



Communication Guidelines for Medical Schemes

Document

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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 these guidelines 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 layman, and this is compounded by the fact that many serious illnesses are not recurrent, so 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 have a better understanding of their entitlements, use of designated service providers (DSPs), prescribed minimum benefits (PMB), formulary medicine and associated exclusions and deductibles, whilst funders using layman's terms will be able to communicate with the beneficiaries explaining the use of DSP's, PMB's, etc.

These guidelines are critical as they will ensure compliance to 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”.

2 OBJECTIVES

The main objective of this document is to develop communication guidelines for medical schemes which will, among other outputs, stipulate the format, level of information and channel of communication required to communicate to members and providers.

3 PURPOSE

The purpose is to clarify the obligation of schemes in line with section 57, 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 benefit offerings.

4 PROCESSES

An internal team was put together by CMS to conduct a review of available modes of communication to rationalize them, and standardise marketing material of medical schemes. This document was published for industry input and comments. The inputs were then collated, considered and deliberated by the aforementioned internal committee and subsequently this final document which serves as a standard guide for member communication was established.

5 SCHEME SURVEY

For illustrative purposes, the guidelines that currently exist in the medical schemes industry are reviewed here. A purposeful sample was selected that to include the biggest 7 open schemes and 2 restricted schemes which represents the majority of beneficiaries in the industry. From the reviewed cases it is recommended that the guidelines should cover the minimum level of information as illustrated in the 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 etc. 95% of this sample also did not properly communicate their DSP's, the level of co-payment payable for voluntarily use of a non-DSP, nor did it explain the consequence of voluntary use of an out of formulary medicine or even provide a list of non-PMB chronic medication not covered.

5.1 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 and Bachman, 2006).

5.2 The Medical Schemes Context

Trends in complaints:

Complaints data analysed and resolved during the period under review, 2011 – 2012, is illustrated in Table 1 below. An increasing trend in the number of complaints has been observed in recent years and the table below depicts the complaints categories. In the year under review, the Adjudication Unit resolved 5 963 complaints in total. A total number of 2 370 complaints related to the funding of prescribed minimum benefits (PMBs) which is 40% of all the complaints the Unit resolved. Furthermore this represents the highest category of complaints. The second highest category of complaints was the non-payment or short – payment of non-PMBs with a total of 1 697 which is 29%. The third highest category of complaints, related to membership status with a total of 260 which represent 4% of all complaints resolved. The fourth highest category of complaints was pre-authorisation with a total of 247 complaints which translates into 4% of the total complaints.

Table 1: Categories of Complaints

Category of complaint	Sub-category of complaint	Number of complaints resolved
Technical / clinical		
Non / short payment of benefits	Prescribed minimum benefits (PMBs)	2370
Non / short payment of benefits	Non-PMBs	1697
Administrative		
Pre-authorisation		2 47
Increase in contributions		176
Information not received from scheme		168
Personal Medical Savings Account		59
Rejection of membership application		39
Other		22
Legal / compliance		
Membership status		260
Waiting periods		119
Unethical conduct		57
Late-joiner penalties		42
Inaccessible networks		20
Misrepresentation		10
Governance		7
Other		5
Fraudulent assignment		4

Box 1 illustrates a summary and outcome of an appeals matter dealt with by CMS 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

6 COMMUNICATING BENEFITS TO MEMBERS

A study conducted by OMAC Actuaries & Consultants Healthcare in 2011 revealed that nearly half of the medical scheme members never read what is covered by their benefit option. The study further narrates that medical scheme members' ignorance of what they are paying for means they risk having too much or too little coverage for their needs. However, there is another dimension to this view: benefits are sometimes not effectively communicated in plain and simple language for members to 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. This further emphasises that schemes need to educate members and clearly define what is covered by their respective benefit option.

7 LEGISLATION

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

7.1 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”

7.2 Medical Schemes Act, 131 of 1998

Requirement and provision of the Medical Schemes Act (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 medical scheme”.

