

CMSnews

March 2009

SPECIAL EDITION

The Registrar says goodbye
Our case study – external stakeholders speak out



In the name of a healthy medical schemes industry – how we put beneficiaries first

In this issue of *CMS News* we decided to try something new and different.

So we had our financial wizards cook up a fictional medical scheme (see p. 2-3). They named it Get-Well Medical Scheme. Get-Well is not well. We want it to get better. We then asked you – a few external experts on private health insurance – to wave your magic wands and tell us how to make this happen. Assuming, of course, that the scheme can be restored to health in the first place ...

Our sincere thanks to each and every one of you for making this the most rewarding issue of *CMS News* that we have published in this financial year.

Editorial Committee

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His legacy lives on

Many hearts skipped a beat when the Registrar of Medical Schemes T. Patrick Masobe announced that he was leaving the Council for Medical Schemes at the end of February. The industry sat up and took notice. What now?

Now we try to put into words feelings that words cannot express. And there are more of us than meets the eye.

Patrick has made the medical schemes industry



what it is today. True to the values of social justice and equality, he dedicated the last nine years of his life to making sure that members of medical schemes are treated fairly and that more

South Africans enjoy access to healthcare. It's thanks to him that the Council has blossomed into the organisation it is today. It's thanks to him that beneficiaries can sleep at night, safe in the knowledge there is someone out there looking after their interests and protecting their rights. It's thanks to Patrick that South Africa can take pride in a stable and sustainable private health insurance industry.

But why now?

"Nine years is a long time," Patrick told *CMS News*. "Having achieved much of what

I set out to do, it is time for me to move on."

"I have thoroughly enjoyed these past nine years at the Council," he added after a while. He was never one to make rash decisions. "This is an organisation I was proud to lead. And I am proud that we achieved success not by giving up on our values, but by having the courage to be true to them."

Since its inception in 2000, the Council has led the efforts to improve the financial solvency of schemes, the manner in which they are governed, and the benefits which

they offer their members.

"We have travelled an extraordinary journey of progress together," Patrick told staff on the day he announced his resignation. "But now it is right that I leave. Know that I'm always with you. Head and heart." ■

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Mr Masobe is a man of his word – a man of impeccable integrity who clearly understands corporate governance. A very humble yet tough person. A very humane person, a selfless individual. A true visionary. A strategic thinker who knows how to play his tactics.

– Daniel Lehutjo, Chief Financial Officer

What makes Mr Masobe a great leader? It is not his charisma, oratory skills, business savvy or political connections. It is his unshakeable moral integrity and faith in his cause.

– Bessie Molomo, Senior Call Centre Agent

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By Aleksandra Serwa
COMMUNICATIONS
MANAGER

The Minister of Health, after consultation with the Council, appointed Patrick Matshidze as Acting Registrar of Medical Schemes with effect from 27 February 2009. He will remain Acting Registrar until a permanent Registrar is appointed.

Stephen Harrison, our Senior Specialist in Strategy – and a member of the Editorial Committee of this publication – left the Council in January. He made time in his busy schedule to speak with *CMS News*.

"After almost nine years at the Council, I realised it was time to move on to other challenges

– and a position at the Treatment Action Campaign has provided me opportunity to contribute to the health system in a new way. I have really appreciated the opportunity to work with so many people in the private health sector over the years. Ultimately, fixing the problems in our health system will require a concerted effort by all of us in government, the private sector and civil society. Thank you for the active engagement and I wish you well in the dynamic environment in which you work."



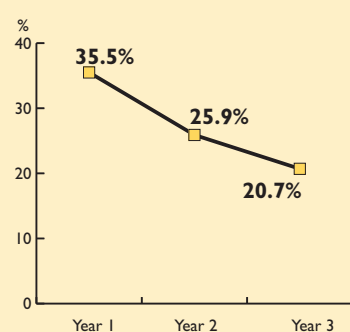
"Stephen has been a remarkable servant to the Council, to the public, to this country."

Patrick Masobe, former Registrar of Medical Schemes

Break the spell

Our financial wizards got together the other day to take yet another look at the numbers. After they had parted ways and the smoke had subsided, Get-Well Medical Scheme* appeared out of nowhere. Magically enough, it was the picture of financial distress all too real for an increasing number of schemes in the world of private health insurance currently facing very real challenges. What kind of magic could save this scheme from disappearing? We approached industry experts to wave their magic wands at the pages of CMS News. But first, a little more on the spell that brought Get-Well into being.

Solvency ratio



Get-Well Medical Scheme is an open scheme that was registered in 1998. Its membership has fallen by 25% and the demographic profile has been deteriorating over the last few years. Its members are ageing and the scheme is struggling to attract sufficient younger members. Furthermore, the scheme is losing members belonging to groups and is left with a high percentage of individuals.

Get-Well is third-party administered by Bloggs (Pty) Ltd. Bloggs is a subsidiary of a large Financial Services Group (FSG), as are the managed care

companies. Get-Well is the only open scheme administered by Bloggs but Bloggs administers a number of restricted schemes.

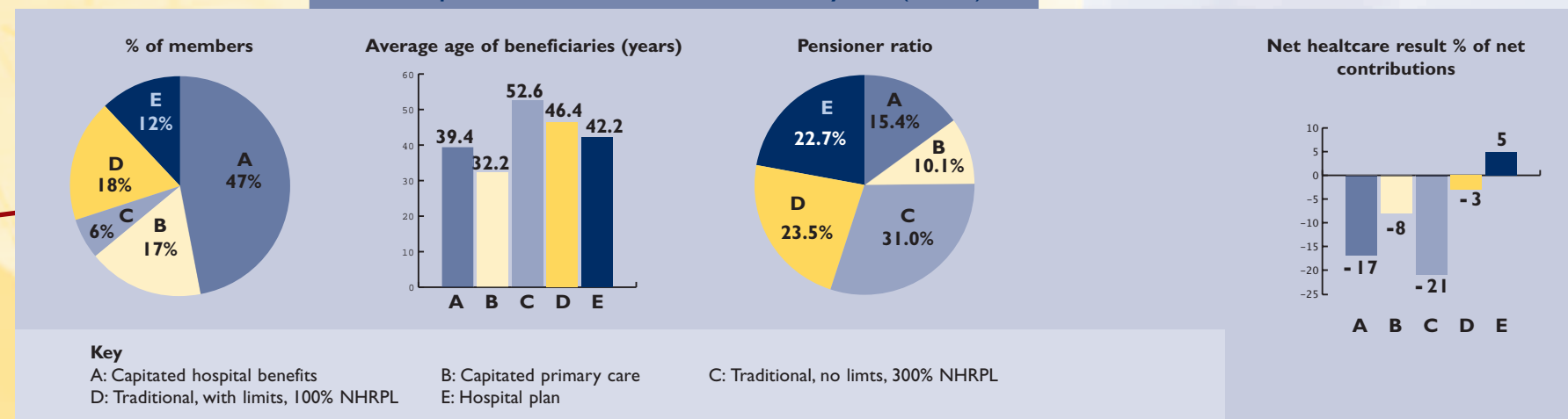
The scheme uses the FSG broker network exclusively. This includes "tied" brokers as well as independents. The FSG charges a "distribution fee" for managing the brokers. Get-Well has entered into a capitation contract with MCO (Pty) Ltd. It is, however, still experiencing increasing claims costs.

