



# Communication Guidelines for Medical Schemes

# Discussion Document

Comments on the document should reach the CMS by no later than **Monday, 2 July 2012**. Kindly note that all submissions must be forwarded to the dedicated e-mail addresses or fax addresses reflected below:

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## 1. INTRODUCTION

The Council for Medical Schemes (CMS) is involved in a process of determining a set of guidelines for communication to beneficiaries within the private healthcare industry. The overall aim of this guideline is to clarify the minimum required information to be disseminated to beneficiaries and service providers and the optimum way of sharing it using various communication channels.

The presence of complex and incomplete information is a pervasive feature of the health care market. This situation leads to a phenomenon referred to as asymmetry of information (Atim, 2009). Providers and/or funders act as agents in determining what care is needed, at what level as well as the associated utilisation costs.

The information asymmetry problem is further exacerbated by the use of technical medical words and/or language to describe a medical condition. These words are not easily understood by a layman and this is made worse by the fact that many serious illnesses do not repeat themselves, so that the cost of gaining the information is very high.

It is also envisaged that this information will empower and to a large extent alter the conduct of beneficiaries, funders as well as services providers. For example beneficiaries will understand their entitlements, use of designated service providers (DSPs), prescribed minimum benefits (PMB), formulary medicine and associated exclusions and deductibles. Whilst funders using layman's language will communicate with the beneficiaries explaining the use of DSP's, PMB package etc.

These guidelines are critical since they will enable enforcement of section 57(4)(d) of the Medical Schemes Act which states that “ *...schemes should ensure that adequate and appropriate information is communicated to members regarding their rules, benefits, contributions, and duties in terms of the rules of the medical scheme.* ”

### 1.1. Objectives

To develop communication guidelines for medical schemes which will, among other outputs, stipulate the format, level of information and medium of communication required to communicate to members and providers.

## **1.2. Purpose**

The purpose is to clarify the obligation on schemes, and to inform members about available legislation which accords them the right of access to information regarding their entitlements including prescribed minimum benefits (PMBs), use of designated service providers (DSP) and other baskets of benefits.

## **1.3. Processes**

An internal team was put together to conduct a review of available modes of communication in order to streamline communication and standardise medical scheme marketing material. This document will be sent to the industry for their input and comments which will be collated and the final document published as a standard guide for member communication.

## **1.4. Scheme Survey**

For illustrative purposes, we reviewed guidelines that currently exist in the medical schemes industry. A purposeful sample was selected that included 7 open schemes and 2 restricted schemes. From the reviewed cases we recommend that the guidelines should cover the minimum level of information as illustrated in paragraph 11 of this document.

After evaluating the sample, it was found that 22% of the sampled marketing material did not have detailed information regarding member education for example application processes; clarifying terminology and etc. 95% of the sample did not for example properly communicate and provide a list of their DSPs; the level of co-payment payable for voluntarily use of a non-DSP or out of formulary medicine; non-PMB chronic medication covered and etc.

## **1.5. International Context**

According to Mills and Gilson (2005), international evidence shows that beneficiary decision making within health care markets is often left to the health care provider. In certain instances providers induce demand with the objective of maximising profits or some insurance providers may sell inferior health products with the knowledge that buyers are not fully empowered to understand what they are paying for (Mills & Gilson, 2005). In order to address this problem most countries regulate the conduct of the funders and the providers whilst empowering consumers through initiatives such as consumer driven health care. This initiative involves empowering individuals with information and financial responsibility to support a position of ownership. It is about supporting and rewarding healthy behaviours regardless of plan design. It is also about engaging employees, employers, providers, carriers, and other stakeholders in a new relationship that deals with health rather than sickness and disease (Ronald, Bachman, 2006).

## 1.6. The Medical Schemes Context

### Trends in complaints:

Complaints data analysed from the January 2010 to March 2011 is illustrated in Figure 1 below. An increasing trend in the number of complaints has been observed in recent years and the graph below depicts the top ten selected complaints categories. These are presented as the proportion of all complaints. The data illustrates that 24.0 percent of resolved complaints relate to benefits and this stretches from limitations of benefits, prescribed minimum benefits, formularies and designated service provider type of complaints. The second category represents 16.00 percent of all complaints relating to unpaid accounts. Six percent of all complaints relate to either authorisation or refusal by the scheme to issue authorisation. Two percent of complaints were largely due to termination of membership. Other categories are also depicted in Figure 1.

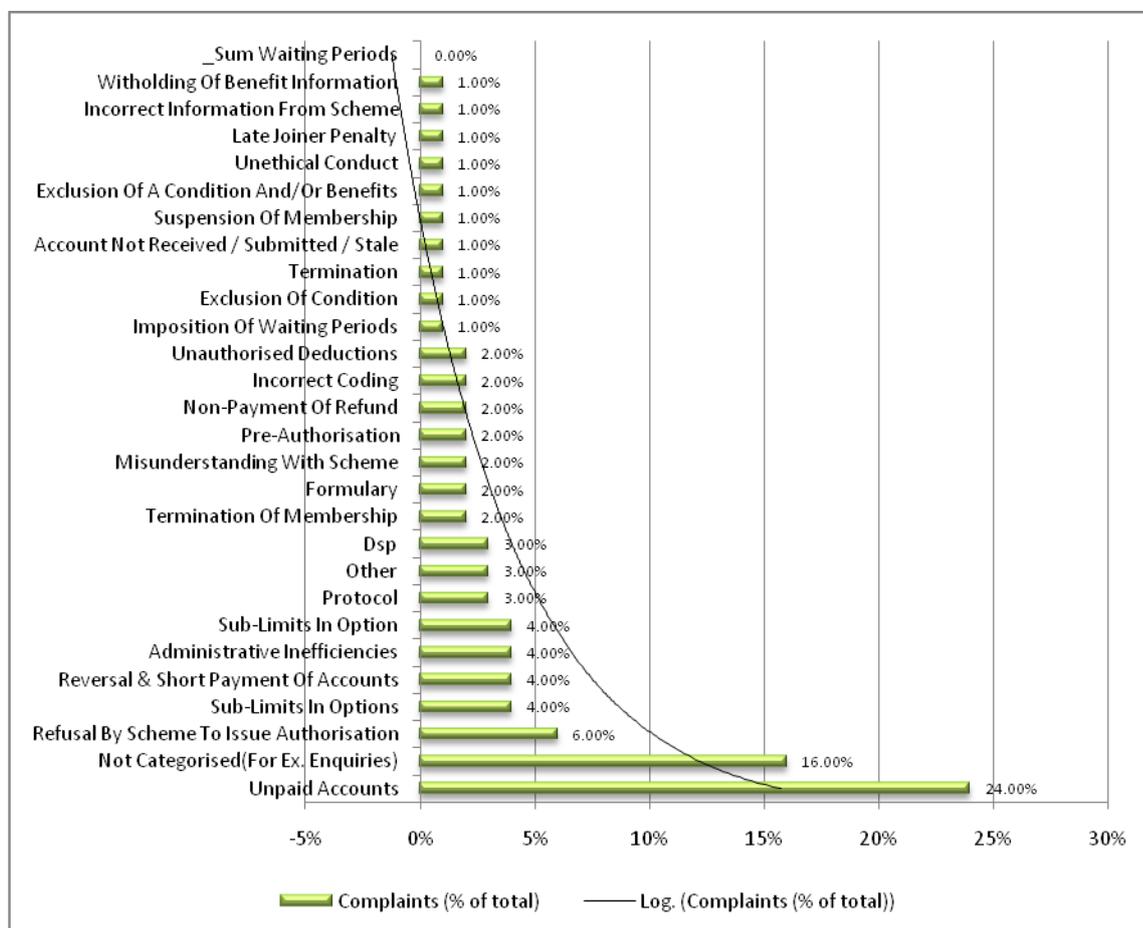


Figure 1: Select ten complaints analysed and resolved in the period January 2010- March 2011

Also depicted in Figure 1 are complaints that relate to lack of knowledge on benefit entitlement by members. Some of complaints dealt with by the Office are a consequence of unethical marketing material; these are instances where schemes promote their products under false pretences. Magnitude of complaints due to misunderstanding of the schemes or lack of knowledge both account for less than a percent of complaints,

however these could have major repercussion to the member. Box 1 illustrates a summary and outcome of an appeals matter dealt by the Office of the Registrar and how this negatively impacted on the member as a result of not effectively communicating to the member by the scheme.

Box 1: Adjudicating appeals: Unambiguous communication by Scheme X and Gates

#### **Gates v Registrar and Medical Schemes X**

This was an appeal against a ruling by the Office of the Registrar where it was found that the scheme had correctly made a short-payment on an account.

