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CMS **NEWS**

Newsletter of the Council For Medical Schemes



***CMS News
Interviews
Professor
William Pick***

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editor's note:

Somehow, the *CMS News* failed to make the regular appearance it was originally intended to make. We would like to change that, and commit ourselves to putting this publication out on a more regular basis from now on. We would like to develop it into an important tool for communicating our ideas and information about regulatory developments to a broad range of stakeholders. If you have ideas or suggestions on what you would like to see appearing in the *CMS News*, please email them to Phumla Khanyile at p.khanyile@medicalschemes.com

CMS NEWS INTERVIEWS

PROFESSOR WILLIAM PICK

Professor William Pick's career of 40 years is not over yet. In 2005 he was appointed Chairperson of the Council for Medical Schemes.

By Phumla Khanyile – Communications Officer

Professor William Pick's career of 40 years is not over yet. In 2005 he was appointed Chairperson of the Council for Medical Schemes.

Prof Pick supplemented his Bachelor in Medicine and Surgery with a Master of Medicine, and diplomas in Public Health and in Tropical Medicine & Hygiene. He spent his early years practising locally and in Britain before moving to academia. He has held senior academic positions at UCT, WITS and Johns Hopkins University, has been advisor on poverty and health to the World Health Organisation (WHO), and has served as acting and interim president of the Medical Research Council.

He has scores of academic publications behind his name, and has conducted research for UNICEF, the European Union, United Nations University, Health Systems Trust and the Africa Regional Office of the WHO.

CMS News asked him some questions:

Q. You have dedicated yourself to healthcare for over 40 years. What was your major motivation to accept the position of Chairperson of the Council for Medical Schemes?

A: *The privilege to serve my people... to work in the service of others is the most fulfilling human experience – this has been my work motto through all the years.*

Q. What would you say is the biggest challenge currently facing the medical schemes industry?

A: *Greater cost efficiency.*

Q. What, in your view would be the solution for the imbalance in resources between the private and public health sectors?

A: *If we are to solve the inequity that pervades our healthcare system we will*

have to look at radical systemic solutions. The solution is therefore not to be found in simply tinkering with the present system of healthcare. The whole system of healthcare needs to be reviewed.

Q. Each year we see increases in medical schemes contribution, in your view what are the major causes of such increases? What plans do you have to curb the increases?



Professor William Pick

A: *The increases are largely due to medical inflation. The CMS is looking seriously at the system of remuneration for service providers. The escalation of healthcare costs in the private sector continues to be alarming. Unless the tariff-setting process is regulated, the trend will continue. Hospital costs also pose a particular challenge.*

Q. Looking at the number of beneficiaries that this industry is currently catering for, how would you view the future of this industry? Is it growing at an acceptable rate?

A: *The numbers are not of great significance; rather it is the ability of the industry to guarantee the best care at the lowest cost that will determine its future. The current trend suggests that health insurance will become less and less affordable over time. In other words,*

the numbers are unlikely to increase if we do not rein in costs.

Q. Do you think the actual functioning of REF would make a difference? What will be the hiccups?

A: *We will certainly be minimizing the inherent inequity of risk enjoyed by different medical schemes. Data quality will be a major consideration and could pose some problems.*

Q. In many instances when the stakeholders of the medical schemes industry meet, the question of reducing the number of schemes tends to come up, what are your views on the matter, would it really have a positive impact to reduce the number of medical schemes. If so, in what way?

A: *Reducing the number of schemes could lead to greater cost efficiency; this would in my view be the ultimate test.*

Q. Over the past year or so, we have seen CMS taking serious steps on governance and non-compliance issues with the Act. What has prompted such actions...?

A: *There is a real concern about governance in all spheres of endeavor in South Africa. Efforts to improve the governance of the medical schemes are part of the national drive to better governance of all institutions.*

Q. If you were to send a message to all stakeholders in the Medical Schemes Industry and the healthcare system in general, what would the message be? What issues are high on your agenda during this Council's term of office?

A: *The rising cost of healthcare and inequity in the healthcare system are major challenges to all of us. The current Council considers these to be among the most important issues on its agenda.*

2007 BENEFITS AND CONTRIBUTION ANALYSIS

By Phakamile Nkomo, Research Analyst

Amongst its various functions, the Office of the Registrar must ensure that the rules of medical schemes are compliant with the Medical Schemes Act and its regulations. In fulfilling this mandate the Registrar's Office has continued to effect improvements to the rules approval process to ensure that rule amendments are in the interest of the scheme beneficiaries. This process has had a profound impact on the trajectory path of contribution rate changes relative to the general consumer price level.

Why engage in this process? The Registrar's Office scrutinizes proposed benefits and contribution rule amendments each year to:

- ensure that what is proposed by schemes does not result in unfairness to members of the scheme;
- does not discriminate unfairly whether directly or indirectly against members on a number of grounds such as age and health status;
- does not result in inconsistencies with other requirements of the legislation
- in respect of benefits, that full provision is made for reasonable access to the prescribed minimum benefits, and that
- The benefit options are financially sound, and have sufficient number of members to sustain them.

The approval process applies regulatory tools such as the Act, its regulations, scheme's financial performance and risk profile, the Consumer Price Index (CPIX) as a soft benchmark for premium contribution growth, directives on benefit configuration within the range of benefit options offered by a scheme to its members and, cost sharing arrangements between members and schemes.

