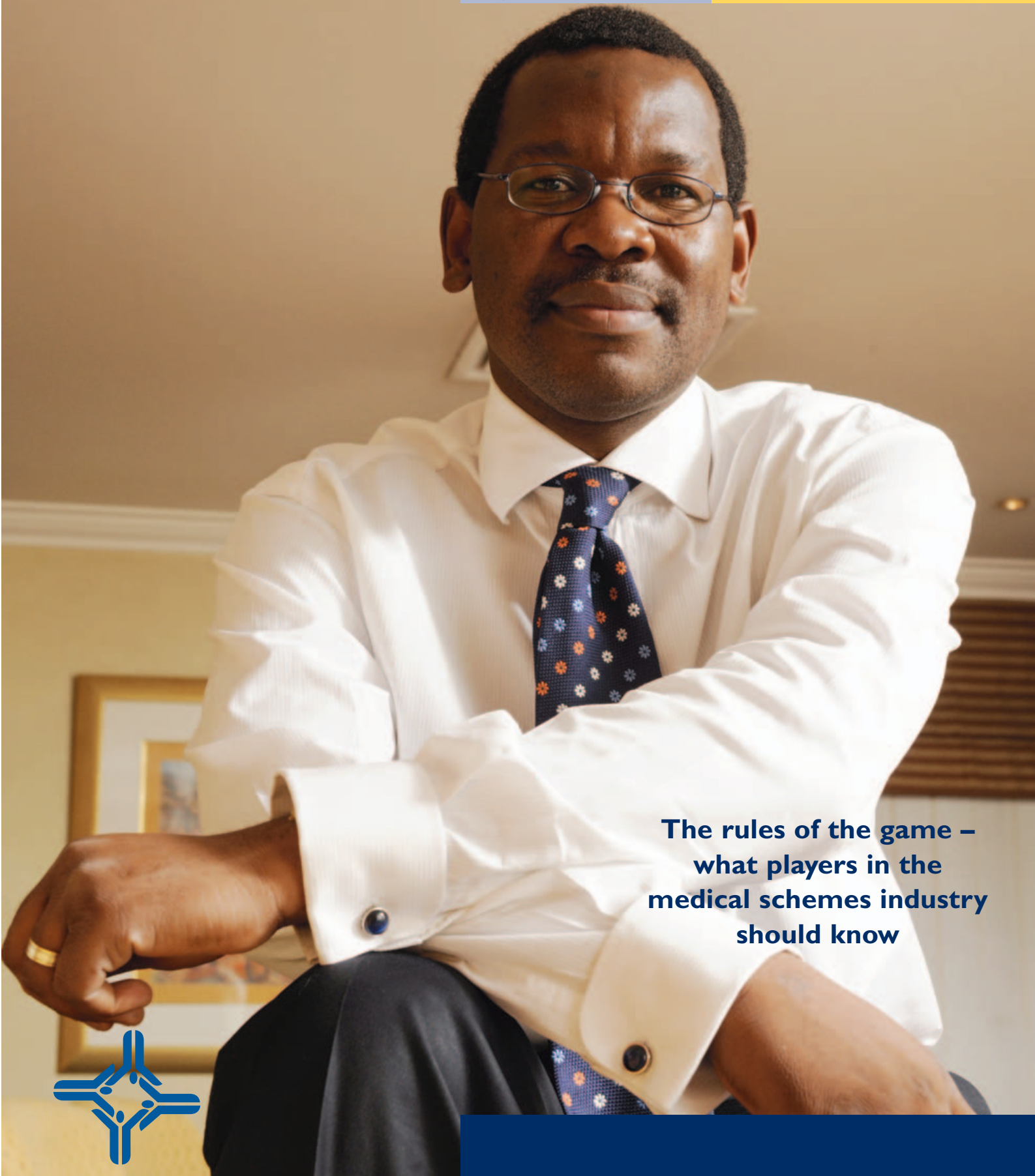


CMS news

September 2008

SPECIAL EDITION



**The rules of the game –
what players in the
medical schemes industry
should know**



Every country has its laws. Governments regulate how fast we can drive, where we can smoke, and how much we can drink. Schools, colleges and universities have their own rules and customs. Your company has policies and procedures that cover everything from your working hours to the way you should dress and behave. Even families have their own unique way of doing things.

Our lives are governed by rules and regulations and the private healthcare industry is no exception. Medical schemes must have rules that define their relationship with their members and, as a member, you should know what they are.

Do you?

In the interest of building an industry that is more fair and financially stable, this special issue of *CMS News* serves as a reminder for us all – from schemes through brokers to members – of just how important it is to, firstly, know the rules, and then to play by them.

Editorial Committee

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Do you know the rules?

If you're a beneficiary of a medical scheme, listen up. There are things you ought to know. Because, as a beneficiary, you have certain rights and responsibilities – and they're enshrined in the rules of your scheme.

Medical schemes in South Africa are governed and managed in terms of the Medical Schemes Act 131 of 1998 (Act). Each scheme is also governed in terms of its rules, which are also called its constitution and which form the basis of the contract that members conclude with their scheme.

Section 29 of the Act stipulates what should be provided for in the rules. The list includes:

- the appointment or election of a Board of Trustees to govern the scheme;
- the appointment of a Principal Officer by the Board of Trustees;
- the removal of officers;
- the manner in which complaints and disputes are to be settled;
- the terms and conditions applicable to the admission of a person as a principal member and his/her dependant(s);
- the scope and level of benefits; and
- the scale or tariff for the payment of benefits.

Rules of schemes become valid only once they have been registered by the Office of the Registrar at the Council for Medical Schemes. They must conform to the provisions of the Act at all times.

Legal impact of scheme rules

Remember: when you join a scheme, whether as a member or a dependant, you enter into a legally binding contract with the scheme. In terms of this contract, the scheme is obliged to provide you with benefits in return for you paying a monthly contribution to the scheme. The details of this contractual relationship are governed by the rules of each particular scheme. Section 32 of the Act makes the rules of the scheme binding on the member; the scheme and its officers.

Where do I find my scheme rules?