The employees of FSG and its subsidiaries are members of the scheme. Half of the trustees are senior employees of FSG and its group. The principal officer is employed by the scheme and has no prior connections with the group. The trustees do not hold regular Board meetings. In the last two years, they have met only twice.

The scheme is incurring a steadily increasing marketing bill. It has high chronic claims, resulting in a high claims ratio. Average contributions are higher than the industry average for open schemes. Get-Well also has higher than average non-health expenditure, both per average beneficiary per month (pabpm) and as a percentage of its Gross Contribution Income (GCI). This is largely due to the inappropriate contracts that the scheme has entered into.

** Not a real scheme. The purpose of the exercise was to extract a variety of views to explore the complexity of the issue.*

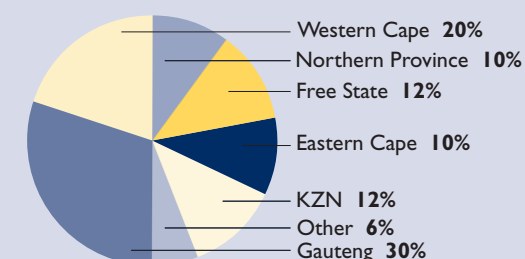
Per option results for the current year (YR 3)



Membership profile

	YR 1	YR 2	YR 3
Principal members	25 300	23 600	19 600
Beneficiaries	57 200	52 800	42 700
Average age of beneficiaries (years)	39.5	40.7	41.6
Pensioner ratio	14.9%	15.6%	16.9%
Open scheme average age of beneficiaries (years)	31.5	31.5	31.9
Open scheme average pensioner ratio	5.9%	5.9%	6.3%

Distribution of members



Financial highlights

	YR 1 R'000	YR 2 R'000	YR 3 R'000
Gross contributions	520 600	500 900	512 100
Net (risk) contribution income	467 700	464 500	476 800
Net relevant healthcare expenditure	432 100	459 000	450 800
Gross healthcare result	35 600	5 500	26 000
Non-health costs	80 100	80 700	74 500
Managed care management fees	10 900	10 500	10 500
Administration costs	59 600	61 400	55 000
Net healthcare result	(44 500)	(75 200)	(48 500)
Surplus/(deficit) for the year	(25 800)	(55 600)	(23 728)
Average risk contributions per beneficiary	R703	R716	R930
Open scheme average	R580	R607	R674
Average net healthcare expense per beneficiary	R650	R722	R880
Open scheme average	R477	R519	R563
Average non-health costs per beneficiary	R121	R126	R143
Open scheme average	R107	R112	R119
Non-healthcare % of gross contributions	15.4%	16.1%	14.5%
Open scheme average	16.1%	16.2%	15.7%
Net claims ratio	92.4%	98.8%	94.5%
Open scheme average	82.0%	85.0%	84.0%
Distribution and marketing	6 000	9 100	1 700

Consider the evolving health policy framework

Get-Well Medical Scheme faces serious challenges on a number of fronts. However, Get-Well is certainly not unique; several schemes in South Africa today will, on some level, associate with the issues presented in this case study.



By Christoff Raath
THE HEALTH
MONITOR COMPANY

Christoff has spent most of his career working in the private sector healthcare financing arena. He joined the Health Monitor Company in 2001, heading up the technical development of the Health Monitor model, a computerised risk management model designed specifically for medical schemes. Christoff qualified as an actuary in 2003 and has interacted with several stakeholders in South Africa's healthcare industry over the past eight years. He was appointed Chief Executive Officer of the Health Monitor Company in 2007.

Get-Well has incurred losses on the back of high non-health expenditure (NHE) and a deteriorating membership profile. What is particularly concerning is that Get-Well's solvency margin has reduced even though the scheme is losing members.

Under normal circumstances, a scheme's solvency would increase if its membership declined (because departing members do not take their reserves with them). The fact that the opposite is true for Get-Well suggests that the members which recently left the scheme were significantly healthier than their remaining peers. Not only does Get-Well need to clamp its loss-making position; it also needs to rebuild its reserves to meet statutory requirements.

The relationship between Get-Well, Bloggs and FSG could be indicative of potentially severe governance shortcomings on the scheme's part. Proper governance is non-negotiable and has to be addressed regardless of the scheme's circumstances. Clearly the scheme's Board needs to be more active and aggressively evaluate the appropriateness of its service provider contracts.

A crude analysis suggests that if Get-Well could reduce its NHE to the industry average by the proverbial stroke of a pen, it would be back in a surplus-making position. Whether such a change is feasible or appropriate is hard to say: Get-Well needs to assess not only what it is paying, but also the value for money that it is deriving in return. It could be that Get-Well's unique circumstances are more (or less) demanding than that of the industry average to which it is being compared.

For example, on the back of member losses it will be difficult for any Board to justify cuts in marketing expenditure; indeed, the scheme may even opt to increase it. A reduction in NHE will assist Get-Well, but it is unlikely to be sufficient to achieve a sustainable turnaround.

Get-Well could also consider contribution increases, benefit reductions and related restructuring of its product offering. These (admittedly

unpopular) rule changes, if executed carefully, could certainly assist Get-Well to curb its losses in the short term – but not without introducing some additional complexities.

A contribution increase would lead to a corresponding increase in Get-Well's statutory solvency requirements, moving the statutory minimum goal-post even further out. The scope of potential

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The recent exodus of healthy members has initiated a process that some industry stakeholders have coined the 'spiral of death'.

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benefit reductions is limited by the legislative minimum benefit requirements (especially for Get-Well's capitated and hospital plans) to the extent that severe benefit reductions may make it difficult for Get-Well to maintain a sufficient level of differentiation between its options.

There is a lot to be said on this subject of contribution and benefit changes but I'll refrain from going into more detail here as I believe that the core issue we are facing lies on a deeper level. I consider these interventions to be rather superficial – like taking a painkiller to treat a fractured limb. Get-Well can expect immediate relief but, as we will see below, in the longer term these interventions may even serve to exacerbate the scheme's situation.

My main concern for Get-Well revolves around its deteriorating membership profile. The recent exodus of healthy members has initiated a process that some industry stakeholders have coined the “spiral of death”. This rather ominously named phenomenon is set in motion when a scheme loses young and healthy members and is forced to respond by increasing contributions or reducing benefits which, in turn, prompts more young and healthy members to reconsider their membership. Older and unhealthier members tend

to be more reluctant to change schemes (potentially being subjected to waiting periods and/or chronic registration processes), and hence the cycle continues.

Can this process be stopped?

The answer is as simple to understand as it is difficult to execute: Get-Well must attract young and healthy members. Furthermore, these new members have to select benefit options where they will be paying significantly more than they will claim. In general, these tend not to be the so-called low-cost options that were, ironically, designed for the young and healthy. In our already saturated commercial scheme market where competition for healthy members is rife this is no easy feat.

If Get-Well's condition continues to deteriorate it could look for a large commercial scheme that is willing to absorb its members through an amalgamation. This will effectively be the end of Get-Well and, importantly, this seems to be a route that our regulators are supporting for schemes in Get-Well's position.