Towards the end of 2006, the rules approval process resulted in the preliminary rejection of a large number of proposed rule changes because the submitted benefits structures and contribution increases were viewed to be

unfair, inadequate, financial unsustainable and also accompanied by inadequate motivations. The vast majority of medical schemes subsequently resolved the concerns of the Registrar.

Benefit Options: of all the submitted options for registration, we noted that the number of Open scheme benefit options went down from 230 for 2006 to 200 for 2007. Restricted schemes, benefit options went down from 168 for 2006 to 145 for 2007. The reduction in the number of options submitted for 2007 registration was as a result of discontinued options (20 = 14 open and 6 restricted), merged options (3 from open schemes), and options in liquidated scheme (1 from open scheme), pre-existing options that were not registered for 2007 (21 = 15 from open and 6 from restricted schemes) and non-submitted options (1 from restricted scheme).

Contributions: In relation to contribution changes, we required medical schemes with contribution changes that exceeded the benchmark recommended by the Registrar (CPIX plus 3%) to provide adequate justification for these increases.

In the end, 2007 saw an average change in gross contributions in all schemes for a family of three beneficiaries as follows: 6.5% at scheme level and 7.2% at option level. Overall, these increases translated into 6.8% for principal members; 9.5% for adult dependants; and 7.1% for child dependants.

The average change in gross contributions in open schemes for a family of three beneficiaries was: 8.1% at scheme and option level; 7.6% for principal members; 9.8% for adult dependants; and 6.9% for child dependants.

The average change in gross contributions in restricted schemes for a family size of three beneficiaries was: 5.6% at the schemes level; 6.0% at the option level; 5.6% for principal members; 9.1% for adult dependants; and 7.3% for child dependants.

MEDICAL SCHEMES ACT TO GET A FACE LIFT

The Council will be responsible for overseeing to the management of the REF transfers and other moneys lawfully paid into the Fund

By Phumla Khanyile, Communications Officer

The Medical Schemes Amendment Bill if passed, will amongst other things, see to the realization of Risk Equalization Fund. It will tighten on issues such as governance, fit and proper status of trustees, and provision of benefits by schemes.

REF: The bill brings about amendments which deal with the establishment of REF, which will be managed by CMS.

The Council will be responsible for overseeing to the management of the REF transfers and other moneys lawfully paid into the Fund. While REF will be managed by CMS, the Fund will keep a separate bank account, financial records and statements.

The bill further provides for schemes to pay financial transfers to the REF as determined by the Registrar. Schemes that fail to comply with these requirements would face administrative penalties

Trustees: There are proposed amendments that would allow for a principal officer or trustees whose term has been prematurely terminated to lodge a complaint with the Council. Amendments done to Section 57 calls for 50% of the members of the board of trustees to be elected by members from amongst members of a scheme, while the other 50% may be appointed in terms of the rules of the scheme. In the case of open schemes, this 50% can only be appointed by the member elected trustees. The amendments specify that election of a trustee shall not be valid unless all members of the scheme were eligible to vote in the election of that trustee. The Registrar is enabled to apply to the High Court for an order

invalidating elections that are flawed.

The Bill also states that people who are either contracted with the scheme (for administrative, marketing or managed care services), a broker or an employee, director, shareholder, officer, consultant or contractor of a person who provides broker services or otherwise has material relationship with these service providers shall not be members of the board of trustees. The same applies for a person who wants to be a principal officer. The bill further provides for trustees to annually disclose in writing to the Registrar any payments or considerations made to them by the scheme and any person contracted by the medical scheme to provide administrative, marketing, brokerage, managed care or other services.

Corporate Governance: The Bill also a section that requires the trustees and the principal officer to establish and maintain adequate and effective process of corporate governance consistent with the nature, complexity and risk inherent in the activities and the business of a medical scheme.

The CMS will also be able to publish guidelines for good corporate governance in order to assist the trustees and principal officers to establish and maintain good corporate governance.

Amendments to section 67 would allow the Minister to prescribe requirements and criteria for "fit and proper" status of trustees, principal officer and any other person required to perform duties in terms of the Medical Schemes Act.

Benefits and contributions: There has also been an insertion of a new section that deals with benefits. Medical schemes would have to provide in their rules for a set of basic benefits to be provided for every member of the scheme. They may also provide members with a supplementary benefit option. All schemes would have to apply to the Registrar for approval of the basic benefits and any supplementary benefit option.

The Bill also clarifies the meaning of "community rating" of contributions and the grounds for the determination of contributions for both the basic benefits and the supplementary benefits options.

Background:

Some of the governance issues were discussed extensively as findings and recommendations of the Governance Theme Project report - "Putting Members First: Towards Better Governance of Medical Schemes," issued by CMS early last year. It was in this document that amendments to the Act were suggested.

Where to Now...? The Bill was published for comments in November 2006, with a final comments deadline of 28 February 2007. The next phase was the assessment of the public comments and the redrafting of the Bill. This has now been concluded, and the new version of the draft bill was submitted to the Minister at the beginning of July. It is hoped that the Bill can still be introduced in Parliament during this year. For more information visit www.medicalschemes.com and view circular 49 and Government Gazette No. 29408, Volume 497.

COUNCIL FACILITATES TALKS BETWEEN FUNDERS AND PROVIDERS

A meeting was hosted by the Council for Medical Schemes to facilitate talks between medical schemes and providers on 10 May 2007 at Sandton on the thorny issues of pre-authorization and reversal of payments.