Once you have been admitted as a member of a scheme, the scheme must give you a copy of its

For the Medical Schemes Act 131 of 1998, visit our website (www.med-icalsschemes.com) and go to [Publications](#), then [Acts & Regulations](#).

What should I look out for?

- Make sure you understand how your scheme should be governed. Know the responsibilities of the Board of Trustees.
- Study the schedule of benefits that the scheme has given you.
- Familiarise yourself with the table of contributions in accordance with your selected benefit options.
- Note the conditions and/or procedures that the scheme does not cover.
- Note the provisions of the rules regarding the convening of a disputes committee to resolve disagreements between the scheme and its member(s).

rules and your schedule of benefits. If you're a dependant, you may ask the scheme for these documents. The Act gives you the right to demand the rules of any scheme upon paying a fee to the Registrar of Medical Schemes. You are also entitled to inspect the rules of your scheme at the Office of the Registrar.

Many schemes provide their rules to members in a condensed form, but you should insist on the unabridged version of the rules, particularly when you need to make an important decision relating to your health and/or finances. The scheme may demand a fee for this. Alternatively, many schemes include their rules on their websites or you may inspect the rules at the scheme's offices without charge. ■

The rules of your scheme should include:

- the provisions of the law and documents by which the scheme is constituted;
- articles of association and other rules for the conduct of the scheme; and
- provisions relating to the benefits that the scheme may grant and the contributions it may ask.

By **Stephen Mmatli**
SENIOR LEGAL
ADVISOR

The rules of medical schemes

Got rules to adjust? contributions to revise? benefits to modify? Here's a reminder of how rule amendments work. (And don't miss this year's deadline!)

By **Brenda Lissner**
SENIOR ANALYST

The rules of medical schemes form the basis of the agreement between the scheme and the member. Once approved and registered in terms of the Medical Schemes Act 131 of 1998 (Act), the rules and any amendments to them become legally binding on the scheme, the members, the officers of the scheme, and any other person who claims any benefit or whose claim is derived from a person so claiming.

Schemes may amend their rules in the manner provided for in their rules. No amendment, rescission or addition of any rule is valid unless it has been approved and registered by the Registrar of Medical Schemes.

Benefits and contributions

Matters dealt with in the rules and their Annexures include benefits and contributions.

Every year schemes are advised well in advance of the deadline for the submission of proposed contribution increases and benefit changes for the following year. The deadline for the 2009 benefit year is 1 October 2008. (See Circular 19 of 2008 on the website of the Council for Medical Schemes under Publications, then Circulars.)

Regarding the submission of amendments to rules other than benefit and contribution changes, schemes

are advised to submit their applications for registration well in advance of the effective date. The retrospective implementation of rule amendments as a result of resolutions taken after the effective date or the late submission of amendments for registration may have serious legal implications.

The following documents must accompany all rule amendments submitted for registration:

- a certificate on the letterhead of the scheme, signed by the chairperson, the Principal Officer, and a trustee designated by the Board to sign documents on behalf of the scheme (see Section 31(3) of the Act and example in sidebar below);
- a summary or list of the rules to be amended, added or deleted, particulars of the amendments, and the effective date of such amendments (see Section 31(3) of the Act);
- one original and one copy of the relevant replacement pages, initialled in black in the right bottom corner of each page;
- if the registration of additional or restructured options is requested, a business plan as per the guidelines published on the Council's website; and
- proof that an all-inclusive prescribed fee was paid (see Regulation 31(d) of the Act).

In the case of amendments to proposed and/or interim increases in contributions, schemes must submit a breakdown of the contributions as per Appendix I in Circular 40 of 2006, which must be submitted electronically in Excel format. Contribution increases in excess of (CPIX* + 3%) must be accompanied by a motivation that will justify the increase, including an impact analysis. Schemes with non-healthcare expenditure significantly higher than the industry average must provide a detailed breakdown of their non-healthcare expenditure and a motivation that will justify it. ■

When analysing proposed amendments to contributions and benefits for registration, the Office of the Registrar takes into account the following:

- solvency of the scheme
- claims ratio
- non-healthcare expenditure as a percentage of Gross Contribution Income
- number of members
- average age
- pensioner ratio
- surplus (deficit)
- provision for prescribed minimum benefits, including designated service providers and co-payments
- exclusions (which are fair)
- tariffs at which benefits are paid
- considerations of fairness
- overall compliance with the Medical Schemes Act

Example of certificate on scheme letterhead

Certified a true extract from the minutes of a meeting of the Board of Trustees held on ... [date] and that the amendments were adopted in accordance with the provisions of the rules of the scheme. These amendments come into effect on ... [date].

Chairperson ...
Date: ...

Board member ...

Principal Officer ...

* CPIX = CPI
(Consumer Price Index) excluding interest rates on mortgage bonds

Model rules

The Council for Medical Schemes is currently revising its draft document on model rules. But what exactly are model rules? And what implications do they hold for the private healthcare industry?

Model rules are dynamic; they change as and when required.

First introduced in 2001 and last updated in 2004, they are currently being modified by the Benefits Management Unit at the Council for Medical Schemes (CMS). The updated version of this draft document will be made available on the website of the CMS in due course.

Model rules have been devised to assist stakeholders in a practical way on matters of compliance with the Medical Schemes Act 131 of 1998 (Act), common law provisions, sound corporate governance practices and various internal policy decisions taken by the Office of the Registrar. They are there to provide clarity on the relationship between a scheme and its members.

Modifying model rules

Model rules change because of consumer needs and ongoing legislative revisions. South Africa has seen many amendments to its Constitution and overall legal landscape in recent years. Some of these impact on the operation of medical schemes, which may in turn necessitate alterations to model rules.

But modifications to these rules are not only restricted to constitutional or legislative rulings. They also include changes as a result of the development of the common law, including principles of fairness, a constant feature in the process of approving schemes' rules in terms of Section 31(3)(a) of the Act.

Many scheme rules are modified to reflect consistency with the Act and to improve governance in the industry.

Another reason why model rules change is because of efforts to promote good corporate governance in schemes. Compliance in terms of Section 57 of the Act had to be included in the model rules to ensure accountability by Boards of Trustees.

Many changes to the model rules were also drawn from the *King II* document on corporate governance and many changes to schemes' rules make reference to it.