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

Open Enrolment

An important principle enshrined in Act to prevent risk selection by medical schemes and provides that any eligible person who wishes to join a medical scheme be allowed to join medical scheme of his/her choice without facing any form of unfair discrimination.

Community Rating

A principle where all members on a particular benefit option within a medical scheme must, as embodied in the Act, contribute the same premium regardless of age, health status or any other arbitrary ground.

Prescribed Minimum Benefits

The scope and the minimum services that include the diagnosis and 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.

Governance

A framework of rules, laws and practices by which a Board ensures accountability, fairness, and transparency of 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”*.

Managed Healthcare

The 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.

7.3 National Health Act 61 of 2003 (NHA)

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

2 Objects of the 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”;

7.4 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”;

7.5 Consumer Protection Act, No 68 of 2008

The Consumer Protection Act (CPA) 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 provision of section 57(4)(d) of the Medical Schemes 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.

The following 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

7.6 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 from the above, consumers have the right to access 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 simple language in order to empower consumers.

8 ROLE OF STAKEHOLDERS IN THE MEDICAL SCHEMES INDUSTRY

8.1 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 facilitate payment of expenditure incurred by beneficiaries whilst accessing health care services in line with the Medical Schemes Act and the medical scheme rules. For a medical scheme to operate legally, it has to be registered with CMS 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”.

8.2 Administrator

Section ... of the Act defines an administrator as: “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.

8.3 Broker Services

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.

Section 1 (1) of the Act defines a broker services as:

- (a) "service 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".*

9 THE ROLE OF THE CUSTOMER CARE CENTRES IN IMPROVING COMMUNICATION

9.1 The role of the Council for Medical Schemes Customer Care Centre

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

More importantly, members must be offered the right to choose their preferred language of communication. It is therefore essential for the call centre agents to have an understanding of the member rights and legislation.

9.2 The role of a medical schemes contact centre

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

- Accommodate members who prefer communicating in an alternative language in addition to their chosen medium of communication in terms of the National Language Framework;
- Simplify technical aspects of product terminology, legislation and registered medical scheme rules;
- Understand and inform the member of their standard operating procedures including the applicable timelines;
- Understand the registration process for the different healthcare programmes offered by the medical scheme;

- Understand and have knowledge of PMBs; CDLs; formularies and the list of DSPs and their use and how they can be accessed;
- Have knowledge of non-PMB chronic medicine covered by the different benefit options; and
- 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.

10 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)(o) of the Medical Schemes Act. There are a number of benefit options in the industry that a medical scheme may choose to offer depending on its target market and health needs of its market. The following are some of the common benefit structures available on the market:

10.1 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.

10.2 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).

10.3 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.

10.4 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 per member per month (p.m.p.m) basis. This arrangement allows a medical scheme to transfer risk to a service provider.

11 INFORMATION MEMBERS SHOULD KNOW

In order to improve access to healthcare and raising member rights the following should be noted:

- Members are required 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.
- Members are required to familiarise themselves with the scheme rules in order for them to understand their rights, responsibilities and benefit entitlement.
- Members are required to continuously update the status of their beneficiaries with their scheme. For example, when a dependant is no longer eligible to be a dependant, the member has to notify the scheme to terminate the membership of such dependant. Members should be familiarised with the scheme's membership eligibility provisions, particularly as it relates to restricted scheme membership including the basis for continued membership after retirement. Members should similarly be advised of their statutory rights towards the continuation of membership after retirement moreover, the rights of dependants to continue membership after the death of the main member.
- 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 more information click [here](#)

11.1 Forms completed by a broker

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.

The broker needs to provide the member with adequate information for example, waiting periods, disclosures and further explain what a pre-existing condition is before the prospective applicant sign. Furthermore, brokers are barred from making commitments to clients, which bind or attempt to bind the scheme in any manner where the discretionary power resides with the scheme, for instance the application of waiting periods or late joiner penalties.

11.2 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 members on the benefits of registering on managed care programs;

and as such, alternative means to encourage members to register on managed care programs must be used.