The member had requested authorisation from the scheme for an elective dental procedure. The scheme granted the authorisation and confirmed that the entire procedure would be covered in full. The annual benefit was R6 300. The member had joined the scheme during the benefit year and as such was only entitled to pro-rated benefits.

When the account was presented for payment, the scheme paid only R2 100, leaving the balance for the member's account. A few weeks after the procedure had taken place, the member received written authorisation in the post with a disclaimer confirming that pro-rated benefits would apply when a member joined the scheme during the benefit year. This, however, had never been conveyed in the various telephone conversations the member had had with the scheme.

The appellant was of the view that the scheme was liable to fund the procedure in full because she had not been advised telephonically that pro-rated benefits were applicable and because she was told that the account would be paid in full. The evidence before the Appeals Committee – in the form of recorded telephone conversations which the member had had with the scheme – confirmed that five people had advised that the account would be paid in full. The issue before the committee accordingly was whether the member had been informed in clear and unambiguous terms that pro-rated benefits would be applicable, regardless of the fact that a later written confirmation had contained a disclaimer.

The committee found that, while it was correct that benefits were governed by scheme rules read with the benefits schedule, to the extent that the scheme had made a misrepresentation to its member about the extent of cover available, the scheme was prevented from seeking refuge in its rules. The committee was of the view that the scheme was not immune from liability when it had misled its member into believing that a procedure would be covered in full when in fact this was not true; it ruled that the scheme make good on its representation and fund the account in full.

Emphasis was placed on the crucial importance of clear and unambiguous communication with members and that a scheme could not absolve itself from liability where its agents had made certain representations on the basis of which a member had relied to his/her detriment. Moreover, a scheme could not seek refuge in its rules where its agents had misrepresented the true position as regards the extent of cover to a member; otherwise schemes would be able to promote their products under false pretences with impunity, which would be unconscionable.

Source: Annual Statutory Returns, 2009

### **1.7. Communicating benefits to members**

A study conducted by OMAC Actuaries & Consultants Healthcare in 2011 revealed that nearly half of medical scheme members never read what they are covered. The study further narrates that medical scheme members' ignorance of what they are paying for means they risk having too much or too little cover for their needs. However there is another dimension to that view and that is benefits are sometimes not effectively communicated in plain and simple language that members can understand. According to the Code of Conduct in respect of PMB benefits, communication in respect of benefits must be clear, in plain language and must be readily available. These further emphasises that schemes need to educate members and clearly define what they are covered for.

## **1.8. Legislation**

This section outlines various pieces of legislation in South Africa which promotes access to information for beneficiaries (patients).

### **1.8.1. Constitution of the Republic of South Africa, 1996**

Section 27 of chapter 2 of the Bill of Rights provides the following;

*“Health care, food, water and social security*

*Everyone has the right to have access to health care services, including reproductive health care”*

### **1.8.2. Medical Schemes Act, 131 of 1998**

Requirement and provision of the MSA: Section 57(4)(d) of the Medical Scheme Act 131 of 1998 states that;

*“the duties of the board of trustees shall be to – ensure that adequate and appropriate information is communicated to the members regarding their rights, benefits, contributions and duties in terms of the rules of the medicals scheme”.*

#### **1.8.2.1. The Core Values of the Medical Schemes Act**

The core values of the Medical Schemes Act encompass the following principles:

##### **1.8.2.1.1. Open Enrolment**

A social security principle set down in the law which require every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme.

##### **1.8.2.1.2. Community Rating**

A principle where all members on a particular benefit option within a medical scheme must by law pay the same contribution that does not discriminate against them unfairly regardless of their age or health status or any other arbitrary ground.

##### **1.8.2.1.3. Prescribed Minimum Benefits**

The scope and the minimum services that include the diagnosis, treatment pairs that is to be available to beneficiaries. The general scope and level of benefits may not be different from the entitlement in terms of services available in public hospitals.

#### **1.8.2.1.4. Governance**

It is a framework of rules, laws and practices by which a Board ensures accountability, fairness, and transparency in a scheme's relationship with all its stakeholders. Hence section 57(2) provides that: *At least 50 percent of the members of the board of trustees shall be elected from amongst members.*

#### **1.8.2.1.5. Managed Healthcare**

*Clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes*

### **1.8.3. National Health Act 61 of 2003 (NHA)**

This Act gives effect to the right to have access to health care services for everyone.

#### *2 Objects of Act*

*“The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by-*

*(a) establishing a national health system which-*

*(i) encompasses public and private providers of health services; and*

*(ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford”;*

*15(1)...Access to information Act, 2000*

### **1.8.4. Health Charter**

The health charter was initiated in support of the National Health Act as well as the principles of Batho Pele/Consumer first policy document. The following section outlines the importance of consumer education.

*a) section 10 (e) “ ... ensuring the safety of consumers and the adequate protection of both people and the environment in the use of products and services that may be dangerous to health or life”;*

*b) section 10 (f) “ respecting and observing the right of consumers to information and to be protected against dishonest or misleading advertising and labelling”;*

c) *section 10 (g) "accepting and respecting the power of consumers to choose from a range of products and services offered at competitive prices with the assurance of externally recognised and accepted standards of quality;"*

d) *section 10 (h) "recognising the right of consumers to fair compensation for misrepresentations by providers of goods and services, for the failure of goods and services to adequately address the health needs of consumers and the failure to comply with externally recognised and accepted standards of safety, quality and efficacy;"*

#### **1.8.5. Consumer Protection Act, No 68 of 2008**

The Consumer Protection Act is a valuable and critical piece of complementary legislation, in the context of the medical schemes and CMS. In particular, the provisions concerning the duty to communicate clearly and in plain understandable language, strengthens the provisions of concerned in section 57 of the Act in this regard. However there are a number of areas where the function of the Consumer Commission overlap with those of CMS, particularly in the sphere of Complaints Adjudication and in this regard the CMS has taken steps to seek exemption from the provisions of the CPA.

These are some of the fundamental principles in relation to the Medical Schemes Act. The most important one being the consumer's right to information in plain and understandable language, as provided for in;

*section 22 ... to be produced, provided or displayed to a consumer must produce, provide or display that notice, document or visual representation—*

*(a) in the form prescribed in terms of this Act or any other legislation, if any, for that notice, document or visual representation; or*

*(b) in plain language, if no form has been prescribed for that notice, document or visual representation.*

*section 22 (2) provides that: For the purposes of this Act, a notice, document or visual representation is in plain language if it is reasonable to conclude that an ordinary consumer of the class of persons for whom the notice, document or visual representation is intended, with average literacy skills and minimal experience as a consumer of the relevant goods or services, could be expected to understand the content, significance and import of the notice, document or visual representation without undue effort, ...*

*section 8 - Right to Equality*

*section 11 - Right to Privacy*

section 13 - *Right to Choose*  
section 23 - *Disclosure of price of goods or services*  
section 29 - *Right to fair and responsible marketing*  
section 40 - *Right to fair and Honest dealing*  
section 55 - *Right to fair value, Good Quality and Safety*  
section 62 - *Right to accountability from suppliers*

#### **1.8.6. Promotion of Access to Information Act, 2 of 2000**

*The objects of this Act are—*

*to give effect to the constitutional right of access to any information held by the State; and any information that is held by another person and that is required if or the exercise or protection of any rights;*

As can be observed above, consumers have the right to access to accurate and relevant information regarding their health, the products they are buying as well as the pricing of those products. The manner in which the information is presented to the consumer must be user friendly preferably using layman language in order to empower consumers.

## **2. ROLE OF STAKEHOLDERS IN THE MEDICAL SCHEMES INDUSTRY**

### **2.1. Council for medical schemes**

CMS is an organ of state that regulates medical schemes, brokers, administrators and managed health care organisations in South Africa. One of its strategic objectives is to ensure an appropriate level of protection for the beneficiaries of medical schemes.

Medical Schemes are private not for-profit entities that collect set contributions from members and facilitating payment of expenditure incurred whilst accessing health care services in line with the Medical Schemes Act. For a medical scheme to operate legally, it has to be registered by Council in terms of Section 24(2)(e) of the Medical Schemes Act which provides that;

*No medical scheme shall be registered under this section unless the Council is satisfied that the medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health.*

## **2.2. Administrator**

*Any person who has been accredited by Council in terms of section 58...* Administrators are not medical schemes however; they can carry administration functions delegated by the medical schemes in terms of the Medical schemes Act. In instances where member communication has been delegated, the administrator has to comply with section 22 of the Consumer Protection Act.

## **2.3. Broker Services**

- (a) services or advise in respect of the introduction or admission of members to a medical scheme; or*
- (b) the ongoing provision of services or advise in respect of access to, or benefits or services offered by, a medical scheme.*

The broker's role is to sell health care cover to prospective members and it is essential that brokers are able to communicate in a language that members can understand and also explain the benefit options available that will suite the member's health needs.