Invite

The Council for Medical Schemes invites further suggestions on how to improve its draft document on model rules for use by the Office of the Registrar and the medical schemes industry. ■

By Mpho Sehloho
SENIOR ANALYST

Stakeholders in the medical schemes industry must be updated on how the rules governing schemes should be crafted.

Schemes' rules and material non-disclosure

I love my job. Actually, let me qualify that. I love my job most of the time. Truth is, there are some parts of my job that I don't enjoy one bit.

By **Stephen Harrison**
SENIOR SPECIALIST:
STRATEGY

High up there on my list of unpleasanties is fielding calls of medical scheme members who have just received a letter in the mail saying their membership has been cancelled retrospectively to date of admission – and that all claims to date have been declined or reversed. The reason typically cited in the letter: material non-disclosure.

The saddest thing about these letters is that they invariably arrive just after the member has incurred some major medical expense, like a major operation or a stint in ICU. This is not coincidental. Many schemes have a policy of background-checking the medical history of members against what was disclosed on application forms in those instances where a member is hospitalised or has a major medical event in some defined period after joining the scheme.

By the time these members call the Council for Medical Schemes, they are typically half-buried in final letters of demand from healthcare

The million-dollar question is of course: what is considered to be "material"? This term is not defined in the Act and is not yet entirely settled in law. In fact, this issue is squarely before the Appeal Board in a pending matter:

One view would have it that only that information which is relevant to the decision by a scheme on whether or not to impose a general or condition-specific waiting period should be considered material for the purposes of applying Section 29(2) of the Act. If this were the case, an applicant would only have to disclose conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which (s)he applied for membership.

However, certain Council decisions have taken a far more expansive view on materiality. In *Genesis v V* (2008), the appeal committee of the Council made the following ruling:

"The Committee has held that the disclosure of factual information has an effect beyond the individual relationship between the Applicant and the Scheme. It is on the basis of the factual information disclosed that schemes are able to determine their overall risk and the benefits that they can consequently offer to members and the contributions that they will levy. ... The Committee has consequently held that a non-disclosure of information will be material if it will affect the ability of the scheme to assess its overall risk, in the context of these broader considerations."

On an issue of this complexity, it is likely that each case will need to be considered on its merits taking into account the growing body of legal principles developing as cases are decided. But it is simply not worth the risk of exposing yourself to having your membership cancelled when you can least afford it by not making a full and open disclosure of your medical history on your application form.

If in doubt about whether or not something is worth mentioning, rather be safe than sorry.

Medical schemes are prohibited by law from denying you membership on the basis of this disclosure, and cannot make you pay more because of your health status or medical history. The worst that can happen to you is that you'll face a 12-month condition-specific waiting period – a whole lot better than having your membership cancelled down the line. ■

If in doubt about whether or not something is worth mentioning, rather be safe than sorry.

providers and their property has been attached – and if they did not have a stress-related condition before, it has now been added to their list of health conditions for which they no longer have cover. In the end, many of the excuses – like "my broker told me I didn't have to disclose that" or "I honestly didn't remember the heart attack when completing the application" – just do not wash and another family faces financial ruin.

For the sake of the financial and mental health of yourself, your family or your clients (and my professional well-being), please take note of what I am about to say and tell your friends about it too.

In terms of Section 29(2) of the Medical Schemes Act 131 of 1998 (Act), a scheme may cancel or suspend your membership if, at the time of applying, you failed to disclose material information. This is a really important protection for schemes to predict their overall risk exposure for purposes of budgeting and planning, and to enable them to manage the risk of members waiting to join a scheme until they know they're about to face a major health event.

Back to the drawing board

... and the genie said: "Now that you've secured an Obama win, Zimbabwe's economic recovery is assured and Bafana Bafana is guaranteed a place in the 2010 finals, let's get onto the important matter of the South African health system. Your choices are: (1) leave the system exactly the way it is, or (2) redesign it from scratch."

Based on the number of health conferences that do the rounds in the medical schemes industry, we'd assume most *CMS News* readers would not hesitate in choosing the latter. As much as one acknowledges the many strengths in the South African health system – such as excellent professional training, broad distribution of public health facilities with free primary care services, and some state-of-the-art public and private hospitals – you'd need to be an ostrich with your head buried really deep to believe it is not without its problems.

Who can forget the ignominy of being ranked 175th out of 191 countries for overall health system performance in WHO's *World Health Report 2000*? In a society founded on one of the most progressive constitutions in the world, how can we justify the fact that in 2005 approximately R9 500 per capita was spent on the healthcare of the 15% of the population who are beneficiaries of medical schemes, compared to spending only R1 300 per capita on the 64.0% of the population entirely dependent on the public sector – and the remainder of the population being partially dependent on the public sector and receiving private primary care on an out-of-pocket basis? How do we sit comfortably in the knowledge that maternal and infant mortality rates have in fact been getting worse over recent years? How do we protect medical scheme members against depreciating value for money in the face of spiraling health costs outstripping inflation?

Against this background, we should be welcoming the renewed political focus on reform of the South African health system – and not predicting gloom and doom, as some stakeholders seem to be doing. This is an opportunity for all of us using or working in the health sector to participate in shaping a future health system that we can all be proud of, which enshrines the fundamental principles underpinning our Constitution, and which is based upon need, not greed.

Of course, we do not have the luxury of a magic genie allowing us to redesign the system from scratch. For example, we unfortunately cannot simply erase the apartheid legacy of service fragmentation and economic inequality that continues to provide challenges to health system planning.

We also would not wish to obliterate the strengths of our system, but rather to build on them. One such strength is the fact that, during 2007, 7 478 040 beneficiaries benefited from med-

ical scheme risk-pooling, giving them access to relatively high quality health services. This represented an increase of 5.0% from 2006 – largely attributed to membership growth of some 300% in the Government Employees Medical Scheme. Some 7.5 million people therefore receive important health protection benefits through the private health funding industry – and this cannot be ignored. Of course, these are only the people who can afford the high costs of medical scheme coverage, and politicians are justified in asking questions of what role schemes and private health providers should be playing in extending health benefits to the whole South African population.