Furthermore, a medical scheme may in terms of Regulation 8(4) of the Act, 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. Medical schemes must outline the list of DSP's, their use, and how they can be assessed.

11.3 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:

- when a member gives explicit permission;
- and this is done legally

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

11.4 Cancellation of membership

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

- 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 or material information.*

11.5 When does membership end?

Members are allowed to resign from the scheme any time during the year by submitting a written notice to their medical scheme. However, a member is required to serve a 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.

11.6 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 sub regulation (2) must be forwarded on request to any medical scheme to which the former member or dependant subsequently applies for membership”.

11.7 PMBs and non-PMBs chronic benefits

PMBs must 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 of their benefit option.

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

For more information on PMBs, follow this [link](#) for the *Code of Conduct in respect of PMB benefits*:

Non-PMB benefits are supplementary benefits and unlike PMBs they are capped at a certain limit which could be either of monetary value or by number of consultations.

11.8 How to register for CDLs and PMB coverage

- Why it is important for a beneficiary to be registered for chronic medication?
- What happens when a beneficiary is not registered for chronic medication?
- 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?
- In addition to the beneficiary, who else must complete and sign the registration form when applying for chronic medication?
- Any additional documents required to support the application must be specified?
- Where to send completed registration form (e-mail; fax or postal address)?
- Indication of how beneficiaries would know that their application has been approved; and what happens once a beneficiary’s application is approved?
- Process to be followed when a registered beneficiary updates any modification to the chronic authorisation?
- How to access chronic medication from the chronic DSP?
- What happens if a doctor changes a beneficiary’s medication in the middle of the month?

- What happens if a beneficiary uses a provider of their choice instead of the medical scheme's DSP to get their chronic medication?
- What happens when a member uses medication that is not on the formulary list for their particular benefit option?
- Can a beneficiary receive benefits for more than one month's supply of medication and procedure to apply for such?
- The list of DSP locations and contact details, must be easily available, be it electronically, hard copy or telephonically.
- 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.
- 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.

11.9 Changes on the formulary list

Due to the high frequency of changes relating to the medical schemes formulary list, instead of communicating with the entire membership, 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 affected by the change.

Members must be provided information on what authorisation is and what it means. Furthermore, it is important to inform members that authorisation does not guarantee payment of subsequent claims. Medical schemes must clearly state benefits that require pre-authorisation; for example hospitalisation; day clinic admissions, special procedures, etc. the following must be explained:

- Process to be followed to obtain pre-authorisation;
- The number to be contacted; who to contact once an authorisation number is received, and what is expected of the beneficiary;
- Beneficiaries have to know what happens once they are admitted; and if there are other processes to be followed.
- The following is some of the information that could be required when authorising:

- Membership number;
- Details of the patient (name and surname, ID number, etc.);
- Reason for the procedure or hospitalisation;
- Diagnostic codes (ICD-10 codes), tariff codes and procedure codes (to be obtained from your attending service provider).

11.10 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.

Adequate information must be provided to allow the members to take informed decisions 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 member’s changed health status.

11.10.1 Access to information relating to the process of applying for membership

- Where to get the enrolment form and which sections on the form are compulsory to complete
- The required supporting documentation
- How to submit an application form to a medical scheme
- Where to send completed registration forms (e-mail; fax or postal address)
- Applicable time lines for processing an application and feedback on an application status
- Application to managed care programmes

11.10.2 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 the 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 subjected to waiting periods and late joiner penalties in terms of section 29A and regulation 13 of the Act respectively.

11.10.3 When and how to change from one benefit option to another

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

12 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”.

13 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

14 WHEN MAY A MEDICAL SCHEME IMPOSE WAITING PERIODS

If a prospective member has had a break in membership of less than 90 days when making membership application and has more than 24 months in medical scheme coverage, then the following waiting period will apply:

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

The following waiting period may apply if a prospective member has had a break in membership for less than 90 days when applying for membership and has less than 24 months in medical scheme coverage:

- A condition specific waiting period of twelve (12) months may be imposed and during this period, access to benefits may be limited to PMBs only,
- Similarly, if a member only served a portion of their waiting periods and not the full twelve (12) months on the previous scheme for example eight (8) months, then the new scheme may request the member to carry-out the remainder of the - four (4) month period.