By Phumla Khanyile: Communications Officer

A meeting was hosted by the Council for Medical Schemes to facilitate talks between medical schemes and providers on 10 May 2007 in Sandton on the thorny issues of pre-authorization and reversal of payments.

The meeting ended with the formation of a forum representative of Board of Healthcare Funders (BHF), the Hospital Association of South Africa (HASA), South African Dental Association (SADA), South African Medical Association (SAMA) and administrators.

Given the differences of opinion expressed at the meeting on a wide range of issues, it is clear that the forum has its work cut out for it.

Take something as fundamental as the meaning of pre-authorisation. Medical schemes argued that pre-authorisation can never be a guarantee of payment.

Due to factors beyond their control, a medical scheme may only subsequently discover that a patient's membership status had lapsed. For example, employers were often guilty of failure to communicate employee resignations soon enough to the medical scheme. Other causes of payment reversals included: erroneous duplicate payments, misrepresentation and undeclared pre-existing conditions.

On the other hand, some of the providers argued that pre-authorisation constitutes a form of contractual agreement between the service provider and the medical scheme, which gave providers the go-ahead to provide services to the member, which they do in good faith. Later reversal of payment based, for example, on lapsed membership status of the patient, was unfair to providers who should not be penalised for the negligence of others. It was also

argued that off-setting payment of one patient in respect of another was not fair. Providers also complained that pre-authorization processes were unnecessarily cumbersome and were apparently often done by personnel without clinical qualifications.

HASA indicated its intention to conduct a vigorous campaign to amend section 59(3) of the Medical Schemes Act. BHF, however, did not see the need to go that route and instead indicated that agreements flowing from this process of engagement could be implemented through appropriate amendments to scheme rules which could properly define the parameters of pre-authorisation and the circumstances in which payment reversals might legitimately occur.

While wrapping up the proceedings the Registrar of Medical Schemes, Patrick Masobe, said the meeting had given rise to a formidable agenda for future discussions. He therefore suggested the formation of a representative forum representative to take the discussions further with the aim of developing guidelines for the future practice of pre-authorization and reversal of payments.

The forum representative of all healthcare service providers was formed and is expected to take the discussions further and reach a consensus on the process to be followed (amending the Act or amending the rules) and the of giving pre-authorizations. It was agreed that BHF would provide logistical and secretarial facilities for these discussions.

A report-back to the Council for Medical Schemes is anticipated in July 2007.

The terms of reference for the forum include the following:

- 1. To investigate further the issue of pre-authorisation vis-à-vis:**
 - a. definition of pre-authorisation
 - b. definition of guarantee of payment
 - c. determination if pre-authorisation should guarantee payment
 - d. if not a guarantee of payment, then on what basis is pre-authorisation given
 - e. making proposals for clinical competence in making pre-authorisation decisions
 - f. clarification of the responsible party in terms of verifying membership
- 2. To investigate further the issue of reversals of payments with specific regard to the following:**
 - a. agreeing on a reasonable period for reversal of payments
 - b. examining the practice of "set-offs" and the legal basis therefore
 - c. if set-offs are found to be inconsistent with that law, then finding some other means of resolving the underlying issues
 - d. determining whether section 59(3) of the Medical Schemes Act imposes undue costs on providers
 - e. making proposals on whether section 59(3) should be amended
- 3. To investigate further the impact of termination of membership on pre-authorisation and payment reversals with specific regard to the following;**
 - a. making proposals vis-à-vis the role of the employer on resignation of a member from a scheme
 - b. exploring the possibility that premiums should be paid in advance to medical schemes
 - c. effective dispute resolution within the ambit of the above.

CMS HOLDS HEALTHCARE PROVIDERS INFORMATION SESSIONS

The overall opinion gathered from the attendees was that the sessions were extremely beneficial.

By Professor Jan van der Merwe and Marli Weldhagen, CMS Clinical Unit

In March and April 2007, the Council for Medical Schemes commenced with provider information sessions – a platform to engage healthcare providers such as general practitioners, dental practitioners, medical specialists, pharmacists, physiotherapists, clinical technologists, psychologists, and managers of hospitals, day-clinics, step-down and rehabilitation facilities, and to discuss the role they play in communicating issues around prescribed minimum benefits (PMBs) to members.

Marli Weldhagen, the CMS Clinical Analyst, said that the purpose of engaging providers in this manner was mainly to promote awareness and understanding of the regulatory environment among healthcare providers. The sessions were also motivated by the fact that healthcare providers interact directly with beneficiaries and therefore, play a vital role in ensuring that beneficiaries are adequately informed about benefit entitlements and responsibilities.

The first three sessions were held in March and April in George, Nelspruit and Bloemfontein and were attended by providers from most of the targeted groups. They were held in the evenings so as not to impact on the providers' practice times. The overall opinion gathered from the attendees was that they were extremely beneficial. It was clear though that most of the providers were only familiar with certain sections of the PMBs and that they had a lot of misconceptions regarding the scope of the PMBs.

Examples of misconceptions included:

- PMBs only consists of the CDL conditions;
- PMBs are only rendered in in-hospital settings; and
- PMBs do not apply to members on the lower options of medical schemes.