I am of the view that an amalgamation of this nature does not solve Get-Well's problem: it merely moves the problem to a different (albeit larger) environment where it is bound to re-emerge in a similar guise at some point in the future. Ultimately, the problem is as much an industry-wide one as it is scheme-specific.

But all is not lost. The components that formed part of South Africa's Social Health Insurance (SHI) framework were carefully designed to address the very issues that we are dealing with here. Since 1999, medical schemes have been operating under the principles of community rating (i.e. schemes have to charge the same premium to all members of a benefit option,

regardless of their state of health) and open enrolment (i.e. commercial schemes may not refuse membership to any applicant). These two pieces

of the SHI puzzle, implemented in isolation, presently form a structure through which the “spiral of death” phenomenon is inevitable. However, the SHI framework was not intended to be limited to only these two pieces. Further components like risk equalisation, income cross-subsidies, benefit restructuring and compulsory participation were designed to close the loop and create a structure

through which uncovered young and healthy lives would be able to enter (or re-enter) the medical schemes environment. The implementation of these final steps has been delayed for various reasons, and on a policy-making level the SHI model has subsequently been superseded by the more recent emergence of the debate around National Health Insurance (NHI).

These challenges and their potential solutions are complex and will re-emerge in some form through the NHI debates that are currently playing out. Get-Well and its competing commercial schemes can and will implement the short-term changes required to tread water in the foreseeable future – and this is perhaps the realistic route to take

while contributing to the NHI debates and looking into the structural changes that would be required to keep private healthcare financing sustainable and commensurate with the government's broader social objectives. ■

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Proper governance is non-negotiable and has to be addressed regardless of the scheme's circumstances.

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Get-Well must attract young and healthy members.

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Ensure independence

Get-Well Medical Scheme is an open scheme which is steadily losing ground as experienced in loss of members and reduction in reserve levels.



By **Malcolm Brown**
SAICA

Malcolm was a partner in Ernst & Young from 1962 to 1996. After retiring he became involved in the healthcare industry, focusing on medical schemes. During his retirement he has been a trustee of an open scheme, a member of 20 audit committees, Chairman of the SAICA (South African Institute for Chartered Accountants) Medical Schemes Project Group responsible for the Accounting Guide, a representative of SAICA on ASSA (Actuarial Society of South Africa) and RETAP (Risk Equalisation Technical Advisory Panel), and Chairman of the Gauteng Health Department Audit Committee. He is consulting to hospitals, medical schemes and provider groups.

In terms of the Medical Schemes Act and acceptable standards of governance, a medical scheme should operate as an independent organisation. The structures of Get-Well indicate that the scheme does not necessarily practice independence as envisaged in corporate governance standards.

Whilst the principal officer is independent, we find that 50% of the Board of Trustees is appointed or elected from employees of the Financial Services Group (FSG). FSG in turn own and control the administrator, the managed care contracted companies and the broker company. This leads to the direction and operation of the scheme's affairs being in favour of the FSG business units and the FSG employees to the detriment of the other members, which may be unintentional.

The contribution and benefit structures of the scheme and its non-healthcare costs are not designed to comply with the requirements of the Act regarding "financial soundness". This is evident from the high net claims ratio and the incurred deficit over the three-year history.

The reserve ratio of the scheme indicates that it will be able to fund a turnaround strategy.

The three major steps required to turn the scheme around are:

- 1 Restructure the Board of Trustees.
- 2 Restructure the benefit and contribution rates to be competitive in the marketplace.
- 3 Review the broker arrangements, opening the network to independent brokers.

The trustees of an open scheme should be elected by the members of the scheme and not appointed by the sponsors, who in this case are FSG. Any

inclusion in the rules that FSG appoints 50% of the Board should be removed. Secondly, there should be provision in the scheme rules for the elected trustees to appoint two additional independent trustees who will bring

industry, financial and legal skills to the Board.

Strategically, the scheme should develop a benefit and contribution structure that would produce a claims loss ratio that covers all non-healthcare costs. In order to achieve this balance, the Board would need to appoint actuaries to establish claiming patterns, estimate further claiming patterns and costs, and determine the appropriate contribution rates. The resulting structure would then be evaluated against open scheme products available in the market to ensure competitive positioning. Benefit and contribution rates would then be amended to ensure that the product is competitive and acceptable to both brokers and their prospective clients.

In determining the contribution rates, the actuary would have to take into account any strategic increase to the reserve ratio that is not covered by investment income.

The broker network should be opened to independent brokers. The marketing strategy needs to be designed to encourage increased membership. The development of the product needs to be carried out in consultation with the broader broker network in order to obtain broker buy-in to the product. Existing broker-member relationships may have to be retained as service fees are payable.

In order to achieve the above, the present Board has to amend the scheme rules to give effect to the revised Board of Trustee structure. Either the Annual General Meeting or a Special General Meeting should be called to appoint a new Board of Trustees.

In the interim period, actuaries need to be appointed to prepare the new benefit and contribution structure. If there is a major difference between the current and new contribution rates, it may be necessary to obtain member approval as required in terms of the Act.

The principal officer should immediately negotiate with FSG for the right to appoint independent brokers and proceed with appointing them.

The new Board of Trustees is to carry out a performance appraisal of the principal officer with a view to reviewing his/her continued employment. ■

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A medical scheme should operate as an independent organisation.

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Prioritise critical areas

A combination of interventions is required to turn Get-Well Medical Scheme around, most of which should and can be simultaneously implemented.

It is important to note that the interventions below are not in any specific order of importance or priority.

Get-Well has too many options, some of them catering for the same population and/or income category groups. Having so many options to manage may prove to be an administrative nightmare and also very confusing to the members.

The scheme needs to review its current benefit options, and limit them to two or three simple offerings. There needs to be a clear distinction between offerings. To this effect, the scheme may consider the merging of similar offerings, i.e. merge the two capitated options into one offering and the two full-benefit options into another; it may also be a good idea to consider terminating the hospital plan. Full cover has to be provided for out-of-hospital prescribed minimum benefit (PMB) conditions anyway. Either that or substitute the latter with a comprehensive savings type option; this will enable exposure to a different target group.

Given its high pensioner and claims ratio, the scheme should consider entering into risk-sharing agreements and designated service provider (DSP) arrangements. There is also the option of negotiating and contracting with service providers for preferential rates without a DSP arrangement. Where preferential rates could not be achieved, the scheme should reimburse at NHRPL (National Health Reference Price List) tariffs. Evidence-based and clinical management programmes must be accordingly implemented. Members will also benefit from an introduction of screening, wellness and disease management programmes.

Get-Well Medical Scheme should review its growth strategy to include, among others, the use of a national footprint of accredited brokers who will be paid a regulated fee for their serv-

ices, excluding the current additional "distribution fee". Marketing efforts should be focused at targeted populations and the marketing budget must be adhered to.

It is clear that there are serious governance issues within Get-Well Medical Scheme. An urgent

AGM must be scheduled within an acceptable period of time where scheme members must elect at least 50% of their own representatives to the Board. All new trustees should be appointed on merit. Training must be organised for all new trustees to enable them to function adequately in their duty of representing the needs of their members. The current Board members should be held

accountable for losses incurred, and for not conducting themselves nor managing the affairs of the scheme in line with the Medical Schemes Act. The perverse relationship between the scheme and FSG and its group must be terminated as a matter of urgency.