In answering this question, the spotlight will undoubtedly fall on questions of efficiency in the private sector and protagonists in the arguments will have to be ready to engage on these issues.

- Are the benefits accruing to these 7.5 million people worth the price tag of R64.7 bn in medical scheme contributions during 2007 (up by 12.3% on 2006)?
- Are they worth the R8.9 bn spent in 2007 on non-healthcare expenditure (including R1 bn spent on brokers) – equivalent to 13.8% of total contributions?
- Is expenditure on private healthcare being allocated correctly when in 2007 expenditure on private hospitals (R20.2 bn or 36.0% of health benefits) and medical specialists (R12.2 bn or 21.7% of benefits) continued to grow as a proportion of total medical scheme spend, while expenditure on general practitioners (R4.3 bn or 7.7% of benefits) decreased in both real and nominal terms from 2006 to 2007? If not, what can be done to correct the imbalances?
- Is there a solution to members facing the pinch of significant out-of-pocket expenditure when providers charge more than schemes offer as benefits?

These are not easy questions, and the answers are even less easy to come by. But now is the time to constructively engage in the public debate on these and the many other issues which will inevitably be evaluated as part of the process of health system reform. If people remain on their high horses and claim government must confine itself to difficulties in the public sector without recognising the need for a truly integrated health system, they'll have no basis to complain if health system reform takes a direction they dislike. ■

By **Michael Willie**
(RESEARCHER),
Tebogo Maziya
(HEAD OF
FINANCIAL
SUPERVISION)
and **Stephen Harrison**
(SENIOR SPECIALIST:
STRATEGY)

“We should be welcoming the renewed political focus on reform of the South African health system.”

A synopsis of the key findings in the *CMS Annual Report 2007-08* is available on our website (www.med-icalschemes.com) under **Publications**, then **Annual Reports**.

Benefits

Benefits can become complicated. For your own good, here's what you should know.

By Daisy
Ditshoene
SENIOR ANALYST

“The
Council for
Medical
Schemes
strives to
ensure that
benefits
are fair.”

Medical schemes undertake liability in return for a premium or contribution. They are required to help their members in obtaining healthcare services and defraying expenditure for such services. The benefits that a scheme may grant must be registered in its rules.

Schemes typically cover the following healthcare services:

- day-to-day benefits: out-of-hospital services and visits to specialists, GPs, dentists and allied and support professionals as well as the prevention, examination, diagnosis and treatment of diseases;
- medicine: chronic and acute medicines; and
- major medical expenses: for hospitalisation, appliances, ambulance services, maternity benefits, and the management of physical and mental deficiencies.

Schemes have the right to control their risk by being effective and efficient as well as using interventions like formularies, pre-authorisation, treatment protocols and designated service providers.

schedule published by the Department of Health. Used by healthcare service providers to bill for consultations and procedures, it is a set of guidelines at which schemes should pay for the healthcare services rendered. Most schemes use the NHRPL, and pay varying percentages of the NHRPL depending on the member's benefit option.

The “per case” tariff structure refers to a single once-off fee for a specific procedure. It remains the same regardless of the time and effort spent on the medical intervention.

“Per diem” represents each day in which a patient is given access to a prescribed therapy. Payment ends on the day that the therapy is permanently discontinued. This tariff is used by both the public and private sectors.

Capitation tariffs imply the prepayment for services per member per month. Benefits on a capitation option are limited to the contractual agreement that a scheme has with its service provider(s).

Common tariff structures

A tariff is the rate at which a scheme is willing to pay for benefits. This rate is determined by the rules of the scheme. There are various kinds of tariffs commonly used by medical schemes.

Fee for service (FFS) is based on resources. The cost of the service reflects the health provider's investment of time, energy and skills. It is currently the most widely applied payment system in the country.

The National Health Reference Price List (NHRPL) for health services is an FFS pricing

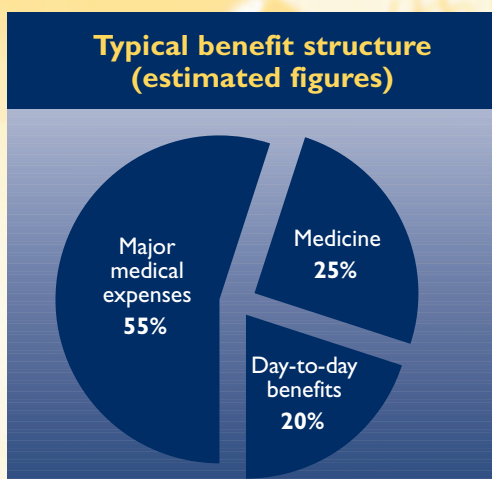
Savings accounts, risk benefits and ATBs

A member's Personal Medical Savings Account (PMSA) must not exceed 25% of his/her gross contributions made during a financial year. This 25% limit minimises the self-funding by members and eliminates benefit structures that discriminate against members. PMSA funds are used to cover discretionary benefits.

Members with a benefit option that has a savings account may use the available funds to pay for discretionary benefits for themselves and/or their dependants. But PMSAs may not be used to offset contributions or to pay for prescribed minimum benefits (PMBs). At the end of each financial year, the member's unused funds are carried over to the next financial year.

Risk benefits are covered by the scheme from the common risk pool where cross-subsidisation occurs (younger and healthier members subsidise older and sickly members). Risk pool benefits include PMBs and in- and out-of-hospital benefits. Unlike with the PMSAs, unused funds are not carried over to the next year.

Some schemes have Above Threshold Benefits (ATBs), whereby schemes cover expenses over and above a self-payment gap. ■



Prescribed minimum what?

Prescribed minimum benefits. Or PMBs. They've been around since 2000 yet many players in the medical schemes industry continue to apply the legislative provisions that define PMBs inconsistently – and some consumers have not yet heard of them.

The Medical Schemes Act 131 of 1998 (Act) makes provision for a minimum set of benefits which all schemes must cover. All options need to provide for these prescribed minimum benefits (PMBs). Schemes may not exclude members or prevent them from accessing relevant benefits and entitlements related to the diagnosis, treatment and care of PMB conditions.

What do PMBs cover?

Regulation 7 of the Act states that PMBs "[consist] of the provision of the diagnosis, treatment and care costs of (a) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and (b) any emergency medical condition".