## **3. THE ROLE OF THE CUSTOMER CARE**

### **3.1. The role of the Council for Medical Schemes Customer Care Centre**

As part of ensuring member protection, the CMS has a contact centre whose role is to ensure that within the first contact with CMS, customers get the appropriate assistance. The call centre agents are required to be pro-active; this extends to the use of preferred mode of communication.

Most importantly, the member must be offered the right to choose their preferred language to communicate in. It is essential for the call centre agents to have the understanding of the member rights and legislation.

### **3.2. The role of a medical schemes contact centre**

It must be easily accessible whether by telephone, fax, email and other reasonable alternatives that the member might require. In order to communicate effectively and efficiently a call centre agent is preferred to able to:

- 3.2.1. accommodate members who prefer communicating in an alternative language in addition to their chosen medium of communication.
- 3.2.2. simplify technical aspects of the product terminology, legislation and registered medical scheme rules.
- 3.2.3. understand and inform the member of their standard operating procedures including the applicable timelines
- 3.2.4. understand the registration process for the different healthcare programmes offered by the medical scheme; as outlined in paragraph 11 of this document
- 3.2.5. understand and have knowledge of PMBs; CDLs; formularies and the list of DSPs and their use and how they can be accessed as detailed in paragraph 11 of this document
- 3.2.6. have knowledge of non-PMB chronic medicine covered by the different options.
- 3.2.7. Any clinical matter that the call centre agent is unable to deal with must be escalated to the medical scheme's clinician. Furthermore, the member's clinician must be allowed contact with the medical scheme's clinician when seeking clarity and guidance on clinical matters.

#### **4. DIFFERENT TYPES OF BENEFIT OPTIONS**

A benefit option is an offering or package of benefits that a member may choose to enrol, which is supplementary to the common benefits of a medical scheme as contemplated in section 29(1)(r) of the Medical Schemes Act. There are a number of benefit options in the industry that a medical schemes may choose to offer depending on their target market and health needs of their market. The following are some of the common benefit structures available on the market:

##### **4.1. A traditional option**

This type of benefit option provides a comprehensive range of medical benefits cover with out of hospital benefits, chronic medication and hospitalisation.

##### **4.2. New generation option**

This benefit option offers comprehensive hospital cover benefits with deductibles on the out of hospital / day-to-day benefit cover. This type of benefit option is characterised by a medical savings account which might also include above threshold benefits with a self payment gap (out of pocket payments).

### **4.3. Hospital plan**

This type of benefit option covers hospital benefits only. Therefore, any expenses incurred for out-of-hospital non-PMB benefits are excluded from cover. Consequently, all PMBs for both in-hospital and out-of-hospital are covered in full.

### **4.4. Capitation arrangement**

It is an agreement between a medical scheme and a service provider in which money is paid directly to the service provider and costs are calculated on a per member per month (p.m.p.m) basis. This arrangement allows a medical scheme to transfer risk to a service provider.

## **5. GENERAL RULES**

### **5.1. Responsibilities of a member:**

**5.1.1.** To provide the medical scheme with all information regarding any treatment, care and diagnosis received in the 12 months preceding the date of application as per section 29A(7) of the Medical Schemes Act.

**5.1.2.** Members are required to familiarise themselves with the scheme rules in order for them to understand their rights, responsibilities and benefit entitlement. (Refer to paragraph 8.3 which indicates when and how to access a copy of the medical scheme rules).

**5.1.3.** Members are required to continuously update their status of beneficiaries with the scheme. For example when a child or any other dependant is no longer eligible to be a dependant, the member has to notify the scheme to remove such dependant as a dependant. Members should be familiarised with the scheme's membership eligibility provisions, particularly as it relates to restricted scheme membership and the basis for continuation membership after retirement. Members should similarly be advised of their rights to statutory rights towards continuation membership after retirement or due to retirement as a result of ill health and moreover, the rights of dependants to continuation membership after the death of the main member.

**5.1.4.** In terms of section 28 of the Medical Schemes Act, a member or dependant may only belong to one scheme at a given time.

For further reading follow the link:

[http://www.medicalschemes.com/files/CMS%20News/CMSNews3Of2009\\_2010\\_20100419.pdf](http://www.medicalschemes.com/files/CMS%20News/CMSNews3Of2009_2010_20100419.pdf)

## **5.2. Forms completed by a broker on behalf of a prospective member and assistance granted to clients to enable them to complete forms:**

In instances where a broker completes a form on behalf of the member and material information is not disclosed as the member directed, the member and not the broker will be liable since members are legally required to read understand and be made aware of the information disclosed in the application forms before they sign such applications. The application document should make this fact very clear in a BOLD format.

Broker needs to provide the member with adequate information, e.g. waiting period, disclosures and further explain what a pre-existing condition is prospective applicant should sign Brokers are not in a position to make any commitments to clients in which he/she binds or attempts to bind the scheme in any matter where a discretionary power resides with the scheme such as the application of waiting periods or late joiner penalties.

## **5.3. Access to benefits**

PMBs cannot be limited due to non-registration on the managed care programme. It is the responsibility of the medical scheme to educate the member on the benefits of registering in the managed care programme; therefore, alternative means to encourage members to register in managed care programs must be used.

However, a medical scheme may in terms of Regulation 8(4), employ appropriate interventions to improve the efficiency and effectiveness of health care provision, including pre-authorisation, application of treatment protocols and the use of formularies.

## **5.4. Confidentiality**

The study undertaken by CMS in 2004 outlined that sharing of beneficiary personal information among healthcare workers is only allowed under the following circumstances:

- 5.4.1.** when a member gives explicit permission
- 5.4.2.** if it is done legally

Medical schemes should therefore make provision on their application forms for a patient to give permission for the sharing of confidential information between the provider and the scheme.

## **5.5. When does membership end?**

Members are allowed to resign from the scheme anytime during the year by submitting written notice to their medical scheme. However, a member is required to serve notice period according to the registered rules of the scheme. At most a three month notice would be applicable. A member serving a notice period is still entitled to receive benefit cover until the last day of their notice period.

## **5.6. Membership certificate**

The Medical Schemes Act provides the following in this regard:

*Regulation 3(2): A medical scheme must, within a period of 30 days of the termination of membership or at any time at the request of any former member, or dependant, provide that member or dependant with a certificate, stating the period of cover, type of cover and whether or not the person qualified for late joiner penalty.*

*Regulation 3(3): A copy of the certificate contemplated in subregulation (2) must be forwarded on request to any medical scheme to which the former member or dependant subsequently applies for membership.*

## **5.7. Cancellation of membership**

Member's membership may also be cancelled by a medical scheme as per section 29(2) which provides that a member's membership will be terminated or suspended when:

- a. *failure to pay contributions, within the time allocated in the scheme rules...;*
- b. *submission of fraudulent claims;*
- c. *committing of any fraudulent act; or*
- d. *the non disclosure of material information.*

## **5.8. PMBs and non-PMBs chronic benefits**

PMBs have to be covered at cost (the price which the service provider charges) as contemplated in regulation 8 of the Medical Schemes Act subject to adhering to the applicable clinical protocols and DSPs unless a beneficiary involuntarily uses a non-DSP or clinical protocols that are outside their benefit option.

As contemplated in section 29(1)(o), all benefit options in a medical scheme must provide for PMBs and they must be covered at cost subject to compliance with the set clinical protocols and use of DSPs.

## **5.9. Payment of PMBs from Medical Savings Accounts**

The Act does not allow for PMBs to be paid from the personal savings account (PMSA)/ medical savings account (MSA).

## **5.10. Changes on the formulary list**

Due to the high frequency of changes relating to the medical schemes formulary list, only affected members may be informed of the changes for example changes in the formulary for hypertension medicine should be communicated to patients who will be influenced by the changes i.e. those that are utilizing the medicines

that was altered or for which the benefits was altered. For example, changes in the formulary for hypertension medicine should be communicated to patients who will be influenced by the changes that is, only those beneficiaries that are utilizing the medicine that has been altered or for which the benefits have been altered. Member access to medical schemes:

Unless a medical scheme is a restricted medical scheme, as contemplated in section 24(2)(e) of the Medical Schemes Act, which provides that, *medical schemes are not allowed to unfairly discriminate directly or indirectly against anyone or one or more on arbitrary grounds...*, open enrolment applies.

### **5.11. Authorization, pre-authorization and payment of accounts**

It is important to inform members that authorisation does not guarantee payment of subsequent claims and medical schemes must clearly state benefits that require pre-authorization; for example hospitalization; day clinic admissions; special procedures etc

**5.11.1.** process to be followed to obtain pre-authorization:

**5.11.2.** the number to be contacted; who to contact once an authorization number is received, what is expected of the beneficiary.