The current contracts with MCO (Pty) Ltd., Bloggs and FSG must be reviewed. As a capitated provider, MCO should take on either partial or full risk of Get-Well to ensure adequate risk management. New broker contacts need to be drawn to encourage an open network of brokers. All contracts must be monitored with service level agreements.

Clear timelines must be defined and a project plan drawn to enable the implementation of all of the above. Critical areas must be identified and given priority for implementation. The principal officer must take responsibility for ensuring the implementation of goals and adherence to timelines. S/he must also take responsibility for managing the affairs of the scheme. ■

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Critical areas must be identified and given priority for implementation.

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Get-Well Medical Scheme should review its growth strategy.

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By **Dr Lebo Maroo**
GEN-HEALTH
MEDICAL SCHEME

Dr Maroo qualified as a medical practitioner in Cuba in 1989. She holds certificates in HIV/AIDS counselling skills and reproductive health. She has worked in paediatrics obstetrics, casualties and paediatric surgery. Dr Maroo has held senior management positions at Mx Health and Sechaba Medical Solutions. She is currently the Head of Risk Management and Strategy at Gen-Health Medical Scheme.

Do this to turn the scheme around:

- 1 Restructure the Board of Trustees.
- 2 Restructure the benefit and contribution rates to be competitive in the marketplace.
- 3 Review the broker arrangements, opening the network to independent brokers.

Change service providers

Get-Well Medical Scheme is clearly in a very difficult situation: it has rapidly falling membership, underwriting losses, and its claims costs are increasing at an alarming rate. The net effect has been that the scheme's solvency has fallen from 35.5% to 20.7% over three years.



By Dr Jonathan Broomberg
DISCOVERY
HEALTH (PTY) LTD.

Dr Broomberg is a medical doctor and health economist, and the Head of Strategy and Risk Management at Discovery Health (Pty) Ltd. He has spent most of his professional career working in health economics and finance, both in the public and private sectors. In 1994 he co-chaired the Committee of Inquiry appointed by the Minister of Health to propose reforms to the funding and delivery of healthcare in South Africa. In 2005 and 2006 Dr Broomberg was appointed by the Ministerial Task Team on Social Health Insurance to coordinate a consultative investigation into low-income medical schemes. He also served as a member of the Technical Review Panel of the Global Fund to fight AIDS, TB and malaria for five years, including two years as Chair, and is currently a Board member of the Alliance for Health Systems and Policy Research, which is based at the WHO in Geneva.

The drop in membership appears to be due to the very high contribution increase in year 3, of 26.4%. This appears to have been a reaction to an expectation of a high increase at the time of pricing.

The actual claims increase was 21.4% from year 2 to year 3, which came on top of the significant deficit arising in year 2.

Nevertheless, by simply imposing a very high contribution increase, the scheme affected its membership adversely, leading to a significant loss in members – and it was probably the younger and healthier that left in year 3, thus aggravating the “actuarial death spiral” of ever higher claims costs in relation to premium income.

It would now be very difficult to get these members to join the scheme again, or to attract other members, as brokers would have noticed this vulnerability and potential failure of Get-Well and would not recommend that their clients join this scheme.

There also seem to be corporate governance failures – notably the fact that some of the trustees are employed by the holding company of the administrator, which is against the law. This clearly has to be rectified. The trustees would no doubt find it easier to question the role of the administrator if the members of the Board did not have such conflicts of interest.

On a simple analysis, non-healthcare costs appear high, although it is hard to tell whether the fees are unreasonable without having any information on the range and quality of services offered

to the scheme. While a reduction in these costs would improve the financial position of the scheme, this change would not, in and of itself, save the scheme.

To illustrate this point, consider four scenarios in solvency: the base scenario, a scenario of having 10% lower administration and managed care fees in each year (scenario 1), a scenario of having 10% higher risk contributions in each year (scenario 2), and a scenario of having 10% lower claims in each year (scenario 3) (see table below).

If, for each of these, we assume that the change is implemented in year 1, the solvency would have developed as indicated in the table over the three years.

Under both the base scenario and scenario 1, solvency falls below 25% by year 3.

However, under scenario 1, the solvency result is close to the regulatory minimum. But had the scheme implemented 10% higher contributions in year 1 and then simply maintained the

subsequent increases that it implemented under the base scenario, it would have maintained solvency of more than 48%.

This is only illustrative because this would have come at considerable pain to members, and the adverse membership movements may then have occurred earlier. Also, the scheme would not have had to impose such a high contribution increase going from year 2 to 3.

However, the table does illustrate how higher contribution increases have a far more significant effect on outcomes than lower non-health

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It is not clear whether the scheme has the credibility to recover from this precarious situation.

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The four scenarios in solvency

	Year 1 %	Year 2 %	Year 3 %	
Base	35.50	25.90	20.70	
Scenario 1	36.85	28.64	24.66	10% lower admin and managed care fees
Scenario 2	44.48	44.41	48.11	10% higher risk contributions
Scenario 3	43.80	43.59	46.80	10% lower claims

expenses, all other things being equal. As explained above though, high contribution increases typically lead to adverse membership movements, and it is therefore not a good strategy on its own.

Clearly the most effective strategy would have been to reduce claims by 10% in year 1. Even if claims inflation was then at the same level as in the base scenario thereafter, the scheme would still have ended up with solvency above 46% in year 3, all other things being equal.

The scheme would have had much more freedom in years 2 and 3 to impose lower contribution increases, and the adverse membership movements could have been avoided.

Such a reduction in claims costs could have been achieved by one or both of the following options:

- option 1: moving the scheme to an administrator and/or managed care organisation that is able to obtain significantly better tariffs in the market (savings of more than 10% are available in the current market, and this could have accounted for the full claims savings required), and is also able to implement state-of-the-art risk analysis and risk management techniques. Again, savings of the magnitude required have been achieved in the current market; and/or
- option 2: redesigning the benefits. For a scheme

To reduce claims costs:

- 1 Move the scheme to an administrator and/or managed care organisation that can obtain significantly better tariffs in the market and can also implement state-of-the-art risk analysis and risk management techniques; and/or
- 2 redesign the benefits.

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The trustees would no doubt find it easier to question the role of the administrator if the members of the Board did not have such conflicts of interest.

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What to do?

- Improve risk management.
- Obtain better service provider tariffs.
- Revisit the scheme's governance structure.
- Failing the above, merge or go into liquidation.

of this size, five benefit options are probably not justified, and a “300% plan” in particular is not affordable.

Members would experience the most disruption or dissatisfaction with option 2 above – which may again lead to adverse member movements. Even so, it may still be necessary to rationalise benefit options. But clearly it would work better if, at the same time, option 1 were implemented.

The preferred route is therefore, without a doubt, option 1, as this would improve the scheme's finances immediately without having a negative impact on members.

However, this scheme is already in a precarious situation, and it is also not clear whether it has the credibility to recover from this situation, even if these actions are taken. In such a case, the scheme would have no option but to seek a merger and, failing that, go into liquidation.

Before getting to this point though, Get-Well should first try to achieve a step change saving in claims costs, preferably through obtaining better service provider tariffs and immediately improving risk management.

This could probably best be achieved by moving to an administrator and/or managed care organisation that could offer this.