These Diagnosis and Treatment Pairs (DTPs) provide for ±270 conditions and the Chronic Disease List (CDL). The explanatory notes and definitions to Annexure A provide guidance for the interpretation of the diagnosis, treatment and care components of PMB entitlements.

The treatment and care costs could include medical management, surgical procedures, acute and chronic medicines, devices, appliances, prostheses and the services of various multi-disciplinary healthcare professionals, depending on the DTP condition and the public sector protocol or practice applicable to it.

Whether a condition is a PMB or not is based mostly on diagnosis, regardless of cause. After diagnosis, the appropriate treatment and care is decided on and the most appropriate setting is determined. In some instances a scheme would need to cover the appropriate diagnosis costs retrospectively, after it had been confirmed that a PMB condition exists.

Schemes should guard against using any administrative delays or unnecessary processes to pro-

hibit members from accessing appropriate PMBs and healthcare services. Managed care tools should be aimed at improving the efficiency and effectiveness of healthcare provision and should not be used to obstruct access to PMBs.



Schemes should guard against using any administrative delays or unnecessary processes to prohibit members from accessing appropriate PMBs and healthcare services.



Obligations of the scheme

Schemes are obliged to pay for PMBs in full and without co-payments or deductibles where members obtained such services from a designated service provider (DSP) or involuntarily from a non-DSP. Co-payments may be levied where a member voluntarily obtains services for PMBs from a non-DSP.

Schemes need to be careful that the co-payment does not result in an effective denial of a PMB. They may only apply the co-payment as provided for in their registered rules.

Section 29(1)(p) of the Act further provides that no limitation shall apply on the re-imbursement of any relevant health service that a member obtained from a public hospital where this service complies with PMBs. ■

By Marli Weldhagen
CLINICAL ANALYST

When selecting a DSP, schemes should remember that:

- Members should be able to access services for PMBs without financial obstacles in at least one reasonably available setting.
- The scheme remains liable for the full costs of PMBs where a DSP is unable to accommodate or treat a member.

Contributions

Setting contribution levels for medical schemes is one of the main functions of managing a scheme. The level of contributions is dependent on a number of factors, including the membership profile of the scheme and, perhaps most importantly, the benefits that the scheme offers.

By **Paul Bosch**
and **Mpho Sehloho**
SENIOR ANALYSTS

Both the benefits and contributions must be included in the rules of schemes (specifically in Annexures A and B). Any changes to these rules must be submitted to the Registrar of Medical Schemes for approval and registration before they can be implemented.

Before the Registrar approves the registration of any rule change, he must ensure that the proposed change "will not be unfair to members" (see Section 31(3)(a) of the Medical Schemes Act 131 of 1998).

If a scheme wants to change contributions or benefits, it must submit the proposed change with a motivation as well as supporting calculations and assumptions on which the new contributions and benefits are to be based.

When evaluating proposed changes, the Council for Medical Schemes (CMS) looks at:

- *the percentage increase in contributions.* Any increase in excess of a limit determined by the Registrar (e.g. CPIX* + 3%) needs to be motivated.
- *a medical savings account.* Is this provided for in terms of Regulation 10 of the Act which requires that it not exceed 25% of contributions in a financial year?
- *the solvency level of the scheme.* If the scheme's solvency is below the statutory level of 25% of gross annual contributions, then the level of contributions must include a factor for reserve-building. This would have been approved in a business plan which a below-solvency scheme is required to submit to indi-

cate how it intends to achieve the required solvency level. Schemes with solvency below the minimum statutory level are placed under close monitoring to determine whether they are meeting their projections in terms of the submitted business plan.

- *the sustainability of options.* Where a scheme offers more than one option, are these financially sound and sustainable? A scheme could be required to submit its contract with a capitation provider for assessment where a capitation option fails to meet the financial soundness to determine the value proposition.
- *the level of non-healthcare costs.* Members pay contributions to cover the costs of relevant health services. To ensure that members receive value for money, it is necessary that non-healthcare costs – such as administration fees, trustee and Principal Officer remuneration, office expenses, audit fees, bank charges, managed care management fees, broker fees, accounting and record-keeping, collection of contributions and paying of claims – are kept to a minimum, bearing in mind the level of service that members expect.
- *prescribed minimum benefits (PMBs).* Are these included as required by law?
- *co-payments, deductibles, levies and limits.* Are these reasonable? Do they ensure equity and access to benefits?
- *managed care.* The value proposition must be reasonable and measurable.
- *designated service providers and provider networks.* Has the scheme established adequate and reasonable accessibility? Are services readily available?

The CMS considers the following when it evaluates proposed changes to contributions:

- the percentage increase in contributions
- medical savings accounts
- the solvency level of the scheme
- options and their sustainability
- the level of non-healthcare costs
- prescribed minimum benefits (PMBs)
- co-payments
- deductibles
- levies
- limits
- managed care
- designated service providers
- provider networks

* CPIX =
Consumer Price
Index (CPI)
excluding interest
rates on mort-
gage bonds

Submitting and approving new contributions and benefits

Each year around June/July the CMS prepares a circular for the industry in which schemes are asked to submit their proposed contribution and benefit changes to the Office of the Registrar by 30 September of that year.

The circular is accompanied by detailed workings and motivations in a prescribed format. It always reminds schemes that no marketing or operation of the proposed changes will be valid unless the Registrar has approved and registered them.

Once we have received the proposed changes,

we analyse and review them. A proposal is then submitted to a committee comprising analysts from the Benefits Management Unit (which includes a clinical analyst and a medical advisor), the Financial Supervision Unit as well as the Research and Monitoring Unit within the CMS. The committee makes a recommendation to the Registrar for his final decision.

Depending on the Registrar's decision, the scheme is advised accordingly.

If the CMS asks a scheme to modify its proposed changes, it allows a time frame for resubmission. Another recommendation is then presented to the Registrar for his final decision.

Most changes take effect from 1 January of each year. Scheme rules and the Act require that members be given advance notice of any changes, so the submission and approval processes must be finalised before the envisaged implementation date. ■



Scheme rules and the Medical Schemes Act require that members be given advance notice of any changes to contributions.