**5.11.3.** beneficiary have to know what happens once they are admitted, are there other processes to be followed?

**5.11.4.** accessibility of details on DSPs and verification of service providers as DSPs.

For more information on PMBs, follow the link below for the document on *Code of Conduct in respect of PMB benefits* :

[http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/CodeOfConduct\\_20100803.pdf](http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/CodeOfConduct_20100803.pdf)

### **5.12. Joining a medical scheme**

The process to apply for membership must be clearly outlined and all the relevant information and applicable forms must be easily accessible to a prospective member. Once an application for membership is approved, the following must be provided in terms of regulation 3 of the Medical Schemes Act:

*regulation 3(1) - Every medical scheme must issue to each of its members, written proof of membership containing at least the following particulars-*

(a) *The name of the medical scheme;*

(b) *The surname the first name, other initials if any, gender, and identity number of the member and his or dependants;*

(c) *The membership number;*

- (d) *The date on which the member becomes entitled to benefits from the medical scheme concerned;*
- (e) *If applicable, details of waiting periods in relation to specific conditions;*
- (f) *If applicable, the fact that rendering of relevant health services is limited to a specific provider of service or a group or category of providers of services; and*
- (g) *If applicable, a reference to the benefit option to which the member is admitted.*

It is important for a prospective member to be made aware that their new membership may be subject to waiting periods and late joiner penalties in terms of section 29A and regulation 13 of the Act respectively.

#### **5.12.1. When may a medical scheme impose waiting periods**

Waiting periods may be applied when a prospective member has had a break in membership of more than 90 days. This implies that:

**5.12.1.1.** during this period, a member will contribute to the scheme but you will not be able to claim any benefits for this period of three months; furthermore

**5.12.1.2.** A pre-existing medical condition is a condition which was diagnosed in the last 12 months and care and/or treatment in the last 12 months, related conditions may not be included in the waiting period.

**5.12.2.** The following waiting period may apply if prospective members have had a break in membership for less than 90 days of a medical scheme when making application and has less than 24 months in medical scheme coverage:

**5.12.2.1.** A condition specific waiting period of twelve (12) months may be imposed which you may not claim benefits for but you may be covered for PMBs.

**5.12.2.2.** Similarly, if you did not serve the full twelve (12) months waiting period on the previous scheme (8 months), the new scheme may request you to carry-out the remainder of this period (4 months).

**5.12.3.** When a prospective members has had a break in membership of less than 90 days when making application and has more than 24 months in medical scheme coverage, the following waiting period will apply:

**5.12.3.1.** A three (3) months waiting period may be imposed on non-PMB conditions.

## **6. WHAT IS A PERSONAL MEDICAL SAVINGS ACCOUNT (PMSA)**

A PMSA is a savings account held by a member's medical scheme to which a certain percentage of a member's contribution is paid on a monthly basis which can only be used to defray health care expenditure. These funds

are trust monies held on behalf of the member by the medical scheme and do not form part of scheme assets.

The following is how it is utilised:

From the beginning of the year, a medical savings account is credited with a percentage of a member's contribution, as determined in the medical scheme rules. Medical savings fund may be made available to a member on a month to month basis as the contributions are received or it may be prospectively made available to a member that is, a full year's savings funds are made available on 1 January of each year.

When a member joins a medical scheme during the course of a year, their medical savings funds will be pro-rated. This means that your benefit limits will be calculated in proportion to the period of membership left for the year from your date of joining. Regulation 10(3) of the Medical Schemes Act provides the following:

*Funds deposited in a member's personal medical savings account shall be available for the exclusive benefit of the member and his or her dependants but may not be used to offset contributions, provided that the medical scheme may use the funds in a member's personal medical savings account to offset debt owed by the member to the medical scheme following that member's termination of membership of the medical scheme.*

Regulation 10(6) provides that - *The funds in a member's personal medical savings account shall not be used to pay for the costs of a prescribed minimum benefit.*

### **6.1. Accumulated savings account**

Unused (accumulated) credit balances in the person medical savings account will be carried over year on year.

### **6.2. When can the PMSA funds be paid out to a member**

Accumulated/ credit balances in the MSA will be refunded after the specific period in terms of the medical scheme rules after termination and according to the regulations. Regulation 10 provides the following:

*Reg 10(4) Credit balances in the member's personal medical savings account shall be transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be, when such a member changes medical schemes or benefit options.*

*Reg 10(5) Credit balances in a member's options or medical savings account must be taken as a cash benefit, subject to applicable taxation laws, when the member terminates his or her membership of a medical scheme or benefit option and then-*

*a enrolls in another benefit option or medical scheme without a personal medical savings account; or*

*b does not enrol in another medical scheme.*

Follow the link below for the PMB code of conduct:

[http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/CodeOfConduct\\_20100803.pdf](http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/CodeOfConduct_20100803.pdf)

## 7. HOW TO CALCULATE PREMIUM PENALTIES FOR PERSON JOINING LATE IN LIFE

The Medical Schemes Act allows medical schemes to impose a penalty on an applicant who joins a medical scheme for the first time from the age of 35 or an individual who has had a break of three consecutive months.

On calculating the premium penalty, the age on date of application and creditable coverage have to be taken into consideration. This penalty can be applied on prospective members who are the age 35 and older.

Regulation 13(2)

<b>Penalty Bands</b>	<b>Maximum penalty</b>
<i>1 – 4 years</i>	<i>0,05 x contribution</i>
<i>5 – 14 years</i>	<i>0,25 x contribution</i>
<i>15 – 24 years</i>	<i>0,50 x contribution</i>
<i>25+ years</i>	<i>0,75 x contribution</i>

Example:

David aged 65 (65) applied to join Medical Scheme A with effect from 1 June 2011. He was previously on Medical Scheme B 1 June 1971-1981, Medical Scheme C 1981-1990. The total standard premium is R2 500 which consist of Risk = R2 000 and PMSA = R500.

David's age is 65.

Creditable coverage is 19 years (number of year of cover by a medical scheme)

David's Age minus late joiner cut-off age equals to number of year to proof creditable coverage to avoid a LJP.

$$A = B - (35 + C)$$

Where:

A = penalty band

B = applicants age at time of application in years

C = years of creditable coverage

$$A = 65 \text{ years} - (35 + 19 \text{ years})$$

$$A = 11 \text{ years not covered}$$

Therefore penalty band of 5 – 14 years which is 25% of contribution penalty

**NOTE: The penalty is only calculated on Risk.**

25% of R2 000 = R500 (penalty)

David's premium = Risk + MSA + Penalty

= R2 000 + R500 + R500

= R3 000

## **8. GENERAL INFORMATION TO BE PROVIDED TO THE MEMBERS**

The following are minimum requirements that must be contained in communication going out to the members of medical schemes:

### **8.1. How to lodge a complaint with CMS?**

Section 47 of the Medical Schemes Act provides the following:

*(1) The Registrar shall, where a written complaint in relation to any matter provided for in this Act has been lodged with the Council, furnish the party complaint against with full particulars of his or her written comments thereon within 30 days or such further period as the Registrar may allow*

The Act allows members to lodge their complaints directly with the CMS. However, members are encouraged to explore the scheme's dispute resolution process prior to lodging their complaints with the CMS. Dispute

### **8.2. Resolution at scheme level**

**8.2.1.** A complaint can be lodged in terms of the medical scheme rules to an independent disputes committee

**8.2.2.** Information regarding dispute resolution has to be communicated to members

**8.2.3.** Members are entitled to prompt attention to and resolution of complaints

**8.2.4.** Outcome of the dispute must be communicated to the member (scheme level)

**8.2.5.** Clinical dispute resolution – emergency or urgent matter must be accommodated through alternative processes in a manner to have it expedited

### **8.3. Information medical schemes must provide for:**

- 8.3.1.** Publish registered rules on their website. On request by a member of the medical scheme, a hard copy of the registered rules must be provided to the members. New members joining the scheme must be provided with a rule book which includes a full set of the registered rules thereafter members must provided with updates on amendments
- 8.3.2.** Updates on amendments to the rules as and when this happens and written modes of communication can be used for examples; announcements; RSS feed; notification on claims and change in formulary list
- 8.3.3.** Circulate information on rule amendments within 30 days before their effective date
- 8.3.4.** All marketing and educational material must contain the contact details of the contact centre and complaints division of CMS
- 8.3.5.** Website and physical address of CMS
- 8.3.6.** All application forms must the contact details of the contact centre and complaints division of CMS
- 8.3.7.** Medical Scheme details for the contact centre; authorisation; MHO and HMO.
- 8.3.8.** Information on disease management programme including registration
- 8.3.9.** The process by which members can apply or register for PMB coverage and the outcome of the application as mentioned in paragraph 11
- 8.3.10.** Detailed and up-dated formularies, to be made available on request and DSP and network list of hospitals and practitioners made available for information.
- 8.3.11.** Benefits will be pro-rated if your entry date is not the 1st of January. This means that your benefit limits will be calculated in proportion to the period of membership left for the year from your date of joining.
- 8.3.12.** What happens when an annual limit non-PMB medication benefit has been exhausted?
  - 8.3.12.1.** Member is liable for any balance once benefits are exhausted
- 8.3.13.** Between the member and their employer who is liable for ensuring payment of a member's monthly contributions to the medical scheme?
  - 8.3.13.1.** The member remains at all times liable for payment of contributions to the scheme, irrespective whether he/she receives financial assistance from the employer towards a subsidy. An employer subsidy remains a matter between the member and his/her employer
- 8.3.14.** What is the period prior to a non-emergency hospital admission required to notify the medical scheme and what happens if they fail to do?