Once again, a well-functioning governance structure, with no conflicts of interest, would facilitate a decision of this kind by the Board. ■

Focus on governance

The first step to turn around Get-Well Medical Scheme would be to apply to the High Court to place the scheme under judicial management due to governance irregularities.



By Michael Schultz
LA-HEALTH
MEDICAL SCHEME

Michael has been a trustee of LAMAF/IL-Health Medical Scheme for 40 years. He has been their Chairperson since 1994, and a Director at the BHF (Board of Healthcare Funders of Southern Africa) since 2002. Michael is an active member of the Public Private Health Forum and the private healthcare sector representative at the Provincial Health Council in the Western Cape.

In a nutshell

The following steps need to be taken to turn the scheme around:

- Place the scheme under curatorship.
- Reconstitute the Board of Trustees.
- Revise all contracts.
- Put the administration, managed care and capitation contracts out on tender.
- Develop a proper business plan.
- Investigate broker commission paid.
- Revise products and pricing philosophy.
- Determine proper marketing and communication strategies.
- Create a core management structure to look after the interests of the scheme.

The scheme has an illegally constituted Board of Trustees for the following reasons:

- The administrator Bloggs (Pty) Ltd. and the managed care company are subsidiaries of the Financial Services Group (FSG). All the employees of FSG and its subsidiaries are members of the scheme. Half of the trustees are senior employees of FSG and its group.
- Clause 57(3)(a) of the Medical Schemes Act 131 of 1998 (Act) clearly stipulates who is not eligible to serve on a Board of Trustees: "an employee, director, officer, consultant or contractor of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator".

For the trustees to carry out their fiduciary responsibilities, the model rules of the Council for Medical Schemes (CMS) propose as a guideline that the trustees should meet at least every two months. By meeting only twice in two years they did not take all the reasonable steps to ensure that the interests of beneficiaries in terms of the rules of the scheme and the provisions of the Act were protected at all times.

The trustees did not adequately apply their minds and address the non-compliance of the four loss-making options.

And the capitation agreement does not meet the requirements of Regulation 15(f) of the Act. It is not in the best interest of members and does not embody genuine transfer of risk if the scheme is still experiencing increasing claims costs.

The second step would be to address the financial performance of the scheme.

The scheme is in a financial death spiral due to losing members, a drop in solvency ratio, an increase in average age, and an increase in operating deficits of four benefit options.

Non-healthcare issues

Although as a percentage of Gross Contribution Income

(GCI) the scheme compares well with the average of open schemes, the average non-healthcare cost per beneficiary in the third year was 20% higher than the average for open schemes. This is due to the fact that the average contribution of the scheme is much higher than the industry average.

To address the non-healthcare costs, the distribution contract needs to be reviewed. The scheme cannot survive by paying distribution fees and experience increased marketing costs whilst the membership is falling by 25% over a three-year period.

The fact that broker commissions did not reduce much over the last three years while the membership dropped by 25% needs to be investigated.

Judging from the claims ratio of 90% plus, it does not seem that the managed care company is adding any value in retaining claims costs.

The current administration cost of R234 per member per month is too high compared to the industry averages. Despite the scheme's unsatisfactory performance, the administration fees increased by 8-11% over the period under review.

Product issues

It needs to be investigated why there are two capitation options and, as indicated above, the existing inappropriate capitation arrangement needs to be looked at as it seems that it does not meet the requirements of the Act.

It could be an option to merge options C and D and scrap the 300% benefit whilst providing for a revision of the current limit structures and attendant protocols. With the claims ratio above 90% the pricing philosophy of the scheme must be reviewed.

Proper and adequate managed care initiatives need to be implemented to contain costs.

Create an option that would attract younger members, particularly those entering the labour market.

Marketing and distribution

Focus marketing on employer groups rather than individuals.

Appoint an independent distribution network.

Develop all-embracing research-based marketing, communication and member growth and retention strategies. ■

Target non-health expenditure first

Just looking at the overview of Get-Well Medical Scheme, the key areas that need to be considered include non-healthcare costs and healthcare costs.

Non-healthcare costs

There is a need for improved and tighter corporate governance.

Half (50%) of the trustees are senior employees of the Financial Services Group (FSG) and its group. But section 57(2) of the Medical Schemes Act 131 of 1998 prescribes that at least 50% of the members of the Board of Trustees shall be elected from amongst members. Section 57(3) of the Act stipulates that a person who is a director or an employee of an administrator of a medical scheme shall not be a member of the Board of such a scheme.

There is a clear conflict of interest here. And perhaps a start would be to tackle the factors influencing non-healthcare expenditure.

The current corporate governance arrangements are not amenable to tackling the current administration expenditure, and in fact transfer more power – or at least the potential transfer of power – into the hands of the administrator and the managed care organisation.

With respect to the number of Board meetings, there are far too few to ensure adequate levels of control over the financial dealings of the scheme. The Board has only met twice in two years. As per the Council for Medical Schemes (CMS) guidelines on governance, Boards should schedule at least four meetings annually.

Therefore, with more regular meetings, the scheme will be able to monitor its performance with proper accountability and lines of accountability and responsibility.

The Audit Committee, for example, should

“There is a need for improved and tighter corporate governance.”

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“This case study points to the need for mandatory cover, clarity on guidelines for the minimum package of benefits, and income cross-subsidisation.”

hold no fewer than three meetings a year, the dates of which should fall within the financial and audit reporting cycle.

There also needs to be stringent application of guidelines on fit and proper trustees and principle officer, as per CMS criteria, to avoid the shortcomings experienced by this scheme.

With the efficiency gains from improved corporate governance and reduced non-healthcare expenditure, the scheme would be better placed to employ marketing agents to strengthen the membership pool and the overall performance of the scheme.

Healthcare costs

The scheme should seriously consider streamlining the number of benefit options. This will translate into more effective risk-pooling with enhanced levels of cross-subsidy.

The fragmentation that comes with multiple risk pools with little or no cross-subsidy between them poses a risk to those risk pools with higher health burdens, older population members and fewer members. It could be that these are the members that are losing out and that they could be moving to other schemes that offer lower premiums and perhaps greater levels of benefits.

Last resort

As a last resort the scheme should consider a consolidation with a larger scheme so as not to compromise the interests of its existing membership.

This case study points to the need for mandatory cover; clarity on guidelines for the minimum package of benefits, and income cross-subsidisation. ■



By Haroon Wadee
BHF

Haroon is the Head of Health Systems and Policy at the Board of Healthcare Funders of Southern Africa (BHF). He has nearly 10 years experience in health systems analysis, specialising primarily in healthcare financing reform and health economics. His areas of work include Social and National Health Insurance, exploring cost drivers in the health system, and unpacking the key challenges for healthcare financing reform. But his major interest lies in public-private interactions in the health system.

Clarify the purpose and take action

The picture for Get-Well is not a pretty one. It would appear as if all the cards are stacked against this scheme but it has been my experience that the situation for the scheme can be turned around.



By Charles Harebottle
MSO

Charles is a specialist in the field of strategic response programmes that deal with the business challenges presented by rapid change in the business and social environment. He has helped organisations to capitalise on the challenges and opportunities brought about by sudden change, and with the development and implementation of strategic response programmes to deal with the HIV/AIDS epidemic. Charles has also been involved in workplace health. He is the Managing Director of the Medical Services Organisation (MSO).