The Council has decided to continue with the sessions for healthcare providers as follows:

Date	Venue	Who Attends?
31 JULY 2007	DURBAN	General practitioners, dental practitioners, medical specialists, pharmacists, physiotherapists, clinical technologists, psychologists, managers of hospitals, day-clinics, step-down and rehabilitation facilities
21 AUGUST 2007	PORT ELIZABETH	
18 SEPTEMBER 2007	PRETORIA	
16 OCTOBER 2007	CAPE TOWN	
13 NOVEMBER 2007	KIMBERLY	
12 FEBRUARY 2008	EAST LONDON	
11 MARCH 2008	KLERKSDORP	

Invitations to these sessions will be emailed to all addresses on the CMS mailing list and faxed or emailed to practices in the identified geographical areas. Invitations will also be sent to different professional organisations and associations of service providers. Some of these organisations send reminders to their members through their newsletters such as the Medigram from SAMA.

It was also noted that some of the administrators and medical schemes interpret PMBs incorrectly. The Council has therefore decided to also host three information sessions on the same topic in Cape Town, Pretoria and Durban for staff of medical schemes, administrators and managed care organisations.

The aim would be to assist them with the correct interpretation of PMB benefits and member rights. The dates for these sessions are as follows:

Date	Venue	Who Attends?
01 AUGUST 2007	DURBAN	Medical schemes, managed care organisations and administrators
18 SEPTEMBER 2007	PRETORIA	
16 OCTOBER 2007	CAPE TOWN	

PROSANO'S JOURNEY TO CURATORSHIP

By Craig Burton-Durham, Head: Legal Services

Prosano Medical Scheme, a scheme formed in 1976 to provide healthcare funding to the public sector was placed under curatorship early this year. The actions of the Registrar were necessitated by material irregularities which had come to his attention and subsequently confirmed by an independent court appointed investigator during 2006.

Prior to the investigation, various material irregularities were brought to the Registrar's attention, which precipitated an application by him to the Cape High Court in October 2006 for the provisional appointment of a curator to take control of and manage the affairs of the scheme. It was however agreed that an investigator would be appointed to investigate the allegations of irregularities. Mr. Horton Griffiths of *PriceWaterhouseCoopers* was appointed by the court on 26 October 2006 to investigate the following:

- o the conclusion by the scheme of certain broker agreements
- o the conclusion by the scheme of a distribution network agreement and matters pertaining to personal interests and conflicts of interest by any trustees or officials in this regard
- o the transfer of members from the scheme to Global Health Medical Scheme in terms of an agreement between the scheme and Global Health including the appointment of Mentor Healthcare Planning as a broker to the scheme
- o the payment of remuneration and allowances to members of the board of trustees
- o legal fees paid by the scheme with regard to the arbitration between the scheme and its former

administrator Medscheme Holdings (Pty) Ltd

- o the prospect of the scheme recovering expenditure paid to certain parties apparently in excess of what they were entitled to
- o the holding by the scheme of shares in its administrator Sigma Health Fund Managers (Pty) Ltd and the circumstances pertaining to the schemes failure to rectify the statutory infringements occasioned by the scheme holding these shares
- o any matter pertaining to the fit and proper status of the trustees
- o the manner in which certain members of the board of trustees went about deciding to oppose the curatorship and to appoint Mallinicks Inc as the attorneys of the scheme

The investigator's report, delivered to the Court in February 2007, substantially confirmed the material concerns raised by the Registrar. Amongst the more pertinent findings made by the investigator was that the scheme lacked good corporate governance and had a virtually dysfunctional Board of Trustees.

During February 2007 the divisions on the board escalated to the point of suspension of the chairperson and two members of the board in terms of a purported resolution by a group of members in an opposing camp, a move which drew strong criticism from the Office of the Registrar. The suspended trustees responded by filing an application to the High Court to be reinstated but their application was dismissed on procedural grounds. Matters came to a head when the scheme's Principal Officer tendered her resignation with effect from 31

March 2007. This new development resulted in the Registrar approaching the Cape High Court on 30 March 2007 for the appointment of a provisional curator. The Registrar's application was unopposed and Mr. Joe Seoloane was duly appointed as a provisional curator for Prosano.

The provisional curator was required to submit to the court a report of his findings by the end of April 2007. The provisional curator's report was duly submitted and confirmed the material concerns of the Registrar and identified certain other problems relating to the deteriorating financial position of the scheme. The Prosano Medical Scheme was placed under the final curatorship of Mr. Joe Seoloane on 31 April 2007. Soon after his appointment, Seoloane assumed immediate control of the scheme's bank account and control of the oversight and management of the scheme.

Despite the lack of good corporate governance by the former trustees of the scheme and the fact that the financial status of the scheme had declined, Prosano retains high solvency levels and is able to meet its obligations towards its members and service providers.

It is anticipated that the interventions which the curator will put to place both from a management and governance point of view will place the scheme on an even stronger footing and ensure the scheme's ability to render a high standard of service to its members on a sustainable basis.

The Registrar and Council for Medical Schemes will not hesitate to act in ensuring that the interests of medical scheme members are protected at all times. We are confident that the action of placing the Prosano Medical Scheme under curatorship will ensure the continued functioning of the scheme to the benefit of all its members.

TURNED DOWN BENEFITS LEAD TO A COURT BATTLE...

In 2006, the Registrar refused to register Genesis' rules based on apparent inconsistencies between Genesis's proposed benefit design and provisions of the Act related to benefit options, medical savings accounts and unfair discrimination.

By Phumla Khanyile – Communications Officer

In 2006, the Registrar refused to register Genesis' rules based on apparent inconsistencies between Genesis's proposed benefit design and provisions of the Act related to benefit options, medical savings accounts and unfair discrimination.