#### **8.4. When and how to change from one benefit option to another**

- 8.4.1. The rules of the medical scheme would specify the period permissible for members to change from one benefit option to another
- 8.4.2. Generally members need to complete and submit forms for transferring from one benefits option to the next
- 8.4.3. According to with regulation 4(3) of the Medical Schemes Act , members can change options once a year and
- 8.4.4. The registered rules of the medical scheme which will stipulate the notice period required for the change to be effected.

#### **8.5. Medical scheme website must contain**

- 8.5.1. up to date information
- 8.5.2. Registered medical scheme rules
- 8.5.3. Annual audited financial statements and notes thereto
- 8.5.4. Annual report from the BOT
- 8.5.5. Details of designated service providers and contracted parties
- 8.5.6. Contact details and procedures of emergency staff providing authorisation
- 8.5.7. Contact details for the contact centre and complaints unit of CMS, including an explanation of the complaints process.
- 8.5.8. Website and contact details of CMS
- 8.5.9. Detailed and up-to-date protocols and drug formularies.
- 8.5.10. Clinical dispute resolution procedure
- 8.5.11. Dispute resolution procedure

## **8.6. Claims statement must contain the following in terms of Regulation 6(5) and other policies**

- 8.6.1. The name of the medical scheme
- 8.6.2. Member's benefit option
- 8.6.3. Member's name
- 8.6.4. Name of the patient and their beneficiary code as displayed to the membership card
- 8.6.5. Treatment date
- 8.6.6. Date of claim received by scheme
- 8.6.7. Membership number
- 8.6.8. ICD10 code
- 8.6.9. Amount of the claim
- 8.6.10. Amount paid by scheme
- 8.6.11. Name of the healthcare service provider and their practise code
- 8.6.12. Payment date
- 8.6.13. Rejection code including the benefit
- 8.6.14. The pool from which the claim was paid
- 8.6.15. Procedure and procedure code

## **8.7. Medical scheme financial information**

- 8.7.1. Format of summary
- 8.7.2. Regulation 29 (minimum reserve level)
- 8.7.3. Solvency and NAV
- 8.7.4. Regulation 30 - Limitations on assets- Annexure B
- 8.7.5. AFS

For more detail information on summarised financial statements and Annual Financial Statements (AFS), follow the following links:

[http://www.medicalschemes.com/files/Circulars/Circular\\_38\\_of\\_2007.pdf](http://www.medicalschemes.com/files/Circulars/Circular_38_of_2007.pdf)

[http://www.medicalschemes.com/files/Circulars/Circular23Of2009\\_20090827.pdf](http://www.medicalschemes.com/files/Circulars/Circular23Of2009_20090827.pdf)

## **8.8. Medical schemes can be joined with no conditions attached**

In terms of section 21A (3) of the Medical Schemes Act 131 of 1998:

*It is an offence to market, advertise or in any other way promote a medical scheme in the manner likely to create that membership of such medical scheme is conditional upon a applicant purchasing or participating in any product, benefit or service provided by a person other than the medical scheme in terms of its rules.*

### **8.9. Demarcation / Gap cover:**

Membership of a medical scheme or participation in a benefit option cannot be on condition that a member purchases any unrelated cover or products such as insurance policies, be it health or gap cover, funeral or travel or life insurance, membership of any other product or commodity such as gym membership. Such products are to be marketed and sold separately and also paid for independently from medical scheme contributions.

### **8.10. At least the following information must be included in marketing materials**

- 8.10.1.** all relevant contact details for example, physical and postal address, telephone and fax numbers and website address of the medical scheme
- 8.10.2.** applicable contribution tables
- 8.10.3.** benefits covered under each benefits option
- 8.10.4.** list of CDLs and non-PMB chronic conditions covered for all benefit options
- 8.10.5.** PMB benefits and the DSPs
- 8.10.6.** limitations and exclusion list
- 8.10.7.** Co-payment
- 8.10.8.** How formularies can be accessed

## **9. MEDIUM OF COMMUNICATION**

Medical schemes are required to use a reasonable medium to disseminate information depending on their member profile for example accommodates members with disabilities like the deaf and blind. In other words medical schemes are required to make provision for reasonable member choice bearing in mind the related cost implication.

## 10. LANGUAGE AND TONE

10.1. All communication and correspondence to members and prospective members should be in plain and simple language in terms of the Consumer Protection Act (CPA).

10.2. Verbal communication of the scheme's call centre staff should preferably be at the level of the caller, whether an illiterate member or a brain surgeon. The tone should be professional, accommodating, clear, firm but sincere.

10.3. All parties including medical schemes, members, prospective members and stakeholders must use the communication modes available in a manner that would not be considered as harassment, intimidation or to annoy others. Instead, those modes should be used for educational purposes and access of to information.

10.4. In the spirit of fairness and equality as envisaged in the constitution, ambiguity in language, written or verbal, should be avoided.

## 11. MODES OF COMMUNICATION

A medical scheme may for example choose English as their preferred medium of communication. They are required to reasonably accommodate their members in instances where they prefer to communicate in any of 10 other official languages. Furthermore, written information must also be made available in different languages.

### 11.1. Various modes of communication medical schemes may use

- 11.1.1. letter (post-hard copy & electronic)
- 11.1.2. newspaper
- 11.1.3. magazines
- 11.1.4. billboards
- 11.1.5. promotional material (flyer, pamphlets / z-fold cards, etc)
- 11.1.6. CD / DVD
- 11.1.7. SMS
- 11.1.8. e-mail
- 11.1.9. social network
- 11.1.10. radio
- 11.1.11. TV

## **11.2. Social network**

Only in addition to formal communication stipulated above, social networks can be used to provide information update regarding amended rules; announcements; notification on claims; DSP information and change in formulary list

**11.2.1.** SMS

**11.2.2.** Twitter

**11.2.3.** Facebook

**11.2.4.** Blackberry massaging

## **12. FREQUENCY OF COMMUNICATION**

The frequency of communication to members would vary based on periods of peak activity that a medical scheme typically goes through. On average, a medical scheme would send out information leaflets twice in a year, new members would receive relevant information which would assist them in clarifying the benefit entitlement, and generally medical schemes would forward to members information regarding benefits and contribution changes at a last quarter of the year. This allows members to be informed about their benefit entitlements for the next year. Communication intervals may be as follows:

**12.1.** Annually through an annual general meeting (AGM), quarterly, monthly or weekly

**12.2.** on joining of the scheme

**12.3.** whenever changes are made that directly affect members' benefits

## **13. LEVEL OF INFORMATION TO BE PROVIDED AT ALL TIMES TO ENSURE FAIR TREATMENT OF MEMBERS**

Any information provided to members may not differ from the registered scheme rules and all advertising and promotional material should be not misleading. However the broad principles of managed care (where applicable) must be communicated to members and know what their health needs are.

Medical schemes are required to ensure the following accurate information is available to all beneficiaries and providers. There is however responsibility on the part of the beneficiaries to familiarise themselves with the ways in which to navigate the PMBs.

**13.1. The following information must be clearly outlined:**

- 13.1.1. adequate information must be provided to allow the members to take informed decision when decided which medical scheme or option to join and if already a member of a particular medical scheme which option to choose that would suite a members changed health status.
- 13.1.2. any relevant underwriting information.
- 13.1.3. the call-centre must be equipped with accurate and up-dated information and have the basic knowledge of the medical scheme's DSPs, how to access information regarding formularies, application forms and limitation and exclusions; as outlined in subparagraph 3.2 of this document.
- 13.1.4. the process to make a "clinical appeal"
- 13.1.5. chronic conditions for which a member is registered and for which treatment is covered
- 13.1.6. Claims statement and medical scheme financial information as discussed in paragraphs 8.2 and 8.5 respectively.