What is needed to achieve a turnaround for Get-Well is a clear sense of purpose and the will to take necessary action.

For some time I worked closely with Dr Andy Andrews (Henley Management College) and he would often start a session with a slide that defined insanity as “doing the same things while expecting a different result”. He appropriately credited the quote but unfortunately I cannot remember who said it.

The quote is, nevertheless, applicable to this situation. If the fortunes of the scheme are to be turned around, things are going to need to be done very differently.

In this instance the first thing that will have to change – and change very drastically – is the approach to the management of the scheme. A scheme, even one of this size, is a very big business that needs to be actively managed. A meeting of the Board of Trustees only once per year is certainly not sufficient to actively take charge of the scheme and direct the very serious plan of action that will need to be put in place to return the scheme to sustainable long-term health.

What the trigger would be to get the trustees to recognise the seriousness of their fiduciary duty is not clear but I have experienced a refreshing new enthusiasm across the full spectrum of trustees and far more active and independent participation in decision making with respect to the running of schemes.

Once this change in management approach has been effected, I believe that the prognosis for the scheme is actually quite good. I have had direct experience with organisations being turned around that were facing far more serious challenges than this scheme. All it took was a recognition that things needed to change and the right management team being put in place.

While the scheme faces the challenges of a reducing member base, declining reserve levels and the ageing of its members, it is still relatively well resourced. This could provide the space for

management to take the required action. Also, almost ironically, some of the scheme’s bad numbers are in fact its opportunity for improvement.

In any business turnaround, only one thing needs to be achieved and then all others fall into place: the organisation must be returned to operational profitability. In the case of a medical scheme, the word “profit” is possibly inappropriate but for the scheme to have a healthy sustainable future it will need to be brought to the position where it can deliver an operating surplus on a sustainable basis.

The profitability equation is a very simple one. Profitability is a function of cost and revenue. Costs must be kept below revenue.

In the case of Get-Well it will be very difficult to increase revenue due to both marketing and regulatory forces. The average risk contribution is already well above the industry average. It will be difficult to attract and retain members if this differential is increased even further.

Fortunately, the numbers show that there is considerable opportunity to improve the cost side of the equation. With the appropriate focus there has been on the scheme’s non-healthcare costs over the past few years, it is tempting to focus all the attention on this aspect. A more detailed analysis of the numbers shows that the new management will fail if this is

the only area concentrated on.

To put this into perspective, the scheme will save R24 per beneficiary if these costs were reduced to the market average but will save R317 per beneficiary if the net healthcare expense could be reduced to the market average.

This is not to say that the new scheme management should not take action to reduce non-healthcare costs. The best administration and risk management services in the market are certainly not necessarily the most expensive; it is just that when making this decision, the scheme decision-makers need to focus more on actual risk

“Once the change in management approach has been effected, the prognosis for the scheme is actually quite good.”

management performance than just on the cost of the service.

I have seen several studies with hard data that show that the risk management performance differential can be as high as 18%. This would suggest that the scheme could potentially reduce its average net healthcare expense by R158 per beneficiary if its risk management was optimised. This is more than the entire non-healthcare cost. The differential to the open scheme average for healthcare expense suggests that it could be achieved.

An improvement of this magnitude will clearly not be achieved by a single action. It will need significant change across the entire risk management spectrum, from benefit design to utilisation management and provider relations. It will almost certainly take longer than a year and will encounter resistance from all manner of vested interest but I know from experience that it can be achieved and is worth attempting.

I have not allowed myself to be sidetracked

into debate about the relationship between the scheme, its administrator and the Financial Services Group (FSG). While these relationships can be open to abuse with the blurring of interests of the scheme and the company, there could equally be a greater incentive for FSG to support the scheme in every way possible to protect their business interests. What is critical here is for the trustees to recognise that they have a real responsibility to members completely independent of their responsibility to FSG, even if they are employees of FSG. Every decision they take must be in the best interest of members, even if it is not necessarily in the best interest of FSG.

It has been my recent experience that, with a recognition of the seriousness of their fiduciary duty, a growing number of Boards of Trustees are beginning to act in this way. ■

A word of advice

One of the approaches that the Board of any scheme in difficulty should always explore is the possible merger with a healthy scheme.

If the merger partner is chosen properly, this action provides an immediate solution to the scheme’s difficulties and should also strengthen the scheme into which the merger takes place.

If this can be achieved, it can be seen to be in the best interest of members as it could then also strengthen the long-term viability of the scheme into which the merger has taken place.

Decide where the problem lies

Before deciding on the most appropriate course of action, the following question needs to be answered: is there a problem with the scheme or with the system?



By **Alex van den Heever**
SENIOR ADVISOR

Alex is a senior advisor to the Office of the Registrar of Medical Schemes for three days a week. By profession he is an economist with a Masters degree from the University of Cape Town. Outside of the CMS he provides technical advice on a consulting basis to government and public entities in the areas of social security, health economics and finance, public finance, and health systems.

Schemes operating within the open commercial sphere may fall into difficulties for reasons either within their control or out of their control. The former may involve poor commercial strategies arising from risky business decisions or conflicts of interest. The latter may involve systemic demographic changes that ultimately narrow the available commercial strategies.

In performing a scheme diagnostic it is important to make this distinction as it could determine specific interventions by the regulator and/or establish a basis for improvements in the regulatory framework.

Where the causes are systemic, amalgamations and related measures may prove appropriate. Where, however, mitigating the central challenges falls within the control of the scheme's management, scheme governance may prove to be the factor requiring an urgent remedy.

Ageing membership

The ageing membership of Get-Well Medical Scheme should not necessarily cause the scheme to become unsustainable or uncompetitive within the market.

The scheme has five options, ranging from hospital cover to comprehensive cover, which should result in a distribution of risk within the scheme, which in turn should not impact on pricing. The older and sicker members would reside in the more comprehensive arrangements, while the younger and healthier members would take up the more limited cover options. Competition with other schemes would involve a degree of cross-subsidisation from the limited cover options to the more comprehensive options in order

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Appropriate corrective action is unlikely to materialise without significant external pressure or intervention.

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Schemes operating within the open commercial sphere may fall into difficulties for reasons either within their control or out of their control.

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to attract a reasonable number of good risks to comprehensive options.

However, if this scheme were facing significant competition from single-option schemes which offer no comprehensive cover, it would be forced to remove any cross-subsidisation to remain price-competitive.

Although this would cause harm to those groups no longer able to afford the increased cost of comprehensive options, the scheme would nevertheless remain viable. The removal of this social harm to high-risk groups would, however, occur through measures such as risk equalisation, which would remove health status as a basis for competition.

through option differentiation.

The fact that Get-Well is ageing cannot be seen as a factor causing this scheme to become unviable as it has adequate mechanisms within the law to counter the effects of an ageing membership profile.

Governance

The scheme demonstrates a highly conflicted governance structure. Whether or not this factor will undermine the commercial viability of the scheme is dependent predominantly on whether the conflicted commercial interests take a short- or long-term view of their interest in the scheme.

A long-term view would be consistent with lower administration fees and properly performing managed care services – even if conflicted.

Where the view is weighted to the short term, the

conflicted commercial interests may be under pressure to rapidly recoup their return on investment, either because of dividend pressures arising from the structuring of share-incentive schemes for senior management and/or because of financial difficulties within the holding company FSG.