Legal requirements as per the Medical Schemes Act 131 of 1998

- *Section 29(1)(l)* – rules must provide for “the giving of advance written notice to members of any change in contributions ... and benefits”
- *Section 29(1)(n)* – rules must provide for “the determination of contributions on the basis of income or the number of dependants, or both income and [the] number of dependants” (this Section also prohibits contributions based on age, sex, past or present state of health of the applicant or any dependants, and the frequency of rendering a relevant health service)
- *Section 29(1)(o)* – the provision of prescribed minimum benefits (PMBs)
- *Section 31(2)* – approval by the Registrar before marketing or operations
- *Section 31(3)* – Board resolution signed by the Chairman, Principal Officer and one other trustee confirming the amendments
- *Section 31(3)(a)* – if the Registrar is satisfied that the amendments of the rules will not be unfair to members, he registers the amendments
- *Section 33(2)* – financial and membership sustainability, financial soundness (schemes can be forced to close option(s) if they fall foul of this Section)

Exclusions and limitations

Private health insurance allows people to protect themselves from the potentially extreme costs of medical care if they become ill. It also gives people access to healthcare when they need it.

By **Jan van der Merwe**

FORMER MEDICAL
ADVISOR TO THE
COUNCIL FOR
MEDICAL SCHEMES

Health insurance should guarantee access to essential healthcare.

It is a noble idea, but there are threats to the sustainability of private health coverage – one of these is affordability.

Hikes in healthcare and non-health costs, sometimes at rates substantially higher than general inflation, require member subscription rates to increase each year. Schemes try to reduce their expenditure and although they target non-essential healthcare first, this often leads to misunderstandings and hardship. What is considered unnecessary by one person is seen as essential by another.

Funds have sought to limit their liability by financial limitations and/or limitations or even exclusions on cover for certain conditions or treatments.

The exclusion list of scheme options (Annexure C of scheme rules) deals with limitations of entitlements. Schemes must ensure that there is good reason for these exclusions and limitations, and that

they are not too broadly worded. Otherwise, they may lead to arbitrary or unreasonable denial of care.

Financing available for healthcare is not infinite. Debates on fair and equitable rationing in healthcare abound worldwide. A fair, transparent and scientifically justified system is necessary also in South Africa.

But why exclusions and limitations?

Entitlements in any option are discretionary (optional) or non-discretionary (compulsory). The latter are covered by the prescribed minimum benefits (PMBs). The Regulations in the Medical Schemes Act 131 of 1998 deal with the entitlement to PMBs: they must be paid in full under certain circumstances, such as when the member obtained the service from a designated service provider. The standard of care (and entitlement to it) is determined by protocols based on the principles of evidence-based medicine or, where these do not exist, the protocols of the public sector. Non-PMB conditions and entitlements are dealt with in scheme rules, and limitations and exclusions are applicable to them.

Exclusions

The following principles should be considered when deciding whether an exclusion is justified or not: best practice, evidence-based healthcare, clinical protocol, cost-effectiveness (affordability), and

Principles to validate exclusions:

- Best practice
- Evidence-based healthcare
- Clinical protocol
- Cost-effectiveness (affordability)
- Laws of the country

Decision matrix

		Discretion		
		High	Medium	Low
Medical necessity	Low	Exclusion	Exclusion	Exclusion
	Medium	Exclusion	Apply principles	Apply principles
	High	Apply principles	Apply principles	Apply principles

the laws of the country.

Conditions or circumstances that should definitely not be excluded are those that are medically necessary, with little discretion from the member and/or service provider. Put differently, consider whether urgent treatment is needed to prevent death or permanent disability, and whether the attending doctor has some discretion as to the timing of treatment, and whether the treatment should be given at all.

It would, for example, be entirely inappropriate to include an exclusion for the treatment of acute appendicitis, whereas an exclusion for cosmetic surgery in the absence of clinical indications would be appropriate.

Not forgetting affordability, clinical protocols based on evidence-based medicine should be the bottom line when deciding whether funding is justified or not.

Limitations

Limitations on cover are appropriate where they permit a degree of financial risk management. But they are inappropriate where their application allows for the selective targeting of specific people or vulnerable risk groups. Thus, reasonable financial management should be permitted, but not to the extent that it allows risk-selection and unfair discrimination.

Limitations should be permitted where they achieve the following:

- reasonable cost-sharing with members for healthcare services where the demand for these services is subject to high member discretion; and
- reasonable cost-

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There are threats to the sustainability of private health coverage – one of these is affordability.
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sharing with members for healthcare services that are routine and consequently do not require insurance. This refers to discretionary services that are used so routinely that contributions tend to equal what the member would have paid from his/her own pocket.

Limitations are inappropriate where they achieve the following:

- cost-sharing with members for healthcare services that are non-discretionary and determined by the healthcare provider; and
- cost-sharing with members for healthcare services that are costly and infrequent. ■

Fair exclusion? You decide.

Most schemes exclude obesity management from their cover. Is this fair?

Obesity can be seen as a lifestyle condition that the patient can deal with on his/her own even though the medium- to long-term outcomes of managing this condition are often disappointing.

But if a patient suffers from morbid obesity, evidence shows that (s)he is likely to suffer from substantial morbidity and may eventually die from this. Gastric bypass procedures are sometimes the only solution.

Many provisos are applicable, which must be accommodated in a protocol, but it seems unfair to allow morbid obesity to be excluded. What do you think?

Trends in benefits and contributions

Earlier this year the Council for Medical Schemes published its findings on the trends in contributions, benefits and membership for 2002-06 in its *Research Brief 2 of 2008*. The publication captures how the South African private healthcare industry evolved in terms of membership, demographic profiles, and number of schemes and options.

By **Phakamile Nkomo**
and **Michael Willie**
RESEARCHERS

Our research helped us to understand trends in scheme benefits and contributions as a result of benefit design and reimbursement of healthcare providers. We gained clarity on how these trends played themselves out in terms of growth in contributions relative to claims. We also gained better insight into the contribution changes for specific benefit option designs.

We found that the number of schemes and options decreased, but that schemes broadened their product ranges.

The average age of beneficiaries increased by six months in open schemes but decreased by the same amount in restricted schemes.