The Registrar's refusal to register these options was based on the conclusion that these options were unlawful on three grounds. First, the options offered both a self-managed fund and a medical savings account. The Registrar considered the self-managed fund to be an extension of the medical savings account beyond the regulated 25% contribution limit toward medical savings accounts. Secondly, the three options were in essence identical; their variation was only on the basis of contributions to the savings account or the self-managed fund. The Act allows for variation of contributions only based on income or number of dependants. Thirdly, the benefits were designed in such a way that the aged and the sickly were likely to pay significant amounts for out-of-hospital expenses and were thus likely to be systematically excluded from the scheme.

The Council's appeal committee, however, did not agree with his conclusions. It ruled in favour of

Genesis medical scheme on all three grounds. In the view of the appeal committee, the self-managed fund was distinguishable from the medical savings account. Furthermore, the committee did not consider there to be sufficient legal basis for the argument that benefit options must differ substantially, and therefore did not consider it necessary to consider whether or not the differences in Genesis' options were mere window-dressing. And finally, the committee was not convinced of the arguments that the benefit design constituted impermissible levels of discrimination against the old and sickly.

Given the substantial issues of public interest involved in this matter and his disagreement with the findings of the Council appeal committee, the Registrar lodged an appeal against the appeal committee decision with the Appeal Board. It is not unprecedented for the Registrar to appeal against a decision of the Council, and in fact the Appeal Board has previously ruled that such appeals are competent.

In early February 2007, Genesis lodged an urgent application in the Pretoria High Court asking the court to declare that the Registrar is not competent to appeal to the Appeal Board against a

decision of the Council. Genesis argued *inter alia* that the Council is effectively the Registrar's employer, and that the Registrar is therefore bound by its decisions.

In response the Registrar argued that the matter involved considerable issues of interpretation. In matters of significant public interest such as this case, it could not have been the intention of the legislature to provide that appeals would only lie to the Appeal Board in instances where the Appeal Board found in favour of the Registrar. This would give rise to an asymmetrical appeal process and would not be in the public interest or in the interests of justice. The wording of the Act also did not preclude an appeal by the Registrar. In addition thereto, it was argued that the Registrar was appointed by the Minister and in some instances was given original powers by the Act, independent of the Council. In these instances, the legislature had intended a symmetrical appeal process culminating in the Appeal Board.

At the time of writing this article, the decision of Justice Preller of the Pretoria High Court was awaited. This is clearly a matter of significant public policy importance.

WORKSHOP ON GUIDELINES TO ENTRY AND VERIFICATION CRITERIA GIVES REF THUMBS UP

By Phumla Khanyile – Communications Officer

The Council gives healthcare industry an overview on how to correctly identify beneficiaries with REF risk factors

The Risk Equalisation Fund (REF) shadow period has brought positive changes to the manner in which medical schemes, administrators and managed care organisations conduct their business.

“We used to have data sitting in our systems doing nothing about it. REF has made us think and work hard, and we are now cleaning our systems,” said Manono Mdoda, Operational Risk Manager of Sovereign Health.

Mdoda and other speakers discussing the perspectives of the administrator, clearing house, managed care and information technology on the Guidelines on Entry and Verification Criteria as outlined and recently published by the Council. The Council organised this workshop on 15 June 2007 to give an overview to the healthcare industry on how to correctly identify beneficiaries with REF risk factors in accordance with the entry and verification criteria. Also, the aim was to solicit comments on the criteria, with a view to incorporating suggestions into a new version of the guidelines that will be applicable in 2008.

While some managed care organisations, seem to be clear about their REF responsibilities, some administrators and clearing houses reported facing challenges.

These included problems associated with the advance supply of medication, and lack of information technology capacity to incorporate changes.

Boshoff Steenekamp, the CMS Risk Equalisation Fund Specialist, summarised various issues which required further input from industry stakeholders. These issues included: difficulties around dates on prescriptions which are used as proof of treatment; ambiguities

around what is meant by “authorisation”; complexities of version control; the need to better explain the differences between prescribed minimum benefits and the REF entry and verification criteria; and issues of communication to healthcare providers.

Participants were asked to provide further comments on these issues until 30 June 2007. In our next issue, we will provide an update on the comments raised by the industry.

CONFLICT OF INTEREST

By Evan Theys –Head: Compliance

A conflict of interest is a situation in which someone in a position of trust, such as a trustee, principal officer, lawyer or director, has competing professional or personal interests.

In an era where we have seen the collapse of Enron and World Com, and the increasing emphasis on good governance, the issue of conflict of interest is worth another look.

The rule against conflict of interest arose out of the English law of master and servant, and the basis for this is that you cannot serve two masters – within the employment context the employee owes the employer a fiduciary duty.

A conflict of interest is a situation in which someone in a position of trust, such as a trustee, principal officer, lawyer or director, has competing professional or personal interests. Such competing interests can make it difficult to fulfil his or her duties impartially.

Even if there is no evidence of improper actions, a conflict of interest can create the appearance of impropriety that can undermine confidence in the ability of that person to act properly in his or her position.

More generally, conflict of interest can be defined as any situation in which an individual is in a position to exploit a professional or official capacity in some way for their personal benefit. Someone accused of a conflict of interest may deny that a conflict exists because he or she did not act improperly.

In fact, a conflict of interest does exist even if there are no improper acts as a result of it. One way to understand this is to use the term “conflict of roles”.

