

EXPLANATORY MEMORANDUM TO THE MODEL RULES

Preamble

The Medical Schemes Act, 1998, (Act No 131 of 1998) provides for a number of issues to ensure a clear understanding of the relationship between a medical scheme, its members and stakeholders. These provisions give effect to the intentions of the legislature in a transparent manner with the aim of preventing unfair discrimination and protecting the interests of the members as well as the medical scheme.

Accordingly, reciprocal rights and obligations are observed in this regard. Once approved and registered, the constitution of the scheme is legally binding on the scheme, the member and his or her dependants and any other party who has a right in terms of this contract and within the framework of **the business of a medical scheme** defined as follows:

"...the business of undertaking liability in return for a premium or contribution to make provision for the obtaining of any relevant health service; to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and where applicable, to render a relevant health service, either by the scheme itself or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme".

Governance of medical schemes vests with a Board of Trustees with fiduciary responsibilities and accountability to the members in terms of the trust principle as medical scheme funds can only be applied for the benefit of the members as the only shareowners. Medical schemes are accordingly restricted in terms of what they can lawfully do and may not engage in other business which falls outside the framework of the definition of the "business of a medical scheme". Whilst managed care arrangements and general contracting out of services are done to ensure that members are provided with the cover they need, the purchasing of commercial insurance for benefits is subject to prescribed requirements and procedures.

In order to perform these duties and to manage the scheme in terms of its constitution, schemes are entitled to access information of members for a variety of reasons. Members of medical schemes must similarly provide accurate information at all times. Schemes have extended rights to suspend and terminate membership or participation of dependants as a result of failure to disclose material information or providing false or misleading information. Confidential patient information must be treated as such and can only be parted with and disseminated to a third party with the consent of the member. Information to be supplied by members relate primarily to the following: Full details (specified in the application form) of the member family including details of health care treatment obtained during a specified period and a bona fide statement as to the legitimacy of dependants so declared.

- Rights to the benefits of the scheme upon submission of valid claims for health care services legitimately obtained by the member and his dependants.
- Disclosure of information required by the scheme to ensure compliance with the Act regarding the application of waiting periods.
- Details of income where applicable and changing circumstances affecting the status of dependants in terms of scheme rules.

Members furthermore have an obligation to pay the relevant contribution which entitle them to have access to the benefits and rights flowing from the legal relationship with the scheme and summarised as follows:

- Right to continued membership of the scheme after retirement resulting from age or ill health.
- Right to access information based on demonstrated interest.
- Right to lodge valid complaints and disputes to an impartial tribunal.
- Right to attend member meetings and to vote thereat. This includes the right to participate in the election of persons to serve as trustees of the scheme.

A medical scheme is prevented from applying unfair discriminatory measures against members. Applicants may not be refused or penalised when admitted to open schemes other than in the prescribed manner and contributions may similarly not be determined on group participation, age, state of health, gender, race, geographical circumstances or any other manner. Contributions may only be determined on the basis of the income and/or number of dependants of the member whilst waiting periods and late joiner penalties are the only measures applied to avoid adverse selection against schemes when members move between schemes or when persons are admitted without previously demonstrated membership.

Employers do not become legal parties in terms of the scheme/member relationship. To the extent that employers subsidise contributions of their employees and may assist with the payroll management and payment of contributions to medical schemes, they would do so as a participating party or “conduit”. Any subsidy paid by an employer to a medical scheme, vests with the scheme and refunds thereof or repayments to employers for any reason is without legal foundation.

The broker fraternity is recognised in this relationship provided such person or organisation is accredited as required by law and they comply with the prescribed requirements throughout. The following measures are of particular importance:

- The broker is recognised as the agent of the member and the member is not compelled to make use of broker services in obtaining membership of a medical scheme. Medical schemes may accordingly not allocate members to a broker for purposes of providing broker services and remunerating such broker.

- The broker is entitled to a maximum prescribed fee as remuneration from the scheme in respect of services rendered to a particular member but no distinction in fees is permitted on the basis of inflated remuneration to attract only groups or reduced fees payable in respect of certain more vulnerable groups as disincentive

Or to allow splitting of risks in a manner which is harmful to groups of members and certain schemes.

- Brokers cannot usurp powers, rights and obligations of the member as it relates to signing of documentation, application forms, resignation of membership and the like, nor can they attend member meetings on behalf of the member.

The model rules serve as a guide to stakeholders for complying with the Act, regulations framed thereunder, common law provisions, sound corporate governance practices and various internal policy decisions which provide clarity on matters affecting the relationship between the scheme and the member in a practical manner.