**13.2. Process of application for medical scheme membership:**

- 13.2.1. where to get the enrolment form and which sections on the form are compulsory to complete
- 13.2.2. the required supporting documentation
- 13.2.3. how to submit an application form to a medical scheme?
- 13.2.4. where to sent completed registration form (e-mail; fax or postal address)
- 13.2.5. applicable time lines for processing an application and feedback on an application status
- 13.2.6. Application to managed care programmes

**13.3. The process by which members can apply for registration for CDLs and PMB coverage must be clearly outlined and at least include the following information:**

- 13.3.1. why it is important for a beneficiary to be registered for chronic medication
- 13.3.2. what happens when a beneficiary is not registered for chronic medication
- 13.3.3. who should be registered for chronic medicine; does each dependant on the member's medical scheme need to apply separately for chronic medication and how many times does a beneficiary have to apply for the medication.
- 13.3.4. in addition to the beneficiary, who else must complete and sign the registration form when applying for chronic medication
- 13.3.5. any additional documents required to support the application must be specified
- 13.3.6. where to sent completed registration form (e-mail; fax or postal address)
- 13.3.7. indicate how beneficiaries would know that their application has been approved and what happens once a beneficiary's application is approved
- 13.3.8. process to be followed when a registered beneficiary updates any modification to the chronic authorisation?
- 13.3.9. how to access chronic medication from the chronic DSP?
- 13.3.10. what happens if a doctor changes a beneficiary's medication in the middle of the month?
- 13.3.11. what happens if a beneficiary uses a provider of their choice instead of the medical scheme's DSP to get their chronic medication?
- 13.3.12. what happens when a member uses medication that is not on the formulary list for their particular benefit option?
- 13.3.13. can a beneficiary receive benefits for more than one month's supply of medication and the procedure to apply.
- 13.3.14. the list of DSP location and contact details of DSPs list, must be easily available be it in the electronically, as a hard copy or telephonically;
- 13.3.15. what will be covered on the claims in the event that a member does not make use of the DSPs or baskets of care. The beneficiary has to know the applicable co-payments in instances where beneficiaries voluntarily use non-DSP or out of formulary medicine;
- 13.3.16. the applicable process and procedure to be followed if there are no available services or beds within the DSP at the time of request, and where such clinical services should be obtained by the member. Furthermore, the obligations of the scheme to ensure that the member is facilitated in obtaining those services from an alternative service provider and that such facilitation should be timeously done and with due regard to the member's clinical needs

**13.4. Applicable costs for all the benefit structures:**

- 13.4.1. full details of the costs of the benefit cover
- 13.4.2. details of any fees, co-payments and deductible other than the relevant member contribution

**13.5. Marketing material on benefit option:**

- 13.5.1. all benefit options offered by the scheme offer
- 13.5.2. what happens to unused benefit limits from the risk pool and MSA funds
- 13.5.3. details on the level of cover and type of benefits covered offered for each benefit option
- 13.5.4. all restrictions or exclusions
- 13.5.5. applicable contribution tables
- 13.5.6. benefits covered under each benefits option
- 13.5.7. list of CDLs and non-PMB chronic medication
- 13.5.8. PMB benefits and the DSPs
- 13.5.9. limitations and exclusion list

**13.6. Authorisation:**

Members must be provided information on what authorization is and what it means, for example authorisation does not necessarily guarantee that the account will be paid. Information required for authorisation must be clearly stated, for example, the following are some of the information that could be required:

- 13.6.1. membership number
- 13.6.2. details of the patient (name and surname, ID number, etc.)
- 13.6.3. reason for the procedure or hospitalisation
- 13.6.4. diagnostic codes (ICD-10 codes), tariff codes and procedure codes (to be obtain from your attending service provider)

**13.7. Important contact details:**

- 13.7.1. name, practice number and contact details of the attending provider (doctor and/ or specialist)
- 13.7.2. name and practice number of the day clinic or hospital.
- 13.7.3. stipulate applicable timeframe to pre-authorise for both emergency and non-emergency cases
- 13.7.4. what penalty is applicable in instances where authorisation was not obtained for non-emergency cases.
- 13.7.5. physical and postal address, telephone and fax numbers and website of the medical scheme
- 13.7.6. telephone and fax numbers of the administrator and managed healthcare
- 13.7.7. telephone and fax numbers for members general enquires
- 13.7.8. call centre fax and telephone numbers; email address for enquiries
- 13.7.9. lodging of complaints: fax, telephone numbers and/or email address
- 13.7.10. chronic medicine: fax, telephone numbers and/or email address
- 13.7.11. preauthorisation for Hospital: fax, telephone numbers and/or email address

**14. CONCLUSION AND RECOMMENDATION**

This review depicts the challenges that beneficiaries and service provider have to abide by due to lack of appropriate, adequate and updated information which is presented in a simplistic manner for the benefit of a layperson. Furthermore, it demonstrates the unnecessary financial strain that the beneficiaries have to incur and the challenges relating to understanding their benefits entitlement.

Therefore, this document illustrates the urgent need to place emphasises on promoting access to appropriate information by streamlining communication in order to ensure a standardised way of communicating to the members.

## 15. REFERENCES

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- 15.5. The National Health Act 61 of 2003; 2008. A Guide
- 15.6. The Charter of the Public and Private Health Sectors of The Republic Of South Africa
- 15.7. Consumer Protection Act, No 68 of 2008
- 15.8. Promotion of Access to Information Act, 2 of 2000
- 15.9. Council for Medical Scheme; 2004. Fair Treatment Project; draft document
- 15.10. Council for Medical Scheme; 2010. Code of Conduct in Respect of PMB Benefits
- 15.11. Medical schemes marketing material for sampled schemes

## **ANNEXURE A**

### **GLOSSARY**

#### **Active ingredient (substance)**

The main substance in a medicine that is responsible for the clinical action on a human.

#### **Acute medication**

Medicine prescribed for an acute illness or condition to relief symptoms for example antibiotics and pain killers for headache.

#### **Additional chronic disease list (ACDL)**

Chronic diseases in addition to those that appear in the legislated list of 27 diseases, for which the scheme provides chronic medication benefits.

#### **Additional disease list (ADL)**

An additional list of conditions covered by scheme

#### **Adult dependant**

A dependant who is 21 years or older.

#### **Agreed tariff**

Sometimes a fund has agreements with preferred providers, such as doctors and/or hospitals, where specific tariffs have been negotiated.

#### **Ambulance services**

This includes all medically equipped transport like ambulances or helicopters utilized for medical emergencies.

#### **AT (Agreed Tariff)**

Your medical scheme might have agreements with DSP's (Designated Service Providers) / Preferred Service Providers. The AT is the tariff that the involved parties agreed upon.

### **Beneficiary**

A principal member or a person registered as a dependant of the member

### **Benefits**

The amount payable for medical services provided in terms of the Rules to a member, whether for himself or in respect of his dependant.

### **Benefit limits**

The maximum treatment / amount payable for a specific benefit.

### **Branded/patented medicine**

Pharmaceutical companies incur high costs for research and development before a product is finally manufactured and released into the market. To recover these costs, the company is given the patent right to be the only manufacturer of the specific medicine brand for a number of years. Medicine without generic equivalents.

**“Broker”** means a person whose business, or part thereof ,entails providing broker services, but does not include-

An employer or employer representative who provides services or advice exclusively to members of that trade union; or

A trade union or a trade union representative who provides services or advice exclusively to members of that trade union; or

A person who provides services or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of a medical scheme,

Unless a person referred to above elects to be accredited as a broker, or actively markets or canvasses for membership of a medical scheme;

### **Cancer treatment**

[See "Oncology"]

### **Capitated services**

Clinical and/or administrative services provided by preferred providers which are paid for on a member per month basis and delivered up to limits specified in contracts with the preferred provider concerned

### **Catastrophic expenditure**

Expenditure at such a high level as to force households to reduce spending on other basic goods (e.g. food or water), to sell assets or to incur high levels of debt, and ultimately to risk (further) impoverishment

### **Chronic Disease List (CDL)**

A sickness condition, in terms of Annexure B of the regulations to the Act. The regulations list consist of 27 chronic conditions that makes up the chronic disease list. Medical schemes may add on top of the 27 CDL.

### **Chronic diseases**

These are illnesses or diseases requiring medicine for prolonged periods of time. The Medical Schemes Act provides a PMB (Prescribed Minimum Benefit) listing the minimum chronic conditions your medical scheme should cover under law. With reference to this list, your medical scheme compiles its own list of approved chronic diseases that it will cover – for example high blood pressure, diabetes or cholesterol.