A person with two roles – an individual who owns shares in an investment manager and who also acts for a medical scheme in making investment decisions, for example – may experience situations where those two roles conflict. The conflict may be mitigated, but still exists. In and of itself, having two roles is not necessarily illegal, but differing roles will certainly provide an incentive for improper acts in some circumstances.

The following are the most common forms of conflicts of interest:

- self-dealing, in which the public and private interests collide, for example issues involving privately held business interests;
- outside employment/consulting, in which the interests of one job contradict another;
- family interests, in which a spouse, child, or other close relative is employed or where goods or services are purchased from such a relative or a firm controlled by a relative; and
- gifts from friends who also do business with the person receiving the gifts.

Further, in terms of the Medical Schemes Act 131 of 1998, more specifically section 57(6)(b), trustees are required to act with “*due care, diligence, skill and good faith*”. It is the breach of these requirements which can give rise to a conflict of interest. Added to this, section 57(6)(c) requires trustees to “*take reasonable steps to avoid conflicts of interests*”.

Case law further reinforces the need to avoid conflicts of interest, as can be seen from the Supreme Court of Appeal case of *Phillips v Fieldstone Africa (Pty) Ltd and another* [2004] 1 All SA 150 (SCA). This case concerned the liability of an employee to account to his employer for secret profits made by the employee out of an opportunity arising in the course of his employment.

Upon an examination of South African legal principles which govern the actions of a person who occupies a position of trust and fiduciary duty, the Court was of the view that the duty of an employee to account for profits received in breach of fiduciary duty did not only arise in the relationship of managerial employees to their employers; each matter is to be decided on its own particular facts. It was fundamental to determine if the employee stood in a fiduciary relationship to the employer when the business opportunity became available to him.

On an examination of the material facts, the Court held that the Appellant (the employee) had breached his duty towards the Respondents (the employer) and had created a conflict of interest between his duty and his self-interest.

The best way to handle conflicts of interest is to avoid them entirely. For example, someone elected to public office might sell all corporate shares he or she owns before taking office, and resign from all corporate boards or that person may move all corporate shares into a blind trust. Short of avoiding conflicts of interest, the best way to deal with them is one or more of the following measures, namely disclosure, recusal, third-party evaluation and/or a code of ethics.

Disclosure entails exactly that. For example, a person elected to public office is required to disclose personal financial information. In order to protect privacy, a range above which disclosure is required is usually stipulated.

Recusal entails conflicted parties recusing themselves from any decision in which they may be able to influence the outcome for their personal benefit.

For example, judges usually recuse themselves from cases when personal conflicts arise. The judge that held against the Bush administration in the wire-tapping case diluted the effect of her judgement when she failed to disclose that the board of the foundation of which she was a member received funding from the plaintiff in the case she decided.

Third-party evaluations are usually applicable in commerce when a majority shareholder decides to make an offer to minorities.

In such an instance a third party (an independent firm) is hired to determine a fair price. Third-party evaluations are also used as proof that the transaction was in fact fair or at arms length.

Codes of ethics generally forbid conflicts of interest. However, specifics can be controversial. For instance, should lecturers be allowed to have extraprofessional relationships with their students? What about with their ex-students? Codes of ethics help to minimise problems with conflicts of interests because they spell out the extent to which such conflicts should be avoided, and what parties should do where conflicts are permitted by the code of ethics.

Boards of trustees, principal officers, brokers and others in positions of responsibility within the medical schemes industry should be mindful of their fiduciary duty to take all reasonable steps to avoid conflicts of interest. Too many instances of conflict still arise, and offenders cannot claim that they are unaware that their improper behaviour was unethical and unlawful.

BROKER ACCREDITATION

Danie Kolver, the Head of Accreditation Unit points to financial soundness, fit and proper status and qualifications requirements as reason for turning down Broker applications.

Every year Council for Medical Schemes turns down brokership applications due to failure by applicants to meet accreditation requirements. In 2007 alone, the Registrar's office has so far turned down 24 broker application by broker organisations and 46 applications by individual brokers. Danie Kolver, the Head of Accreditation Unit points to reasons such as financial soundness, fit and proper status and qualifications requirements.

Financial Soundness:

One of the main reasons for turning down applications is the financial soundness of individuals or organisations. Quite often, individuals apply in their individual capacity to be accredited and then approach medical schemes to contract with them in the name of a family or business trust. Trusts (family, business or other) are not accredited as broker organizations in terms of prevailing legislation for the reason that a trust is not an entity having a legal persona and can therefore not contract in a manner which will afford it legal status. It follows that a trust can only contract through a trustee who, in his or her individual capacity, represents and binds the Trust. The fact that a person is or may be licensed as a financial service provider or as a key individual of a brokerage at the Financial Services Board does not change this legal position, as accreditation does not extend exclusively to key individuals associated with an organisation.

What does fit and proper mean for brokers?

The requirements for health care intermediaries to be "fit and proper" implies that all health care

intermediaries must at all times comply with the provisions of both the Medical Schemes Act of 1998 and the Financial Advisory and Intermediary Services Act of 2002 (FAIS Act). This requires brokers and brokerages to be accredited in terms of the Medical Schemes Act and to also be licensed in terms of the FAIS Act in order to function as intermediaries and be entitled to remuneration from medical schemes. Licensing requires brokers to be fit and proper which includes, amongst other factors, demonstrating characteristics pertaining to honesty and integrity and the onus of providing best advice to clients.