The main objective is to provide a consistent sequence of logical rules which govern the legal relationship between the medical scheme and its members. As indicated before, this document is dynamic and will be modified from time to time. This version incorporates the latest amendments to the Medical Schemes Act and regulations which came into force on 1 January 2003.

This memo should be read with the model rules. In this regard your attention is drawn to the following model rules:

Rule 1

Due cognizance should be taken of the provisions of Section 23.

Rule 4.14

The reference to "child" applies to a minor child. The immediate family of a member is regarded as the member's nearest family by way of affinity and blood, both lineally and collaterally, that is to say, his or her parents, brothers and sisters. These dependants are recognised for purposes of the definition as dependant only as and when there is a duty of support in respect of them by the member. Therefore, the liability of family care and support is founded on the common law practice that there always exists in principle a duty of support between ascendants and descendants such as by a child to a parent. The common law requirement for care is interpreted to mean:

- The person (dependant) who claims support must be unable to support himself/ herself;
- The person for whom support is claimed (member) must be able to support the claimant; and

- The relationship between the member and the dependant is such to create a legal duty of support.
- Accordingly, a person is not a dependant within the definition where the member simply applies for registration because of a decision to care for such person where in fact that person is able to support himself / herself.

It is furthermore not a requirement that immediate family must reside with the member to be recognised as such.

Persons falling outside of this definition, such as a grandchild or parents-in-law of the member, may become dependants in terms of rule 4.14.4.

Rule 4.18

Since any emergency medical condition now forms part of the prescribed minimum benefits, the definition has been included in the rules for clarity.

Rules 6.2 and 6.3

It is important to note that members are no longer subject to a qualifying period of membership in order to obtain continuation membership. Rule 6.3.1 furthermore implies that the person's status changes without re-admission to the scheme.

Rule 8.3

The Scheme is entitled to request information for a period longer than 1 year prior to the application. However the medical report referred to may be in respect of only that condition as envisaged by the definition of "Condition specific waiting period".

Rule 8.4

A "condition specific waiting period" may also be imposed on benefits for pregnancy and confinements.

Rule 8.5.3

No waiting period may be imposed on a child dependant born during his parent's membership of the scheme, irrespective of the age of the child at the date of application for registration.

Rule 8.9 - deleted

This rule previously provided that a scheme was not obliged to re-admit a person as a beneficiary in instances where membership was terminated in terms of section 29 (2). This principle has been found to be inconsistent with section 29 (3)(a) and may therefore not be applied.

Rule 11

The Act does not require a member to resign his membership in the event that he resides in a foreign country. A scheme may however insist that a member who

resides outside the borders of South Africa provide it with an address in the RSA for communication purposes and a RSA bank account for the collection of contributions.

Rule 12.1.1

Continuation of membership in these circumstances implies ongoing without any break and consequently not being re-admitted.

Rule 13

Any waiver of contributions, preferential arrangements or contributions which deviate from the registered rules is irreconcilable with the Act and unacceptable for registration.

Schemes are reminded of the peremptory provisions relevant to direct payment of contributions into the bank account of the Scheme. (Section 26 (7))

Furthermore, rule 13.2 should clearly indicate whether contributions are payable in advance or in arrears.

Rule 14

The nature of the contract between the Scheme and its members does not regulate the responsibilities of and the extent to which participating employers subsidise contributions payable by employees or workers. This matter falls within the framework of labour relations and agreements or arrangements which affect conditions of employment.

Rule 15.6

The period in which a corrected account, claim or statement must be resubmitted to the scheme has been reduced from 4 months to sixty days following the date on which it is returned for correction.

Rule 16

It is essential that the scheme restricts the provision of benefits to services identified with those under the definition of "relevant health service". Accordingly, it is unacceptable that marketing material or any other reference links marketing of the scheme to any other product. Conditional selling of medical scheme membership is expressly prohibited by section 21A of the Act.

Rule 17.1

In terms of section 59(2) of the Act, a Scheme may pay only the benefit to which the member is entitled. Any amount paid which exceeds the benefit will be regarded as a loan to the member.

Rule 17.2

Should a relevant health service be discounted, the nett amount paid is to be deducted from the benefit limit in compliance with regulation 5(h).

Rule 18.1

In order for meaningful decisions to be taken and in the interest of sound corporate governance, it is suggested that the Board consists of at least five persons.

Rule 18.4

It is imperative that the rules indicate how the balance of the trustees are appointed.

Rule 18.5

To ensure continuity, the period of office of 3 years is regarded as appropriate.

The extension of the period of office of the Board beyond 3 years is acceptable. However, should a Board resolve to extend such period and continue to serve as trustees during such extended period, it is in the interest of corporate governance that such rule amendment be approved by members.