15 HOW TO CALCULATE PREMIUM PENALTIES FOR PERSONS 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 at the age 35 and older. Regulation 13(2)

<i>Penalty Bands</i>	<i>Maximum penalty</i>
<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 applied to join Medical Scheme A with effect from 1 June 2011.

He was previously on Medical Scheme B from 1 June 1971-1981, and Medical Scheme C 1981-1990.

The total standard premium of Medical Scheme A is R2 500 which consist of Risk = R2 000 and PMSA = R500.

David's age is 65.

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

David's Age minus late joiner cut-off age equals the number of years to proof creditable coverage to avoid a late joiner penalty (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 applies to David's case which is 25% of contribution penalty

NOTE: The penalty is only calculated on Risk.

$$25\% \text{ of R2 000} = \text{R500 (penalty)}$$

$$\text{David's premium} = \text{Risk} + \text{MSA} + \text{Penalty}$$

$$= \text{R2 000} + \text{R500} + \text{R500}$$

$$= \text{R3 000}$$

16 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. These funds can only be used to defray health care expenditure and are trust monies held on behalf of the member by the medical scheme and do not form part of scheme assets (please click [here](#) to read Circular 38 of 2011)

16.1 How is the PMSA Funded

From the beginning of each year, a medical savings account is credited with a percentage of a member's contribution, as determined in the medical scheme rules. A 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 members join a medical scheme during the course of a year, their medical savings funds will be pro-rated. This means that benefit limits will be calculated in proportion to the period of membership left for the year from date of joining.

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

16.2 Accumulated savings account

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

16.3 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 regulation 10 which provides the following:

Regulation 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.*

For more information on the PMB code of conduct click [here](#).

17 IMPORTANT FACTS TO NOTE REGARDING MEMBER COMMUNICATION

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

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

- Published 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 member. New members joining the scheme must be provided with a rule book which includes a full set of the registered rules. Thereafter members must be provided with updates of amendments as prescribed.

- Updates on amendments to the rules as and when this happens, and written modes of communication can be used, for example, announcements; RSS feeds; notification on claims and change in formulary list in terms of section 41.
- Information on rule amendments must be circulated within 30 days before their effective date.
- All marketing and educational material must contain the contact details of the contact centre and complaints division of CMS.
- Website and physical address of CMS.
- All application forms must contain the contact details of the contact centre and complaints division of CMS.
- Details for the Medical Scheme's contact centre; authorisation contact number; Managed Healthcare Organisation and Administrators.
- Information on disease management programme including registration.
- Clinical entrance criteria.
- Formularies of acute and chronic medicines.
- Frequency of tests, consultations and "treatments" allowed in terms of the PMB algorithms.
- Where MMAP or other generic pricing limits are applied, a lookup facility for generic equivalents to brand name medicines (or ingredients).
- The process by which members can apply or register for PMB coverage and the outcome of the application.
- Detailed and up-dated formularies must be made available on request including DSP and network list of hospitals and practitioners.
- Benefits which will be pro-rated if the member's membership starts after January. This means that benefit limits will be calculated in proportion to the period of membership left for the year from the date of joining.
- What happens when an annual limit non-PMB medication benefit has been exhausted?
 - The member is liable for any balance once benefits are exhausted.
- The liability for ensuring payment of a member's monthly contributions to the medical scheme between the member and their employer.

