn against possible future failure.
- It should indicate the need for further investigations rather than providing absolute information as to the solvency position of the organisation.

*continued on page 10*

<sup>1</sup> Cooper: *Solvency and Medical Schemes in South Africa, 2001*

- It also recommended the use of 25% of gross contributions to test solvency.

This shows that the 25% level should not be viewed as a pass rate. Schemes that meet this requirement are still at risk of significant reversals of financial fortunes resulting in failure within a short period of time. Indeed, the Registrar's office has seen a number of cases where schemes have experienced horrendous losses within a period of one year, resulting in these schemes being on the brink of insolvency. Accordingly, the 25% is but a number. If the savings accounts were to be removed, the percentage required would likely be increased, to 33%, for instance.

Another point to consider is that the industry has not reached a stage where it can be said that all the risk components faced by schemes are clearly understood. Isolating one risk factor and excising it from the requirement is considered imprudent. It is rather better to wait until such understanding exists, perhaps through a study, when therefore all risks can be addressed in the solvency requirements in an appropriate manner.

The Risk Based Capital (RBC) approach is currently touted as a possible way of comprehensively identifying risk elements and addressing them more appropriately. The problem with this approach as it stands, is that it was developed in a foreign environment (USA) for organisations that are significantly different from our medical schemes. These organisations are called Health Maintenance Organisations or HMOs. Further, the trustees of medical schemes have indicated displeasure with the apparent complicated nature of the calculation. A lot of work needs to be done to adapt the approach to the South African environment. Once that has been done, then a case for the adoption of the RBC approach in South Africa will have to be assessed against the current approach.

The Registrar's office has maintained the position that the solvency calculation will be based on the gross contributions – and that includes savings contributions.

## Belgians in Hatfield



*Council staff and Belgian visitors.*

**I**N February, the Council for Medical Schemes hosted a visit from its counterparts in Belgium during which the visitors were treated to some of the best South African experiences while they, in turn, shared ideas with the locals.

In venues from Hatfield to Cape Town and the Kruger Park, the four-person delegation had its collective brain drained by South African interrogators who were anxious to improve and build on the regulation of South African medical schemes.

Belgium's health insurance system bears a striking resemblance to our medical scheme system – and despite differences in some critical areas, provides guidance for some areas and inspiration in others.

Scores of trustees of South African medical schemes attended presentations given by the delegation, which was headed by Christian Langendries, the administrator-general of the Belgian Control Office of Mutual Funds. He was accompanied by his general advisor, Yves Debruyne; Jos Kesenne, the national director of the National Alliance of Christian Mutual Health Funds; and Willy Palm, director of the International Association of Mutual Benefit Societies (AIM).

The visit coincided with a peculiarly South African health care row – that of tariff setting in the industry. The process in Belgium is far more stable, with several differences in the detail. But many of the principles warrant closer consideration.

Included in the process is the Belgian government (which has an interest in balancing health expenditure with other social security expenditure); employers (who wish to contain expenditure to increase economic competitiveness); unions (who wish to maximise health benefits to their members); providers (who want to make more money) and the mutual health funds – who are seen as advocates of consumer interests.

Although the process contains many elements, South Africans will have been struck by the fact that the process is aimed at gaining agreement from doctors and dentists. If 60% of general practitioners, and 50% of specialists and GPs, agree, the tariff becomes final. Those practitioners who have agreed to the tariffs are bound by them. Others can charge in excess of the rate – though they are reimbursed by the mutual funds at the same rate as those who are "contracted in" to the funds. But there are incentives for doctors to agree to the tariffs. Those who are contracted in have their names published on the fund's website and the state pays a supplementary pension to doctors who subscribe to the tariff.

If agreement is not reached, a variety of options are used to break the deadlock.

The process also does not take place at the end of the year, but takes place within an institutionalised framework throughout the year – avoiding an annual bun fight.







*Belgian visitors and Council members at Skukuza in the Kruger Park.*

Administration costs of the mutual funds in Belgium are far lower than in this country. At the moment these amount to 4,5% of contributions. The Belgians do not have third party administrators or brokers in their system to bump up costs, however, and this may contribute to the lower costs.

In Belgium, reinsurance is not permitted at all for the compulsory package of benefits – and this package comprises the major part of what Belgian consumers receive when they are members of such a fund. Somewhat surprised at the extent of reinsurance in schemes in South Africa, the delegates observed that this would make the entity less a mutual than an insurance entity.

Reinsurance is permitted for aspects of the top-up, optional coverage

which are available for consumers to buy. This top-up insurance is only a small portion of the package, most of which is a compulsory package. Reinsurance is permitted for coverage of medical care abroad and for financial interventions that can exceed 5000 Euros a year – up to a maximum of 80%. Reinsurance can have an impact on solvency requirements in funds – but these contracts are typically taken out for five to ten years, during which the conditions remain fixed.

The Control Office reviews reinsurance contracts before any set-off against technical provisions in solvency requirements are permitted.

Among the larger differences between the Belgian and South African healthcare systems is the fact that, with one exception, all private

and public hospitals operate on a not-for-profit basis.

Only one member of the delegation had been to South Africa before, and the Registrar's office thought it appropriate to ensure that the visitors got to see a bit of the country, despite an otherwise tough schedule of more than 10 presentations in different centres. Between presentations in Cape Town, the visitors were treated to the sights of the Cape Peninsula, and then flown to the Kruger Park, which in sweltering heat and between animal viewing outings, was the venue for discussions on the intricacies of the Belgian health care system with Council and its guest Penny Thlabe, the CEO of the Board of Healthcare Funders.



### ***Practice Code Numbering System issue unresolved***

DOCTORS and several other health professionals have received letters from the Board of Healthcare Funders asking for payment for the use of the Practice Code Numbering System.