The evidence indicates that the conflicted governance arrangements are supporting a short-term view. This would be of significant concern where the short-term view is undermining the financial viability of the scheme, which suggests that the conflicted commercial interests are unable or unwilling to adjust their self-defeating behaviour.

This scenario is extremely dangerous for scheme members as the commercial interests may be in some form of a downward spiral that may result in increasingly desperate attempts to extract funds from the scheme without cutting expenses. These increasingly desperate actions will result in faster membership attrition within a financial year, distorting the pricing faster than it can be adjusted.

Broker arrangements

Given the inherent conflicts of interest embedded in this scheme, it is reasonable to assume that brokers have been over-remunerated to attract members at some point. The brokers would therefore have been party to the consequences of the short-term strategy of the holding company and in part responsible for the scheme's decline.

However, once the situation becomes obviously desperate, the broker group is inevitably going to disengage from the scheme and encourage the better risk groups to move.

This will only exacerbate the decline of the scheme, causing rapid deterioration from this point forward.

Overall assessment

The predicament of Get-Well Medical Scheme appears to derive from the conflicted scheme governance structure where the relevant external commercial interests have adopted a short-term view of the scheme.

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Where the causes are systemic, amalgamations and related measures may prove appropriate. Where, however, mitigating the central challenges falls within the control of the scheme's management, scheme governance may prove to be the factor requiring an urgent remedy.

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The consequences for the scheme may be serious as appropriate corrective action is unlikely to materialise without significant external pressure or intervention.

Recommendation

Given that the problems at Get-Well are related to governance, resolving the financial viability of the scheme is possible only if unconflicted management decisions can be implemented timeously.

But correcting a governance problem takes time, which suggests that immediate action should be taken by the regulator to fix non-health expenses at a level that can make the scheme viable again.

This should buy some time to take action against conflicted Board members, and to consider options such as curatorship.

Where the conflicts are extensive, then a period of curatorship should be considered. ■

What should happen?

Resolving the financial viability of the scheme is possible only if unconflicted management decisions can be implemented timeously. But correcting a governance problem takes time, which suggests that immediate action should be taken by the regulator to fix non-health expenses at a level that can make the scheme viable again.

Place the scheme under curatorship*

Get-Well Medical Scheme is a large open scheme which is facing serious difficulties from various fronts.

By the **Financial Supervision Unit of the COUNCIL FOR MEDICAL SCHEMES**

Get-Well is currently experiencing member loss to the tune of 25% for the last couple of years. This should be viewed against the background of the intensive and aggressive marketing strategy that the scheme has adopted. The increased marketing expenditure and reduced membership suggests that the scheme is not deriving value for money out of this arrangement. This is an area that needs to be reviewed by the Board. Furthermore, the fact that the scheme utilises a broker network of its administrator's holding company poses potential conflict of interest.

Managed care

On managed care, Get-Well entered into a capitation contract which failed to curb its increasing claims costs. This again questions the appropriateness of this contract; it is not resulting in expected efficiencies for the scheme. This is another area where the Board needs to assess the fees that are being paid in terms of this contract against value for money derived.

One would expect an appropriate managed care contract to introduce relevant and sufficient risk management strategies that bring the claims costs down. An increase in claims will result in added pressure on the reserves of the scheme. A reduction in claims could be achieved by redesigning the benefits; this should, however, be matched against the already higher than average contributions.

Ageing membership profile

The major long-term issue to be addressed is the ageing membership profile. Unless this is done, the claims ratio will continue to rise despite adjustments to the benefits.

As the average contributions are already higher

than the industry average, the reduction of benefits will cause more members to leave. These will tend to be groups rather than individuals as the groups will be able to negotiate favourable underwriting terms with a new scheme. Individuals will be subjected to waiting periods and possible exclusions.

On the other hand, an increase in contributions will also not provide the scheme with any relief as this would result in more members leaving, particularly the younger and healthier ones.

The scheme and FSG (the holding company of the administrator) have attempted for a number of years to change the member profile by marketing to groups.

Clearly this has not been successful and there is no indication that with the current options and pricing they will be able to attract sufficient numbers of groups to drastically change this situation.

Problems of governance

Get-Well Medical Scheme also faces serious governance problems.

Firstly, the Board of Trustees is not properly constituted in terms of section 57(3)(a) of the Medical Schemes Act which states that "a person shall not be a member of the board of trustees of a medical scheme, if that person is an employee, director, officer, consultant or contractor of the administrator of the medical scheme concerned, or of the holding company, subsidiary, joint venture or associate of that administrator".

Proper constitution of the Board is critical to ensure an appropriate balance of power and authority for greater independence and reduced conflict of interest.

Secondly, the trustees have not held regular Board meetings in the last two years. This is an important aspect of the management of the scheme as Board meetings are essential to ensure that the relevant decisions are taken timeously, and also to monitor the operations of the scheme and ensure that all controls are in place, and functioning effectively.

As already indicated, the association between the scheme, its administrator Bloggs and FSG also poses potential issues of conflicts of interest and causes one to question the extent to which decisions taken by the Board are independent.

Finances

This scheme is also experiencing problems on the financial front.

Get-Well is currently not meeting the requirements of Regulation 29 of the Act which stipulates that a scheme must maintain accumulated funds amounting to at least 25% of gross annual contributions.

The reduction in the solvency ratio of the scheme in the last three years appears to be largely due to high claims costs (as a result of an ageing membership and high chronic claims) as well as high non-health expenditure (NHE). Get-Well is spending significantly more on total NHE than other open schemes. This appears contrary to the expectation that the larger the scheme, the lower the cost per beneficiary should be.

In essence, members of Get-Well are getting less out of every healthcare Rand spent. This results in a further dilution of reserves.

Action to take

Given the challenges that Get-Well is experiencing, the following course of action should be undertaken:

- 1 The scheme should be placed under curatorship. It is evident that the trustees are not fit and proper to effectively manage the scheme. This would also be an attempt to deal with the governance problems experienced by the scheme. The governance structures adopted by the scheme need to be reviewed to ensure that the interests of its members are protected.

- 2 The scheme should submit a business plan to the Office of the Registrar of Medical Schemes detailing a turnaround strategy in terms of section 35 and Regulation 29(4) of the Act.

This plan should cover, inter alia, how the scheme will reduce its claims costs and NHE. Should the scheme fail to propose an appropriate plan in respect of NHE, in particular administration costs, a restriction can be imposed on the scheme in terms of section 44(8).

- 3 The prospects of the scheme operating in a sustainable manner again appear bleak. This is primarily because of its inability to attract younger and healthier members (and the resulting deteriorating age profile). The scheme should not be allowed to continue operating until its reserves are completely depleted; allowing it to operate would amount to postponing the inevitable. The curator can thus consider amalgamating Get-Well with another scheme. Even though the scheme has been losing members and reserves, the membership base and reserves are still big enough to

attract a suitable partner to merge with. It is, however, important that the scheme seek a partner that is suitable from a cost and benefit point of view. The potential partner should have a risk pool and reserves large enough to absorb Get-Well without impacting negatively on the members of the recipient scheme.