Rule 18.6.4

Although not legally disqualified, it is advisable that the Principal Officer does not become a trustee in view of the fact that the Board appoints him and there could be a conflict of interest. However, if provision is made for such appointment, he should be an *ex officio* member of the Board.

Rule 18.11

In respect of the quorum for Board of Trustee meetings, no distinction may be made between employer and member representatives. Since Trustees have equal rights and voting powers at meetings and since they all serve a common goal, the quorum consists of trustees irrespective of who they represent.

Rule 18.12

It is in the interest of good governance that the Board elects the Chair and Vice-chairperson from its number.

Rule 18.21 and 19.18

There is no statutory provision or guideline regarding the remuneration of trustees. Schemes may determine such payment which should preferably be approved by members in a general meeting.

Rule 26.1.1

It is important to note that the date of the members' meeting does not in any way negate responsibility on the part of the scheme to submit annual financial statements and returns in the prescribed manner and timeframe. Members are therefore not required to adopt audited financial statements prior to submission thereof to this office.

Rule 26.1.3 and 26.2.4

For the purposes of establishing a quorum at general meetings, it is in the interests of members, good governance and common law principles that only those members present, as opposed to those represented by proxy, form a quorum. This however does not change the principle envisaged by rule 27.

Rule 27

Since the members have an interest in all matters pertaining to the scheme, voting at member meetings in respect of matters relating to a specific benefit option must be by all members of the scheme. Voting by only those members who belong to a particular option is therefore considered undesirable.

Rule 28

There is no provision in the Act in terms of which the disputes committee may issue an order as to cost payable by a member who files a dispute against the scheme. The intention of the legislator is to provide an impartial and cost effective administrative tribunal to consider disputes without having to revert to expensive litigation. Each party to the dispute is responsible for its own costs.

It is also acceptable that the rules provide for members, at a meeting, to appoint the disputes committee in terms of rule 28.3. It is imperative that disputes be resolved promptly.

Rule 31

For purposes of guidance your attention is drawn to the National Archives and Record Service of South Africa Act, Act No 43 of 1996 in respect of the proper management and care of records.

Rule 31.1

The rules should specify the amount payable for the copies. It is unacceptable that members should pay a fee in excess of the reasonable cost of making the copy.

Rule 32.2

This rule has caused much confusion and cognizance should be taken of its intention. These provisions reserve certain amendments and rights to amend same for resolution only by members. Accordingly, it is an entrenched clause to the extent provided for therein and this office has to enforce such reserved powers when it becomes relevant. The Board may therefore not amend or rescind the rule to nullify this protection of members without their prior approval.

Rule amendments:

Schemes are urged to submit rule amendments for registration prior to the effective dates which must be stipulated in the accompanying certificate and the summary of the amendments. It is not acceptable to merely state "with immediate effect" since

it could have various meanings and could be legally challenged. The retrospective implementation of rule amendments as a result of resolutions taken after the effective date and/or late submission of amendments to this office for registration, may expose the scheme to serious risks if legally challenged.

Rule amendments submitted for registration must be accompanied by the following supporting documents:

1. A certificate on a letterhead of the Scheme, signed by the chairperson, one other trustee designated by the Board to sign documents on behalf of the Scheme and the Principal Officer. Refer to section 31(3) of the Act and specimen hereunder;
2. a summary or list of the rules being amended, added to or rescinded, particulars of the amendments and the effective date of such amendment. This is prescribed by section 31(3) of the Act;
3. two sets of replacement pages duly initialed in black pen at the right bottom corner of each page by those who sign the certificate. Please ensure that the rules of the scheme are paginated throughout. Sub-pages could be inserted to avoid repagination.
4. Payment of an all inclusive prescribed fee (Reg 31(d)) of R50 per A4 page or part thereof being amended.

Example of certificate on Scheme letterhead

Certified a true extract from the minutes of a meeting of the Board of Trustees held on _____ (date) and that the amendments were adopted in accordance with the provisions of the rules of the Scheme.

These amendments come into effect on (date).

Chairperson

Board member

Principal Officer

Date:

Advance notice of contribution increases and benefit changes

Rule amendments are generally self explanatory, however, the same cannot be said for contribution increases and benefit changes.

Medical schemes are required to comply with Section 33(2) in managing their risks pertaining to multiple benefit options. The Board must therefore ensure that all benefit options:

1. include the prescribed benefits;
2. shall be self-supporting in terms of membership and financial performance;

3. are financially sound; and
4. do not jeopardize the financial soundness of any other benefit option within the medical scheme.

The office of the Registrar requests that medical schemes applying for contribution increases include a brief description **(in a format to be communicated to schemes)** of how such increases were determined together with all underlying assumptions for each option.