- 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.
- The period prior to a non-emergency hospital admission required to notify the medical scheme and consequences of failure to inform.
- Medicine exclusions by class and name, including schedule 0-2 medicines not paid from Above Threshold Benefits / complimentary benefits
- Applicable costs for all the benefit structures:
 - Full details of the costs of the benefit cover
 - Details of any fees, co-payments and deductibles other than the relevant member contributions
- At the minimum marketing materials must contain the following:
 - All relevant contact details, for example physical and postal address, telephone and fax numbers and website address of the medical scheme
 - Applicable contribution tables
 - Benefits covered under each benefits option
 - List of CDLs and non-PMB chronic conditions covered for all benefit options
 - PMB benefits and the DSPs
 - Limitations and exclusion list
 - Co-payment
 - How formularies can be accessed

18 CLAIMS STATEMENT MUST CONTAIN THE FOLLOWING IN TERMS OF REGULATION 6(5) AND OTHER POLICIES

- The name of the medical scheme
- Member's benefit option

- Member's name
- Name of the patient and his/her beneficiary code as displayed on the membership card
- Treatment date
- Date of claim received by scheme
- Membership number
- ICD10 code
- Amount of the claim
- Amount paid by scheme
- Name of the healthcare service provider and their practice code
- Payment date
- Rejection code including the benefit
- The pool from which the claim was paid
- Procedure and procedure code

19 MEDICAL SCHEME FINANCIAL INFORMATION

- Board of Trustees Report
- Annual Financial Statements (either the full set or as per CMS directive).

For more detailed information on Annual Financial Statements please click [here](#). This is the Prescribed Format for the Statement of Comprehensive Income and disclosure required in respect of Personal Medical Savings Accounts.

For information regarding the annual financial information provided to members, please click [here](#).

20 IMPORTANT CONTACT DETAILS:

- Name, practice number and contact details of the attending provider (doctor and/ or specialist);
- Name and practice number of the day clinic or hospital / DSP;
- Physical and postal address, telephone and fax numbers and website of the medical scheme;
- Telephone and fax numbers of the administrator and managed healthcare;
- Telephone and fax numbers for members general enquires;
- Call centre fax and telephone numbers; email address for enquiries;
- Lodging of complaints: fax, telephone numbers and/or email address;
- Chronic medicine: fax, telephone numbers and/or email address; and

- Pre-authorisation: fax, telephone numbers and/or email address;

21 MEDICAL SCHEME WEBSITE MUST CONTAIN

- Up to date information at all times
- Registered medical schemes' rules (main rules, contributions, benefits and exclusions)
- The latest tariff codes with amounts
- Annual audited financial statements and notes thereto
- Annual Report from the Board of Trustees (BOT)
- Details of designated service providers and contracted parties
- Contact details and procedures of emergency staff providing authorisation
- Contact details for the contact centre and complaints unit of CMS, including an explanation of the complaints process.
- Website and contact details of CMS
- Detailed and up-to-date protocols and drug formularies
- Clinical dispute resolution procedure
- Dispute resolution procedure

22 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 particular of his or her written comments thereon with 30 days or such further period as the Registrar may allow’.

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

22.1 Dispute Resolution at scheme level

- A complaint can be lodged in terms of the medical scheme rules to an independent disputes committee.
- Information regarding dispute resolution has to be communicated to members.
- Members are entitled to prompt attention to and resolution of complaints.
- Outcome the dispute must be communicated to the member (scheme level).

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

23 MEDIUM OF COMMUNICATION

Medical schemes are required to use a reasonable medium to disseminate information depending on their member profile, medical schemes are required to make provision for reasonable member choice, bearing in mind the related cost implication. For example, appropriate communication for hearing and sight impaired members at the medical schemes cost.

24 LANGUAGE AND TONE

- All communication and correspondence to members and prospective members should be in plain and simple language in terms of the Consumer Protection Act (CPA).
- Verbal communication of the scheme's call centre staff should preferably be at the level of the caller, and call centre agents must be empowered to discern. The tone should be professional, accommodating, clear, firm but sincere.
- 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, these modes should be used for educational purposes and access of to information.
- In the spirit of fairness and equality as envisaged in the constitution, ambiguity in language, written or verbal, should be avoided.

25 MODES OF COMMUNICATION

Medical schemes 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 the 10 other official languages. Furthermore, written information must also be made available in different languages.