Provision is made in the Medical Schemes Act to accredit apprentice brokers who, at the time of application, do not have the requisite experience as healthcare brokers. Accreditation is granted subject to such brokers being supervised by a fully accredited broker during the initial period of two years. Apprentice brokers are however not recognised by the Financial Services Board (FSB) for purposes of being licensed, since they do not comply with the FAIS Act.

Qualification requirement in terms of FAIS Act

The fit and proper requirements in terms of the FAIS Act stipulates that all health care intermediaries must, within 3 years after the date of first appointment but not later than 31 December 2009, complete an appropriate National Qualification Framework (NQF) level 5 skills programme consisting of unit standards registered by South African Qualification Authority and quality assured by an Education and Training Quality Assurance as listed in the National Learner Record Database.

In terms thereof, a broker must acquire a minimum of 60 credits or an appropriate certificate at NQF level 5 or an appropriate NQF level 5 qualification provided by a registered higher education institution quality assured by the Higher Education Quality Committee.

In our next issue we will provide more details of "fit and proper" requirement in relation to brokers, administrators, managed care organisations, trustees and principal officers.

REF ON TRACK...

While the healthcare industry might perceive Risk Equalisation Fund (REF) as progressing in a snail pace due to failure to meet the 2007 operations deadline, the truth is that REF is on track, this is according to Boshoff Steenekamp, the REF Project Specialist at Council for Medical Schemes.

Taking into consideration the urge on stakeholders' side to see REF moving out of the shadow period, Steenekamp cautions that hastiness would only bring woes, therefore a major focus should not be on how quick systems are put into place, tested and declared operational but on how appropriate and efficient they work to everyone's satisfaction.

Recently, the REF project team working in consultation with the Risk Equalisation Fund Technical Advisory Panel (RETAP) had been working on the following areas of development:

- the key areas of Improvement;
- The findings of the REF 2005 study.
- Amendments to the Medical Schemes Act

1. The Key areas of improvement:

The Council recently published the analysis of REF submissions from Quarter 4 of 2005 and up to Quarter 2 of 2006. The main finding in the latest analysis was that there has been a large improvement in the quality of the REF data. Compared to previous periods many more beneficiaries have good quality data, there has been improvement in the clinical credibility of submissions and the potential financial impact on schemes is much more stable than it has been during the first quarters of 2005. Also, the deviational scores have shown a remarkable improvement from an overall score of 4, 27 in December 2005 down to 3, 40 in June 2006. Another area of improvement was seen in the observed values compared to the expected. All administrators and schemes were seen to be converging towards the expected values.

The Council is currently analysing the REF submissions for Quarters 3 and 4 of 2006.

2. The REF 2005 study:

During July 2003, the Risk Equalisation Fund task group established the Formula Consultative task team, consisting of 64 stakeholder representatives who, under the leadership of Professor Heather McLeod, developed the proposed formula that would be used in a risk equalisation in South Africa. The

technical work performed by this team established the basis on which risk equalisation will take place, and was largely based on a study that established the pricing of the Prescribed Minimum Benefit (PMB) package by Fish et al (2002) and McLeod, Rothberg et al (2003),

In preparation for the introduction of the REF, it was important that more recent information on PMB costs was available. In addition, the previous study was performed before ICD10 coding was widely used and was done on data that represented about 2 Million members before the CDLS were part of the Prescribed Minimum Benefits (PMBs). The beneficiaries included in this study were all administered by Medscheme and Discovery.

To improve on the certainty of the PMB cost, the Council requested the Risk Equalisation Technical Advisory Panel (RETAP) to repeat the pricing study. The REF Study 2005 was lead by Professor Heather McLeod and constitutes the largest research project to date on the price of Prescribed Minimum Benefits in South Africa. Four administrators participated in the study: Discovery Health (Pty) Ltd, Medscheme (Pty) Ltd, Old Mutual Healthcare (Pty) Ltd and Metropolitan Health Group (Pty) Ltd. The REF Study 2005 was provided with nearly 50 million member months of data or the equivalent of 4, 2 million members.

This enabling piece of legislation will enable the Council to further test and develop the IT systems that are required for the introduction of the REF.

In addition to the study providing the REF weighting table (previously known as the REF contribution table) for 2007, other useful insights were gained. This included the impact on REF if beneficiaries with REF risk factors (Age, CDLS, HIV and Maternity) were not accurately identified by schemes. This

prompted Council to reconsider the Guidelines for the identification of beneficiaries with REF risk factors, and Version 2.1 of these guidelines was recently published. In terms of Version 2.1 of the guidelines it is now required that, in addition to the previously defined requirements, an authorisation must have been given for specific treatment before a beneficiary could be counted for the REF grids. In addition to a number of technical corrections to the guidelines, the guidelines now require members to be counted for the month in which they received the treatment, and not on the basis of the payment date

3. The Amendments to the Medical Schemes Act:

The introduction of REF will require amendments to the medical schemes Act. Amendments have been drafted to provide for establishment of REF, extend functions of CMS, for application of REF to medical schemes subject to certain exceptions, to provide for provision of prescribed data by schemes to CMS for the purpose of REF and to grant powers to the Minister to make regulations prescribing methodology and procedures for REF.

The Medical Schemes Amendment Bill (2007) was published for public comments in the government gazette during November 2006 and should be introduced in parliament soon. In the meantime the REF Steering committee is preparing to deal with the management of the REF and is in the process of establishing policies that will deal with the handling of confidential data required for the REF process, RETAP governance, the appeals process, how and when to audit schemes and to further build the capacity of the team.