Restricted schemes had a higher pensioner ratio than open schemes.

There were more female beneficiaries than male beneficiaries.

The increases in claims payments to private hospitals and medical specialists were significantly greater than those to other service providers.

Expenditure on ward and theatre fees increased consistently in 2002-06. While data on the utilisation of private hospitals showed a decline, the costs of hospitalisation increased.

There were increases in the utilisation of (number of visits) and expenditure on GPs, dental specialists, medical specialists, and the supplementary and allied health professionals.

The study revealed a declining trend for the utilisation of and expenditure on dentists. ■

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The regulator must remain vigilant for the benefit of all beneficiaries.

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Gross contributions increased by 11.2% for all schemes: by 14.0% in open and by 4.3% in restricted schemes.

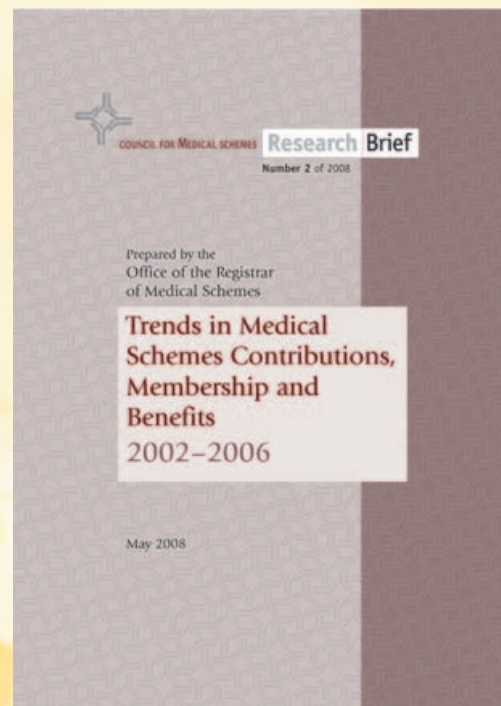
Gross claims increased by 20.1% for all schemes: by 22.1% in open and by 15.5% in restricted schemes.

The rate of increase for gross claims was higher than for gross contributions.

Average monthly contributions per member increased by 8.3% for all schemes: by 6.8% in open and by 0.2% in restricted schemes.

Claims ratios remained in the band of 88-89.1% in open schemes and 91-92.0% in restricted schemes.

The most expensive to the cheapest gross monthly contributions were: co-payment options, traditional and major medical options, partial cover options, and capitation options.



Membership increased, fuelled mainly by the registration of a large new restricted scheme: the Government Employees Medical Scheme (GEMS).

Scheme rules and the Medical Schemes Amendment Bill

Subject to any amendments, the Medical Schemes Amendment Bill, when enacted, will impact on the rules of medical schemes. Read on to discover some of the main ways in which rules will be affected.

By **Stephen Harrison**
SENIOR SPECIALIST:
STRATEGY

In relation to benefit design, scheme rules will differentiate between “basic benefits” and “supplementary benefits”. Every member of a scheme will have access to the same basic benefits (which include prescribed minimum benefits and other in-hospital benefits). In addition to that, scheme rules will give members the choice of joining a supplementary benefit option which offers benefits over and above the basic benefits.

The contribution table for the basic benefits (applicable to all members) will be separate from contribution tables for the supplementary benefit options. It is possible that the Minister of Health may prescribe that contributions for supplementary benefit options may be differentiated between risk categories within regulated parameters. Contribution tables for both basic and supplementary benefits may also look different in so far as they could provide for discounts based on the member’s choice of provider or provider network.

Scheme rules would also most likely be amended to reflect schemes’ obligations to participate in the Risk Equalisation Fund (REF). This would include obligations on trustees to exercise due care in making or receiving financial transfers to or from the REF. They would also reflect the scheme’s legal obligations to furnish certain personal particulars and health status information to the REF (which would be subject to strict privacy protections provided for in the Bill).

Rules relating to governance are also likely to change. In the case of open schemes, the rules will state that the 50% or more trustees elected by members will be responsible for appointing the



Rules relating to governance are also likely to change.



balance of the Board. Non-elected trustees of restricted schemes may be appointed in a different way, but the rules of those schemes will determine how this is done.

The rules will also limit the tenure of any single trustee to a maximum of six years on that scheme (although a person reaching this limit may serve as a trustee on another scheme). Schemes finding themselves in a position where trustees are disqualified will have 12 months in which to comply with this requirement.

The functions of trustees have also been reworked in the Bill to differentiate between the governance function of trustees and the executive management role of the Principal Officer. This is likely to affect the formulation of Board functions in scheme rules.

The Bill provides that not all the legislative changes will necessarily take effect immediately, and that different provisions may come into operation on different dates. This is to allow for the rational sequencing of implementation of the legislation from a policy perspective. All the changes to scheme rules described in this article are therefore not likely to happen overnight.

Once the Council has reviewed the Bill as passed by Parliament and has received confirmation of the timing of implementation of provisions of the Medical Schemes Act, it will publish a revised set of model rules accordingly. This will allow changes to be implemented in a coordinated way across the industry. ■



Every member of a scheme will have access to the same basic benefits.



Meet the faces behind the paperwork

By **Phumla Khanyile**
COMMUNICATIONS
OFFICER

The Benefits Management Unit at the Council for Medical Schemes registers new schemes and approves or rejects their rules and any changes to contributions and benefits. Meet the team of experts who put the interests of beneficiaries first by making sure schemes comply with regulatory requirements to secure a financially sound industry.

Headed by Patrick Matshidze, the Acting Registrar of Medical Schemes, the Benefits Management Unit is made up of four Senior Analysts, two Analysts and an Administrator.



Robert Tshabalala Financial Mail

Patrick Matshidze (Acting Head of Unit)

Patrick obtained his degree in Biological Sciences at the University of Venda and subsequently graduated from Wits University with a BSc (Honours) in 1988. He completed a Masters degree in Public Health (MPH) in Epidemiology and Biostatistics at Columbia University in New York in 1997, followed by an MBA in Healthcare Management at the Free State University in 2005.