25.1 Various modes of communication medical schemes may use

- Letters (post-hard copy & electronic)
- Newspapers
- Magazines
- Billboards

- Promotional material (flyer, pamphlets / z-fold cards, etc)
- CD's/DVD's
- Smses
- E-mail
- Social networks
- Radio
- TV

25.2 Social networks

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

- Twitter
- Facebook
- Blackberry messaging

26 FREQUENCY OF COMMUNICATION

The frequency of communication to members will vary based on periods of peak activity that a medical scheme typically goes through. On average, a medical scheme should 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 should 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:

- Annually through the Annual General Meeting (AGM),
- Quarterly, monthly or weekly
- On joining of the scheme
- Whenever changes are made that directly affect members' benefits,

27 CONCLUSION AND RECOMMENDATION

This review depicts the challenges that beneficiaries and service providers face due to the lack of appropriate, adequate and up-to-date information, which is presented in a simplistic manner for the benefit of everyone.

Furthermore, it demonstrates the unnecessary financial strain that the beneficiaries have to incur in the quest to understanding their benefits entitlement.

This document therefore illustrates the urgent need to promote access to appropriate information by streamlining communication, thereby ensuring a standardised way of communicating to members.

28 REFERENCES

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- Medical schemes marketing material for sampled schemes

29 ANNEXURE A

29.1 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 types like ambulances or helicopters utilised for medical emergencies.

AT (Agreed Tariff)

A particular medical scheme might have agreements with DSP's (Designated Service Providers) / Preferred Service Providers. The Agreed tariff 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. This medicine is 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)

Chronic conditions listed in terms of Annexure B of the regulations to the Medical Schemes 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 a member received medical treatment, he / she or the service provider (the doctor or hospital) submits a claim to your medical scheme to request payment of the bill. Usually members can wait for

their scheme to pay out the claim, or you can pay the bill from their 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 member's visit for treatment to a service provider, like a doctor, specialist, physiotherapist, etc.

Contribution

The fixed amount payable on a monthly basis to a medical scheme in exchange for benefits. Members 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 a 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

Principal members and their 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 a member's 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 is 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 health care 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 health care 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 a member sought health care services. This coding system then ensures that member's 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 a member becomes a member of a scheme and his / her dependants' membership is registered. The member's 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 hospitalisation, procedures and treatment a member can receive while in hospital.

Manage health care

This is any effort to promote the rational, cost-effective and appropriate use of health care 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 health care would probably mean that a member has to join a case management programme. The doctors and the specialists from the 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 a member's 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, the member will probably have to join a disease management programme, of which the 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 a member 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 a pharmacy without a doctor's prescription. If a member's medical scheme option offers you a PAT benefit, it means that some of these costs will be paid for by the 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 health care services and to participate in the managed health care 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 Health care Provider

A primary healthcare provider deals with members' and members' 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. As a member of a medical scheme, the member will probably receive health care 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 the medical scheme benefits are provided on a calendar year basis, which means that members have an annual limit on them. If a member join a scheme on a date other than 1 January, his / her benefits are calculated pro-rata, which means that he / she receive a year's benefits in advance. If

the member exceed his / her annual limit, he / she will have to pay excess costs out of his / her 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, members' monthly contributions to their 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 health care 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 benefit 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 a member is are married to under any law or custom that is recognised 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 members' rights as a medical scheme member. The Act and the regulations there under are amended or replaced from time to time. During the time of amendment these changes are referred to as a Bill.

Threshold

On some medical scheme options, members pay for their day-to-day medical expenses from their medical savings account or from their 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"), their 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 utilise service providers other than what the scheme proposed.

Underwriting

Depending on members' previous medical scheme history, members' 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 members' previous medical scheme history, a scheme may impose a waiting period of up to 12 months from the inception date of their membership, for any pre-existing conditions. No benefits will be paid 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 during this period, not even from a MSA (medical savings account), except for some procedures that are covered within the PMB (Prescribed Minimum Benefit) as prescribed by the Medical Schemes Act.