Consumer Corner

A medical scheme is required to reimburse for medical expenses in terms of the rules of the medical scheme, irrespective of whether the member also has recourse against the RAF (which may pay out some time

Consumer Asks:

If I were to get involved in a road accident and in need of urgent medical attention, is my medical scheme or the Road Accident Fund (RAF) liable to pay for emergency medical expenses?

CMS Responds:

A medical scheme is required to reimburse for medical expenses in terms of the rules of the medical scheme, irrespective of whether the member also has recourse against the RAF (which may pay out some time later). However, the rules of the medical scheme may provide that the member must refund the medical

scheme to the extent that the member subsequently recovers from the RAF for expenses which had already been reimbursed by the medical scheme.

It is also worth noting that, in terms of regulation 7 of the Regulations made in terms of the Medical Schemes Act, an emergency medical condition is a prescribed minimum benefit. "Emergency medical condition" is defined to mean the "sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ

or part, or would place the person's life in serious jeopardy."

Medical schemes may designate service providers (DSPs) for the delivery of prescribed minimum benefits (PMBs), but if immediate medical or surgical treatment for a PMB condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a DSP, the scheme must cover the costs of the benefit in an alternative provider. This would include the costs of emergency stabilization of a patient at a non-DSP facility where this was required prior to the member being transferred to a DSP.

Consumer asks: Can I approach the Council for Medical Schemes for advice on which medical scheme to join?

CMS responds: Often when CMS goes out to meet and educate people about their rights and obligations as members of medical schemes (during road shows or even at our first Rand Easter Show in April 2007), we come across people who want us to advise them on which scheme to join. Unfortunately, this is one area where we cannot help. Our hands are tied by our legislation as it directs us to regulate all registered schemes fairly and equitably.

To promote one scheme above others would call our fairness as a regulator into question. This is why we always point that we can only go as far as verifying the scheme's legal existence, and provide information on its benefits and financial position, without preferring one over the other. It is the duty of a member to do ground work, shop

around and compare costs and benefits offered by various schemes. This is an exercise that will help members take informed decisions about their coverage.

Each year, the Council for Medical Schemes compiles and issues an Annual Report which contains information on the performance of all medical schemes. Members can use this report to gain information necessary to make their choice.

Other than this, members should know that:

- o They have a number of schemes to choose from. We currently have 131 registered medical schemes in South Africa to choose from. While 84 of these schemes are restricted to certain groups, 47 schemes are open to the public and can be joined by anyone who can afford to do so. The list of all registered schemes can be downloaded from our

website www.medicalschemes.com

- o Schemes are not allowed to discriminate against people on the basis of ill-health, race, gender and age. Contributions are currently only based on income and/ or on number of dependants
- o When looking for a scheme to join, shop around and settle for the coverage that will suit your pocket and cater for your health needs.
- o If there is something you do not understand about what is offered, do not keep quiet until it is too late. Ask questions of your scheme or broker.
- o Once you have decided on a scheme to join, you can apply for membership by yourself or by use of a broker. The advantage of using a broker is that you have an informed person who can help you understand the necessary level of coverage. But do make sure that your broker is accredited with us. Accredited brokers will have a certificate issued by Council for Medical Schemes.

Information Directory

1. Reception:

Tel: +27 (0) 12 431 0500

Fax: +27 (0) 12 430 7644

2. Call Centre:

ShareCall: 0861 123 267 / 0861 123cms

3. Resource Centre:

Tel: 012 431 0500

Fax: 012 430 7644

E-mail: information@medicalschemes.com

4. Communications Desk: (Media Enquiries)

Tel: 012 431 0581

Fax: 012 431 0681

E-mail: mediadesk@medicalschemes.com

5. Use our website: www.medicalschemes.com to view:

- o List of registered schemes in South Africa
- o List of accredited brokers
- o List of accredited managed care organizations
- o List of accredited scheme administrators
- o Download information (forms, Act and Regulations)
- o Read latest news, developments and upcoming workshops
- o Lodge a complaint on-line

6. Complaints:

Tel: 012 431 0500/ 0861 123 0861

Fax: 012 431 0560/ 012 430 7644

E-mail: complaints@medicalschemes.com

6.1. Complaints Procedures:

- o Complain to your scheme: contact the scheme by phone or write to the Principal Officer giving full details of your complaint as well as any supporting documents relating to your complaint.
- o Complain to the Registrar of Medical Schemes: if you are not satisfied with the outcome of your complaint with the scheme, you can complain in writing to the Registrar's office.
- o Appeal to the Council: If you are aggrieved by the decision of the Registrar or by the decision of the scheme's disputes Committee or any decision relating to the settlement of your complaint.
- o Appeal to the Appeal board: if you are aggrieved by the decision of the Council.

6.2. You can avoid complaints by:

- o Making sure that you know and understand the rules of your medical scheme.
- o Reading all correspondence from your scheme.
- o Studying your benefits guide and familiarize yourself with the terms and conditions of the benefit option that you have chosen
- o Making sure that your contributions are paid in full and on time every month.



Council For Medical Schemes

Private Bag X34, Hatfield 0028

Hadefields Block E
1267 Pretorius Street, Hatfield, Pretoria

Tel: +27 (0) 12 431 0500
Fax: +27 (0) 12 430 7644