[See "Chronic medicine" and "Chronic medicine benefit"]

### **Chronic medicine**

Medicine prescribed by a medical practitioner for an uninterrupted prolonged period of time. This medicine is used for a medical condition that appears on your scheme's list of approved chronic conditions. [See "Chronic diseases" and "Chronic medicine benefit"]. It should however be noted that not all conditions necessitating treatment for more than three months can be termed chronic conditions, some acute conditions may also last a few months.

### **Chronic medication programme**

A programme adopted by the scheme for the management of claims in respect of medicine used by beneficiary on an ongoing basis or for an incurable /life-threatening disease, by applying principles for clinical appropriateness and cost-effectiveness.

## **Claim**

After you've received medical treatment, you or the service provider (the doctor or hospital) submits a claim to your medical scheme to request payment of the bill. Usually you can wait for your scheme to pay out the claim, or you can pay the bill from your own pocket and then claim the amount back from your scheme.

## **Clinical Algorithms and Protocols**

A step-by-step problem solving procedure, especially an established to diagnosed and treats illness, considering severity and treatment response.

## **Commencement date**

[See "Inception date"]

## **Community-rated contribution**

A contribution to health insurance calculated on the basis of the insurance claims profile of the entire community or of the insurance scheme, or on the basis of the average expected cost of health service use of the entire insured group rather than of an individual

## **Consultation**

This refers to your visit for treatment to your service provider, like your doctor, specialist, physiotherapist, etc.

## **Contribution**

That is the fixed amount that you are paying monthly to be a member of your medical scheme. You pay a fixed amount for each adult dependant and each minor dependant that is registered under your membership.

## **Co-payment**

A percentage of an admitted claim by a member or a specific amount in relation to such a claim, that the member concerned shall be liable to pay in other words out-of-pocket, partial payment by a health insurance member for health services used in addition to the amount paid by the insurance: the aim is to place some cost burden on members and thereby discourage them from excessive use of health services

### **Cream-skimming or cherry-picking**

The practice whereby an insurance scheme enrolls a disproportionate percentage of individuals (e.g. young people) who present a lower than average risk of ill-health

### **Creditable coverage**

any period during which a late joiner was –

*A member or dependant of a medical scheme*

*A member or dependant of any entity doing the business of a medical scheme which, at the time of membership of such entity, was exempt from the provisions of the Act;*

*A uniformed employee of the National Defence Force, or a dependant of such a employee, who received medical benefits from the National Defence Force: or*

*A member or dependant of the Permanent Force Continuation Fund, but excluding any period of coverage as a dependant under the age of 21 years;*

### **CT and MRI scans**

Special x-rays taken of the inside of your body to try to find the diagnosis and/or treatment.

### **“Curator”**

means a curator appointed under section 56 of the Medical Schemes Act .

### **Day-to-day benefits**

You and your dependants can spend a certain maximum amount of money in a particular year for out-of-hospital expenses. These day-to-day limits can be calculated for overall expenses or expenses that fall into certain categories. [See "Threshold"]

### **Deductible**

The Amount that one must pay (upfront), from your own pocket, to the service providers.

### **Dental benefits**

Depending on the medical scheme option you chose, you can have dental benefits, which can include a wide range of different dental treatments and procedures.

### **Dependant**

As defined in the Act and includes;

A members spouse or partner who is not a registered member of a medical scheme;

A dependent child;

The intermediate family of a member in respect of whom the member is liable for family care and support;

In relation to a dependant other than the member's spouse or partner, a dependant who is not in receipt of a regular remuneration of more than the maximum social pension per month or a child who, due a mental or physical disability, is dependent upon the member; and

Any other person who is recognised by the Board as a dependant for the purpose of these Rules

### **Disease management**

It's a holistic approach that focuses on the patient's disease or condition, using all the cost elements involved. It can include patient counselling and education, behaviour modification, therapeutic guidelines, incentives and penalties and case management. The beneficiary usually has to co-operate with the program in order to receive the benefits.

### **Depth of coverage**

The composition of the health insurance benefit package — the more comprehensive the package, the greater the depth of coverage

### **Designated service provider (DSP)**

A healthcare provider or a group of providers selected by the scheme as a preferred provider to the beneficiaries, diagnoses, treatment and care in respect of or more PMB conditions or any other relevant health service covered by the scheme. This includes selected hospitals, pharmacies, doctors, physiotherapists, pathology and radiology services.

**Effective date**

[See "Inception date"]

**Emergency medical condition**

[See "Inception date"]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 dysfunctions of a bodily organ or part or would place the person's life in serious jeopardy in accordance with the scheme's protocols

**Exclusions**

Medical treatment and/or care not covered by the scheme [Also See "Waiting period (condition specific)"]

**Family**

This is a medical scheme member and his/her dependants.

**Formal sector**

The official sector of the economy, regulated by society's institutions, recognised by the government and recorded in official statistics

**Formulary**

A defined preferred list of medicine used to treat specific diseases.

**General waiting practitioner**

The period in which a beneficiary is not entitled to claim any benefits

**Generic medicine**

Generic medicines are medicines that contain exactly the same active ingredients, strength and formulation as their branded equivalents. The same or another company manufactures these medicines when the patent on the branded product expires. As a result, these medicines are usually much cheaper.

## **HIV/AIDS**

The Human Immunodeficiency Virus is a retrovirus that breaks down the human body's immune system and can cause Acquired Immunodeficiency Syndrome (AIDS). AIDS is a condition where the immune system begins to fail, leading to life-threatening opportunistic infections.

## **Hospital plan**

This type of option covers hospital benefits only. Therefore, no benefits are covered for any expenses incurred on the out-of-hospital benefits unless for PMB conditions.

## **ICD codes**

Inclusion of ICD 10 codes on claims from healthcare providers to medical schemes is a mandatory requirement since 1 January 2005. Every medical condition and diagnosis has a specific code, called the ICD 10 code. These codes are used primarily to enable medical schemes to accurately identify the conditions for which you sought healthcare services. This coding system then ensures that your claims for specific illnesses are paid out of the correct benefit and that healthcare providers are appropriately reimbursed for the services they rendered. It stands for "International Classification of Diseases and related problems".

## **Inception date**

The date on which you become a member of a scheme and your dependants' membership is registered. Your premiums are payable from this date.

## **Late joiner penalty (LJP)**

A penalty which is imposed on an applicant or adult dependant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without break in coverage exceeding 3 consecutive months since 1 April 2001;

## **Major medical benefits**

See "Hospital Plan" Includes all the benefits for services you are insured for, like hospitalization, procedures and treatment you can receive while in hospital.

## **Manage healthcare**

This is any effort to promote the rational, cost-effective and appropriate use of healthcare resources. Usually members only qualify for benefits if they have followed the guidelines and protocols the medical scheme has set out to manage the illness. Example: In the case of oncology treatment, managed healthcare would probably mean that you'd have to join a case management programme. Your doctors and specialists and the specialists from your medical scheme will work together to decide on the most cost effective treatment programme. [Link to "History of managed healthcare"]

Managed health care may assist in appropriate management of conditions with chronic medication including HIV.

## **Mandatory health insurance**

A health insurance scheme to which certain population groups or the entire population must belong by law; such schemes are founded on the principle of social solidarity, whereby individuals contribute to the insurance according to their ability to pay (or their income) and benefit from coverage according to their need for health care

## **Medical insurance**

[See "Hospital Plan"]

## **Medicine class**

Medicine with similar chemical structures or similar therapeutic effects

## **Medical formulary**

This is a list of cost-effective medicines that guides the doctor in the treatment of specific medical conditions. Medicine formularies are continuously checked and updated by medical experts to ensure that they are consistent with the latest treatment guidelines.

## **Medicine exclusion list (MEL)**

This list is specific to a scheme that excludes payment for certain medicines from the acute or chronic benefit for various reasons, unless a PMB.

**Medicine price list (MPL)**

Is a reference pricing system whereby a ceiling price has been allocated to a group of drugs, which are similar in terms of composition, clinical efficacy, safety and quality.

**Member**

Any person who is eligible to be a member of the scheme in terms of scheme rules, and who is registered as such by the scheme

**Minor**

A dependant who is not yet 21 years old. Some schemes also include older students as "minors".

**MMAP (Maximum Medical Aid Price)**

This is the maximum medical aid price that your scheme will pay for the cost of generic medicine, where a generic alternative for branded medicine does exist. Only the cost of the generic equivalent is covered.

**Moral hazard**

The tendency for entitlement to benefits under health insurance to act as an incentive for people to consume more and 'better' health care than they would if they were not covered by insurance.

**National health insurance**

A mandatory health insurance scheme that covers all or most of the population, whether or not individuals have contributed to the scheme.