A breakdown of the aspects responsible for the increase is to be provided and this will include such items as reserve building, recovering previous losses, member movement, change in utilisation, number of lives, prescribed minimum benefits, benefits changes, medical technology, claims ratio, etc. The information provided will enable this office to assess the justification and fairness of contribution increases. In order for this to be effected timeously, medical schemes are requested to submit to this office proposed contribution tables and benefit changes by 1 October for implementation on 1 January of the next year.

Appendix 1 – The rules in respect of savings accounts should be provided for only once with a clear indication to which options the savings account applies. The period stated in rules 6 and 7 may be increased to 6 months to allow for rejected claims.

Appendix 2 - Prescribed Minimum Benefits

The intention of defining the scope of the prescribed minimum benefits (PMBs) as the Minister has done in regulation 8, is to ensure that the minimum benefits are always available to beneficiaries of medical schemes in accordance with the intention of section 29(1)(o) of the Act. This should also serve to reduce indirect discrimination against less healthy beneficiaries of medical schemes.

The primary intention of the legislation is therefore to ensure availability of a minimum set of funded health care benefits to beneficiaries of medical schemes. Ensuring availability of these benefits in the most efficient way possible should be incentivised.

In an effort to ensure availability of minimum benefits to members, responsible medical schemes should not rely on the public sector only as a default provider but needs to contract with good quality providers both in the public and private sectors. This is important both from an efficiency perspective and also to proactively deal with circumstances where those minimum benefits are not reasonably available to beneficiaries through the public sector.

Having said that, use of public sector facilities for the delivery of minimum benefits where those benefits are reasonably available to beneficiaries of medical schemes

remains an option – in any event, no limitation can ever apply to reimbursement for minimum benefits provided in these facilities (section 29(p) of the Act).

If a medical scheme were to designate only public sector facilities as designated service providers in terms of regulation 8(2), there is no prohibition on that medical scheme structuring its rules to apply normal benefit limitations (co-payments or deductibles) on prescribed minimum benefits (PMB's) voluntarily obtained in private sector facilities, provided that –

- a. the beneficiaries of that medical scheme always retain the option of receiving that care from the designated service provider (in this case public sector facilities) with payment in full from the medical scheme; and
- b. if those beneficiaries choose to receive care from a public sector facility (for example once they have exhausted their ordinary limits), but involuntarily must obtain that care from a private provider due to reasons set out in regulation 8(3), the medical scheme would be liable to pay for the care provided by that private provider in full.

While the designation of service providers for PMB's in the rules of a medical scheme, as provided for in regulation 8(2), is indeed not peremptory, it is advisable from a risk management perspective. Failure to do so would result in regulation 8(1) being applicable without limitation on the scope of the benefit to be provided (i.e. payment in full in any setting selected by the beneficiary).

In relation to interpretation of the obligation on medical schemes to pay costs of PMBs "in full" in a designated provider or when services are involuntarily obtained from a non-designated service provider, the regulations do not specify a particular tariff and the Council for Medical Schemes does not have the legal authority to change this. Schemes are, however, not exposed to unlimited liability in this regard, because:

- a. in respect of schemes which designate the public sector as a designated service provider, fees charged are standard as determined in the Uniform Patient Fee Schedule (UPFS) unless an alternative contract or arrangement is in place with the relevant public sector administration;
- b. in respect of other designated service providers, schemes are able to enter into specific fee arrangements with those providers;
- c. as described above, the involuntary use of non-designated providers (and accordingly the obligation to pay the costs of PMB's in full to such non-designated providers) will be the exception rather than the rule – and can be further limited in large measure by:

- i. schemes entering into contractual or other arrangements with designated service providers for the accommodation of their members;
- ii. effective case management by schemes in conjunction with pre-authorisation requirements to verify the need for involuntary utilization of alternative facilities.



SUMMARY OF THE PROVISIONS APPLICABLE TO WAITING PERIODS (SUBJECT TO CONDITIONS IN THE ACT)

Category	3-month general w/p	12-month condition spec w/p	Application to PMB's
New applicants, or persons not beneficiaries for preceding 90 days *	Yes (concurrent)	Yes (concurrent)	Yes (concurrent)
Applicants who were beneficiaries for less than 2 years *	No	Yes	No
Applicants who were beneficiaries for more than 2 years	Yes	No	No
Change of benefit option	No	No	N/A
Child – dependant born during period of membership	No	No	N/A
Involuntary transfer's due to change of employment (individuals) *	No	No	N/A
Employer changing schemes ▪ 1 January ▪ or reasonable notice *	No	No	N/A

In respect of beneficiaries indicated by an*, the unexpired duration of a waiting period imposed by the former medical scheme may, in addition, be imposed. In

cases where a beneficiary changes benefit option and is still subject to a waiting period, the remaining period may be imposed.