- 4 Should the curator fail to institute an amalgamation, the scheme should be liquidated in terms of its rules. This should happen timeously lest the members are left out of pocket. ■

What needs to happen?

- 1 Get-Well should be placed under curatorship.
- 2 It should submit a detailed business plan to the CMS.
- 3 The scheme should attempt to merge with a suitable partner.
- 4 Failing a merger, Get-Well should be liquidated in good time.

The larger the scheme, the lower the non-health expenditure per beneficiary should be.

**We have given our opinion without reviewing the positions of others. Under normal circumstances, we would combine a variety of views to generate a complete picture before determining what regulatory action is necessary. Please also note that this analysis is not prescriptive and must not be regarded as setting a precedent for any future interventions by the Office of the Registrar. It should be regarded as an opinion piece only. The Office interacts with medical schemes on a case-by-case basis, and interventions, where indicated, are based on the merits of each particular scheme and its unique circumstances.*

Ours is to protect

The mission of the Financial Supervision Unit (FSU) at the Council for Medical Schemes (CMS) goes beyond analysing and balancing the financial spreadsheets of medical schemes.

By **Phumla Khanyile**
COMMUNICATIONS
OFFICER

FSU is an energetic team committed to monitoring the financial performance of schemes and so doing its bit to ensuring that no stone is left unturned in the quest of the CMS to protect the welfare of members.

Tebogo Maziya (Head of FSU)

Having joined the CMS in 2003, Tebogo is one of the young professionals who blossomed under the leadership of our former Registrar, Patrick Masobe. She is a strong-willed woman with presence dedicated to the mandate of the CMS.



"Being mandated with ensuring the financial health of medical schemes is a very big task, one which I would not be able to carry out without the support of the great professionals I have on my team," she told CMS News.

"The secret to successful leadership lies in how well you treat the people you lead. To quote Nelson Mandela, a good leader leads from the front but does not leave their base behind."

In her spare time, Tebogo enjoys reading, watching movies, spending time with family and friends, and travelling.

Paul Bosch (Senior Financial Analyst)

Paul is the babysitter of the team. He is a seasoned professional with over 25 years of experience in the medical schemes industry.



Prior to joining the CMS family in 2002, Paul spent over 18 years at a medical administrator organisation. He admits that being a regulator does have its pros and cons.

"The highs of being a regulator are seeing improvements in the solvency levels of schemes. The lows come when schemes close due to bankruptcy and members are left without medical cover. This is why it's so important for Boards to have financial experts and actuarial strength in their midst to keep an eye on the financial side of things and be ready to take proper decisions as changes take place."

Paul is also dedicated to his wife, four daughters and four grandchildren. And lawn bowling.

Julindi Scheepers (Senior Financial Analyst)

Julindi joined the FSU team two years ago as a qualified Chartered Accountant. Before the CMS



she worked for a pension fund administrator.

She enjoys spending time at home with her husband James and their two dogs, Klara (a basset) and Mia (a bulldog). And when she's not buried under a pile of quarterly return submissions from medical schemes, Julindi pursues her book-collecting project, goes horse-riding, plays action netball, does mountain biking or attends pottery classes.

Elizabeth Figueiredo (Senior Financial Analyst)

Elizabeth is the latest addition to the FSU team, having joined us in February this year. She worked



as an Audit Manager for one of the big audit firms in South Africa before she decided to take on the next challenge.

A qualified Chartered Accountant with an Honours degree in Financial Accounting from the University of Pretoria, Elizabeth feels passionate about the importance of what she does: "Monitoring the financial performance of medical schemes is critical to ensuring that schemes are financially sound."

Elizabeth is an avid wine taster who enjoys relaxing with a stimulating book in hand. She plays squash and enjoys travelling too; she has been to the USA, Portugal, the UK, France and Tanzania. She got married just 11 months ago; the couple has recently taken up ballroom dancing.

Lerato Sehularo (Senior Financial Analyst)

Lerato's love for figures dates back to her school days. She decided to study accounting instead of engineering after she had found herself underground in worker's boots in a mine during a holiday in her high school days. "I decided there and then to rather wear Gucci shoes and have an office above the ground," she told CMS News.

In the six years that she has been with the CMS, her belief has not changed: "Life is there to be enjoyed. And whatever happens – sweet or sour – happens for a reason."

Lerato is a wife and a mother to a two-year-old boy, Oratile, and is expecting her second child soon. "I am always looking forward to going home to my son. I love motherhood."

She also enjoys dancing, jogging, reading and listening to music.



Molebogeng Molabe (Assistant Senior Financial Analyst)

"I am forever chasing after deadlines," Lebo told CMS News. "But I stay motivated in the times spent away from my daughter by remembering that I'm



playing the role of a protector by making sure that schemes have sufficient reserves to meet the healthcare needs of their members."

Lebo plays tennis and enjoys the occasional Latin American dance. She also enjoys reading, watching movies, aerobics, travelling and exploring extreme adventures like her recent bungee-jumping experience.

"There is never a dull moment at FSU. Accounting can be challenging but it is fun too."

Kabelo Mahobye (Financial Analyst)

Kabelo is tasked with interpreting complex financial statements into understandable information that helps members of medical schemes make informed decisions.

He joined the CMS in 2004 as a Financial



Analyst after a stint in the banking industry.

His work colleagues know him as a polite gentleman with exquisite taste in clothing. He has had the privilege of shopping overseas: in Italy, France, Greece and Turkey.

When he's not at work, Kabelo is playing golf or squash, or toning his body at the gym.

Glenda Mosley (Personal Assistant)

Glenda is a sassy mother of two who joined the CMS three years ago to assume the responsibility of being a personal assistant to the FSU crowd.

She is always happy. "I try not to get upset over things I have no control over."

In her spare time Glenda enjoys designing web pages. ■



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Use our website to:

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

Complaints

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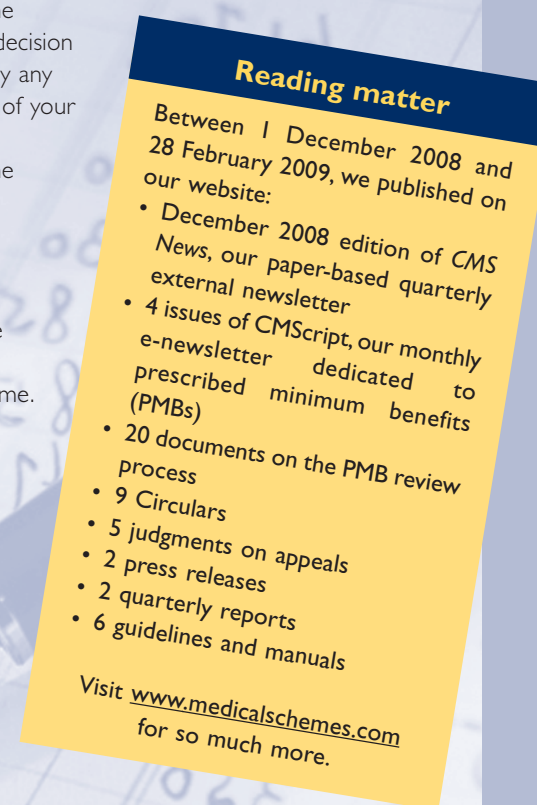
e: complaints@medicalschemes.com

Complaints procedure

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

How to avoid complaints

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





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