**Net asset value (NAV)**

Is tangible net asset value

**Network**

An institution or an individual service provider with which the scheme has contracted to obtain specific services according to the to a defined reimbursement structure or When a scheme has negotiated preferential rates with a specific service provider in offering benefits, the list of preferred providers is called the "network". There will

most probably be limited to use the suppliers (like doctors, pharmacies, hospitals) that are registered with this network of providers. [See "Designated Service Provider (DSP)"]

### **Non-prescribed medicine**

[See "Pharmacist Advised Therapy (PAT)"]

### **Oncology**

This field of medicine is included in the treatment of cancer. It can consist of chemotherapy and radiation therapy. If you're a member of a medical scheme, you will probably have to join a disease management programme, of which your oncology treatment will form a part.

### **Benefit Options**

The different products registered by medical schemes, offering members sets of specific benefits.

### **Out-of-pocket payment**

payment made by an individual patient directly to a health care provider, as distinct from payments made by a health insurance scheme or taken from government revenue

### **Overall annual limit (OAL)**

The overall maximum benefit which a member and registered dependants are entitled in terms of the scheme rules, which are calculated annually to coincide with the financial year of the scheme.

### **Over the Counter Drugs (OTC)**

Medication obtained without a prescription at a pharmacy. This includes S0, S1 and S2 medicines ("S" stands for schedule).

### **Personal Medical Savings Account (PMSA)**

A medical savings account held by a member's medical scheme to which a certain percentage of a member's contribution is paid on a monthly basis. When you need day-to-day medical services or supplies, you can pay these from this account. PMSA is also referred to as medical savings account (MSA)

## **Pharmacy Advise Therapy (PAT)**

Most common ailments can be treated effectively by medicines available from your pharmacy without a doctor's prescription. If your medical scheme option offers you a PAT benefit, it means that some of these costs will be paid for by your medical scheme

## **Pre-authorisation**

The process of informing a scheme of a procedure, prior to the event, in order for approval to be obtained.

## **Pre-existing condition**

A condition which medical advice, diagnosis, care or treatment was recommended or received within the twelve month period ending on the date on which an application for membership was made.

## **Preferred provider**

[See "Designated Service Provider (DSP)"]

## **Preferred Provider Network (PPN)**

A provider of service or a group of provider of services contracted to the scheme to deliver quality healthcare services and to participate in the managed healthcare process of beneficiaries.

## **Prescribed Minimum Benefit (PMB)**

The benefits contemplated in Section 29(1)(o) of the Act which consists of the provision of the diagnosis, treatment and care costs of –

Conditions listed in Annexure A of the regulations specified therein; and

Any emergency medical condition.

## **Primary Healthcare Provider**

A primary healthcare provider deals with you and your family's day-to-day healthcare needs – like treating a minor burn. These can include general practitioners (GP's), nurses, oral hygienist, dentist and Allied Health Workers.

## **Private hospital**

Unlike state hospitals, private hospital groups are run as businesses and cost a whole lot more. Although some state facilities are excellent, private hospitals usually offer more luxury and better aftercare. If you're a member of a medical scheme, you will probably receive healthcare in a private hospital.

## **Principal Officer**

A person appointed by the board of trustees (BOT) who is fit and proper to hold office for the scheme.

## **Professional dispensing fee**

A legislated maximum fee that a pharmacist or dispensing doctor may charge for services rendered to dispense medicine.

## **Progressive contribution mechanism**

A financing mechanism whereby high-income groups contribute a higher percentage of their income than do low-income groups

## **Proportional contribution mechanism**

A financing mechanism, whereby everyone contributes the same percentage of income to a health insurance scheme, irrespective of income level

## **Pro-rated benefits**

Some of your medical scheme benefits are given on a calendar year basis, which means that you have an annual limit on them. If you join a scheme on a date other than 1 January, your benefits are calculated pro-rata, which means that you receive a year's benefits in advance. If you exceed your annual limit, you'll have to pay excess costs out of your own pocket.

## **Prosthesis**

A fabricated artificial substitute for a disease or missing part of the body, surgically implanted and shall be deemed to include all components, forming an integral and necessary part of part of the device so implanted and shall be changed as a single unit. This also include the urinary, cardiac and vascular stents and graft, as well as all electronic implantable devices, spinal instrumentation and fixators (including external fixators)

### **Regressive contribution mechanism**

A financing mechanism whereby low-income groups contribute a higher percentage of their income than high-income groups.

### **Restricted medical scheme**

A medical scheme that only employees from a particular or affiliate organisation may belong to.

### **Rejection codes**

A list of codes normally reflecting on the remittance advice indicating reason for payment discrepancies

### **Related account**

Any account / claim related to an approved in-hospital admission other than the hospital account.

### **Risk**

In some cases, your monthly contributions to your medical scheme will be split into two portions – a risk and a savings portion. The risk portion reflects your contribution to benefits that are being paid by the scheme and not from a savings component.

### **Risk underwriting**

when a scheme looks at the application of a group, they will require certain information from the company in order to see what the risk to the scheme will be. Risk factors include the average age of the employees, the pensioner ratio as well as the number of chronic medicine users within the group. Once this information has been established, the scheme can decide what underwriting will be applied to the group with regards to new applicants. [See "Underwriting"]

## **Risk-equalisation**

A mechanism whereby revenue accruing from contributions to several health insurance schemes or health funds acting as financing intermediaries (i.e. organisations that receive contributions and pay health care providers) for a social health insurance system is pooled and the individual schemes allocated an amount which reflects the expected costs of each scheme according to the overall ill-health risk profile of its membership

## **Risk-rated contribution:**

The contribution an individual or group pays to an insurance scheme adjusted to the level of the individual's or group's risk of illness, expected future cost of health care use or past claims experience

## **SAMA rates (South African Medical Association)**

This is the tariff structure that the South African Medical Association deems to be appropriate for their members (doctors and specialists). It is a guideline for doctors in private practice regarding what fees they may charge for their services. [See "BHF rates" and "NHRPL"]

## **Scheme rate / tariff**

The rate that the scheme sets for paying healthcare professionals.

## **Self payment Gap**

The gap (monetary) between the maximum benefits reach and the starting point of the threshold benefits

## **Shared limit**

A shared limit of a benefit amount which applies to two or more benefit categories for example a shared in- and out -of hospital benefits for Advance Radiology. Where one benefit (in hospital) limit has been reached, the other (out-of-hospital) benefit will be exhausted.

## **Single exit price (SEP)**

The price set by the manufacturer or importer of a medicine or scheduled substance, combined with the logistics fee and VAT, as regulated in terms of the Medicine and Related Substances Act, 1965 (Act no 101 of 1965) as amended.

**Spouse**

The person you are married to under any law or custom that is recognized by South African law.

**Social health insurance**

A mandatory health insurance to which only certain groups (frequently formal sector employees) are legally required to subscribe or which provides benefits only to those who make insurance contributions

**Start date**

[See "Inception date"]

**Supplier-induced demand**

Where more services are provided than are 'clinically necessary', such as more than necessary diagnostic tests or more frequent than necessary repeat 'checkups' visits where these services are initiated by the health care provider; frequently linked to fee-for-service payment mechanism, which provides an incentive for providers to deliver as many services as possible to generate more income.

**Termination of membership**

The cancellation / end of being a member of the scheme

**The Bill**

It refers to the Medical Schemes Act of 1998. This act stipulates your rights as a medical scheme member. The Bill and the regulations there under are amended or replaced from time to time.

**Threshold**

On some medical scheme options, you pay for your day-to-day medical expenses from your medical savings account or from your own pocket, until your claims reach a certain limit. Once your day-to-day expenses have reached that fixed rand amount, for example, R5 000, (your "threshold"), your medical scheme kicks in and will pay further claims up to a certain limit.

### **Treatment taken out-Medication (TTO)**

The medication that is required to take home but is prescribed to the beneficiary whilst in hospital.

### **Voluntary health insurance:**

A health insurance, to which an individual or group can subscribe without a legal requirement to do so.

### **Voluntary use of DSP**

When a member/ beneficiary choose to utilize service providers other than what the scheme proposed.

### **Underwriting**

Depending on your previous medical scheme history, your new medical scheme can apply underwriting on your new membership. This means that according to regulation, they are allowed to impose a three-month general waiting period and/or a twelve-month waiting period on an existing illness condition. A Late Joiner Penalty can also be placed. [See "Waiting period (condition specific)", "Waiting period (general)" and "Late joiner"]

### **Waiting period (condition specific)**

Depending on your previous medical scheme history, a scheme may impose a waiting period of up to 12 months from the inception date of your membership, for any pre-existing conditions. No benefits will be paid out for any costs involved in this condition.

### **Waiting period (general)**

A scheme will probably have a three-month general waiting period on benefits for new members. No benefits are paid out during this period, not even from a MSA (medical savings account), except for some procedures that are covered within the PMS (Prescribed Minimum Benefit) as prescribed by the Medical Schemes Act.