He started his career as an intern at the Medical Research Council in 1992 and later moved to the Reproductive Health Research Unit at the Baragwanath Hospital where he became Deputy Director in Research. In 1998 he joined Medscheme Administrators as an Epidemiologist

in their Managed Care Division but left two years later to join the Council for Medical Schemes (CMS) as a Researcher.

Patrick became Head of Research and Monitoring in 2004. One year later he became the Acting Head of the then-new Benefits Management Unit. He was named Acting Registrar in June of this year and will remain in this position until the Registrar's return from his sabbatical.



Brenda Lissner (Senior Analyst)

Brenda has been involved in the medical schemes industry for over 20 years. She started her journey in 1988 as a Senior Administrative Officer in what was then called the Medical Schemes Directorate at the Department of Health. When the CMS was established in 2000, she received the new job title of Analyst.

Colleagues and stakeholders describe Brenda as down to earth, helpful and very friendly. When she's not pursuing rule enforcement, she buries herself in a book, knits, shops or travels.

"Back in the 80s there were no options, no managed care organisations, no medical savings accounts, no brokers, no prescribed minimum benefits, no statutory solvency requirements and no investment restrictions. Benefits and contributions were not as complex as they are today. Back then the analysis of rules was not as detailed and in-depth, and the financial supervision of schemes was not as intense. Things changed in the early 90s with the implementation of the various amendments to the Medical Schemes Act and its Regulations."

We are here to protect the interests of members and to guide trustees in ensuring the long-term sustainability of medical schemes.



Mpho Sehloho (Senior Analyst)

Three months after the CMS opened its doors in 2000, Mpho began what she calls “an exciting opportunity to finally regulate the industry that used to be fraught with irregularities and mismanagement”.

But she soon became frustrated with the process of analysing rules. Back in 2000, no mechanisms existed to assess the appropriateness of benefits. But this soon changed when the Unit was restructured and proper systems and processes were put in place. “Interrogation is now easy,” Mpho says. “And the outcomes are accurate to a very large extent.”

Mpho describes herself as family-oriented, orderly and attentive to detail. “I’m also a good judge of character.” Now and then she enjoys a glass (or two) of good red wine.

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Compliance is our major focus. We aim to ensure 100% adherence to the Medical Schemes Act.

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Nolukholo Phoshoko (Senior Analyst)

Talk about the reconciliation of numbers and you will be talking a familiar language with Nolukholo. Her love of mathematics goes back to her school days. This mother of two could have chosen to be a statistician but she chose the healthcare sector instead.

Prior to joining the CMS, Nolukholo worked as an Analyst in the medical schemes industry. She joined the CMS in April 2007.

“I’m a home bird,” she says. “I enjoy solitary moments of self-reflection but time spent with my lovely family is my first priority.”



Daisy Ditshoene (Senior Analyst)

Daisy joined the CMS in 2001 as an Administrator. She was promoted to an Analyst in 2004 and to a Senior Analyst early this year.

Daisy has always been driven by the desire “to make a difference by uplifting the disadvantaged”. At the CMS, she lives out her passion by ensuring that members of medical schemes are treated fairly.

The core function of the Unit is to ensure that beneficiaries are treated fairly and that schemes comply with the Medical Schemes Act.

She calls her family her "second shadow". "They are always with me, wherever I go," she says. She enjoys reading and watching movies. She has also pursued her passion for dancing for the past ten years.

"Dancing makes me feel like I am free and on top of the world."



Jessy Masango
(Analyst)

Jessy joined the Medical Scheme Directorate at the Department of Health in 1997 as an Administration Clerk. With the establishment of the CMS in 2000, she was appointed as an Analyst.

Jessy is a woman of few words; she prefers to apply her focus and energy to tasks at hand. She dedicates her time to her two children but shops and travels whenever she gets the opportunity.

"Medical schemes can speed up the approval and registration processes if they ensure that the rules they submit to the CMS adhere to the Medical Schemes Act and its Regulations."



Lindiwe Twala
(Administrator)

Lindiwe joined the CMS in December 2007.

"My colleagues nurtured me and assisted me with advice whenever I needed it. If it hadn't been for them, I would have been lost in the complexity of the environment. Instead, I feel inspired to learn more."

When she's not assisting the Unit with administration services (or familiarising herself with benefits analysis), Lindiwe is toning her muscles at the gym or spending time with family and friends.



Marli Weldhagen
(Clinical Analyst)

Marli became part of the CMS family in 2003. She deals with the clinical aspects of the benefits approval process and reviews the rules and benefit schedules of schemes to ensure that all benefits are appropriately allocated. Her job is also to promote an understanding of prescribed minimum benefits (PMBs).

"The medical schemes industry is still faced with the inadequate provision of designated service providers or DSPs where schemes nominate public hospitals as DSPs but don't ensure that services are available."

Fun-loving and adventurous, Marli finds retreat in the company of her best friend: her husband. When she's not fishing or birding, she hikes, takes photographs, travels and reads. She is currently glued to John Gierach's *Death, taxes and leaky waders*.

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There is no way one cannot be inspired when working with such a spirited and professional team.

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e: information@medicalschemes.com

Communications desk (media enquiries)

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Use our website to:

- view lists of registered schemes as well as accredited brokers, managed care organisations and scheme administrators in South Africa;
- download information (forms, the Medical Schemes Act 131 of 1998 and Regulations);
- read the latest news, developments and upcoming workshops; and
- lodge a complaint online.

Complaints

t: +27 (0)12 431 0500 / 0861 123 CMS (267)

f: +27 (0)12 431 0560 / +27 (0)12 430 7644

e: complaints@medicalschemes.com

Complaints procedure

- First, complain to your scheme. Phone the scheme or write to the Principal Officer. Give full details of your complaint and include any supporting documents.
- If you are not satisfied with the outcome of your complaint to the scheme, complain to the Registrar of Medical Schemes (in writing).
- If you are aggrieved by the decision of the Registrar of Medical Schemes or by the decision of the scheme's disputes committee or by any other decision relating to the settlement of your complaint, appeal to the Council.
- If you are aggrieved by the decision of the Council, appeal to the Appeal Board.

How to avoid complaints

- Make sure you know and understand the rules of your scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option that you have chosen.
- Make sure your contributions are paid in full and on time every month.



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