This system is at the centre of a storm of litigation and other legal action which appears to have confused some doctors' practices. Practice codes are vital for the reimbursement of fees by medical schemes which need practice codes against which payments can be made.

The Council for Medical Schemes is empowered in terms of the Medical Schemes Act to award the administration of a practice code numbering system to a party which can carry out the task. This was awarded last year to the Board of Healthcare Funders.

However, one of the tendering parties was medical scheme Bestmed, which had originally owned the system and which was at that time suing BHF over the ownership

and copyright of the system. The court action eventually succeeded earlier this year and Bestmed followed it up by asking schemes to pay for the right to use the system.

In the mayhem which followed, the Council sent a note to schemes and a press release to the media indicating that although Bestmed had won the court action, they were not entitled to use the coding system, and schemes should not pay Bestmed.

The matter was far from resolved at that point. Bestmed have decided to appeal against Council's decision to award the administration contract to BHF. BHF, meanwhile, is appealing the court's copyright decision in favour of Bestmed.

Earlier this year, a coding system for tariffs became the subject of a similar dispute, placing a spotlight on the issue of public interest in such copyright disputes.

# Council gets to bottom of complaints

## Non-disclosure of material facts

"Rules of the scheme are binding to both the scheme and member," section 32 of the Medical Schemes Act 131 of 1998 stipulates. An element of good faith is essential in all contractual undertakings. Failure by one party to adhere to the terms of the contract would amount to material misrepresentation and the consequential effects would be detrimental to the guilty party. This allows the scheme to determine its risk assessment. Council mediated a meeting between Mrs A and Discovery Health regarding the member's failure to disclose material facts when joining the scheme.

In June 2001, Mrs A moved from one scheme to Discovery Health for personal reasons. She divulged to Discovery Health that she was previously diagnosed with endometriosis (in 1999), but failed to notify the scheme that she had continued to experience ongoing problems with the condition. Five months after joining the scheme,

Mrs A was admitted to hospital, and underwent surgery. Discovery Health requested a medical report prior to approving hospital payment. It was revealed that Mrs A had an ongoing, pre-existing condition which had not been brought to the scheme's attention. Discovery Health declined to compensate Mrs A's hospital account based on failure to disclose material facts.

With Council's intercession, it surfaced that Mrs A had had no intention of keeping her medical condition from the scheme. In good faith, Discovery Health resorted to taking the matter to its ex-gratia committee for consideration. However, Mrs A was put on a twelve-month waiting period for a pre-existing condition. All parties were content with the outcome.



## Unpaid Accounts

The complainant, Mrs B, lodged a complaint with the complaints unit against Klerksdorp Medical Benefit Scheme, for an unpaid, exorbitant hospital account of R 274,000. The medical scheme refused to pay Unitas Hospital almost half this amount and the member was expected to settle the account. The scheme had provided authorisation upon admission of Mrs B's dependant, approving a total amount of R145,000 be utilised for hospitalisation. Due to the member's extended stay at the hospital, the hospital requested a further, extensive amount. The scheme refused to pay the additional amount, arguing that no supplementary authorisation was given prior to the added expenses being incurred.

The hospital rejected the scheme's claim that it had not attempted to notify it of the extended stay. It argued that a faxed report was sent to the scheme regarding the member's condition and medication and that the scheme never made any enquiries into the matter. On the other hand, the scheme contested that the report the hospital referred to had made any indication of the fur-

ther costs incurred. The scheme maintained that the hospital should have requested additional authorisation before incurring any further expenses.

From the argument that emerged between the two parties, it was established that both were at fault. The scheme had failed to inform the member of her depleting hospital account benefits in advance and did not bother to locate a bed in a public hospital for the patient to be treated there, while the hospital was not successful in providing the documentation the scheme requested.

Following Council's investigation and intervention, an amicable resolution was reached. The scheme made an offer to pay R82,000 of the remaining hospital account and agreed with the hospital to write off the R47,000 remaining from the balance which had initially been rejected by the scheme.

The Medical Schemes Act 131 of 1998 provides for the Council to investigate complaints and settle disputes in relation to the affairs of medical schemes. Every day, the complaints unit of the Registrar's office receives about 100 complaints, 50 correspondences for previously lodged complaints and more than 1250 telephone enquiries, varying from unpaid accounts to members' termination of membership and poor governance of schemes. Pressured as the unit may be, the team of five members manages to get to the bottom of these complaints and enquiries effectively.





## ***Governance of Medical Schemes***

Four trustees of Prosano Medical Scheme are facing charges in terms of the Income Tax Act and others may have to follow the same process.

This follows action taken by the Registrar of Medical Schemes to stop 11 of 15 of the scheme's trustees from working for the scheme, pending the outcome of an investigation into allegations of maladministration.

Three of the four trustees who have been charged are among eight members of the board of trustees who have decided to resign in the wake of the Registrar's action. One other was a previous member of the board of trustees.

The action taken by the Registrar was in terms of Section 46 of the Medical Schemes Act, which provides for the removal from office of a member of a board of trustees by the Council under circumstances where the

Council has sufficient reason to believe that the person concerned is not a fit and proper person to hold the office concerned.

Among the Council's concerns is evidence that attempts were made by trustees to have personal tax liabilities of up to R4 million paid from medical scheme trust funds and that the Principal Officer of the scheme was ordered to pay R23 940 to tax consultants.

A letter from Registrar Patrick Masobe to the 11 trustees, delivered in Cape Town to them in person, also noted that the Council had become aware that the South African Revenue Service intended to proceed with action against them.

The scheme has its annual general meeting in June, where a new board of trustees is likely to be elected.  
*See My view page 1*





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