


CMS news

June 2009



**Discrimination based
on age and/or health
status is unfair**



Decades later, the concept of risk selection is as contentious as ever. In practice, treating people differently because of their health status remains a perennial tendency in all health insurance systems – and South Africa is no exception.

Despite being discouraged by law, the practice of favouring the young and healthy over the old and sick remains prevalent in our private health insurance sector. Where our Constitution and the Medical Schemes Act already protect us against unfair discrimination, they are unfortunately sometimes ignored. So it seems that the only other solution – which is already on the parliamentary table – is to introduce structural changes to the regulatory framework governing medical schemes.

But things are rarely that simple. There are at least two sides to this epic story. At the Council for Medical Schemes we place the interests of beneficiaries first, but we are also cognizant of the importance of ensuring the long-term well-being of medical schemes. After the heated debates have subsided, the ultimate goal needs to be the elimination of all avoidable unfairness, with competition in the industry aimed at maximising affordable and comprehensive lifetime coverage for all South Africans.

Sooner or later, age catches up with us all. And if medical schemes are not supported, access to quality care may just become more instead of less elusive.

Editorial Committee

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Risk selection as a policy issue

Despite the introduction of the Medical Schemes Act in 2000 which aims to eliminate unfair discrimination based on age and health status, schemes continue to risk-select.

The medical schemes industry was deregulated in 1989-99. Schemes were allowed to price their benefit options by taking into account a member's health status and age. Almost all the open schemes embarked on the practice of risk selection which entailed the selection of predictably profitable members through direct or indirect means. This process was generally intended to encourage low-risk members to enlist in schemes whilst discouraging high-risk members from entering the private health insurance environment.

Since 2000, risk selection has been discouraged with the introduction of the Medical Schemes Act, which has brought about interventions such as open enrolment, community rating, guaranteed benefits, and social solidarity. All schemes are now legally obliged to admit members without engaging in any form of discrimination. Also, contributions payable by members must be set only on the basis of income, number of dependants, or both.

As a result of the Medical Schemes Act, schemes can no longer legally risk-select members based on their health status and/or age. Yet despite these provisions, schemes continue to discriminate against members through practices such as exclusions, restrictive limits, discriminatory benefit designs, risk-shifting, inaccessible designated service providers, protocols, and formularies.

In many instances, such practices have resulted in the denial of access to healthcare to members who needed it most. They have also resulted in members buying up to the more expensive benefit options which they could ill-afford. This behaviour trend has often led to risk-pooling on the basis of demographics and health status, resulting in above-average year-on-year contribution increases for members of those schemes. The overall effect is the denial of efficient income- and health-cross-subsidisation between groups.

Over time, interventions have been affected which ranged from the enforcement of existing legislation by the Council for Medical Schemes to the review of the registration process of schemes and the approval of scheme rules. However, despite these, members continue to experience residual risk selection.

In light of this, a process was begun to address the ongoing residual risk selection practices by schemes. It was acknowledged that the interventions brought about through open enrolment and social solidarity had not been as effective as was initially hoped. They were ineffective largely due to the absence of a risk equalisation mechanism; research shows that in countries with private health market structures similar to ours, when community rating and social solidarity were introduced, they were followed by the introduction of a risk equalisation fund.

Risk equalisation assists in the redistribution of financial resources among schemes to reflect more accurately the expected risk costs of members.

Another proposed legislative intervention to address unfair risk selection by schemes is the transformation of benefit designs to incorporate a basic package of benefits and the introduction of a revised package of prescribed minimum benefits.

But the promulgation of legislation on risk equalisation and other related provisions has unfortunately been delayed. The undesirable consequence of this delay has been the exacerbation of a skewed market structure

with some schemes continuing to benefit in their risk profiles while others experience worsening demographic profiles.

In the absence of the necessary legislation, South Africa continues to face the stark reality: when schemes do not compete fairly, they are often faced with two possible options – either amalgamation or liquidation. We have recently witnessed several schemes amalgamating or being liquidated due to their worsening risk profiles. This can be attributed to a large degree to the delay in the introduction of legislation that could have helped schemes continue to trade fairly. In other instances, the poor management by the Board and/or administrator has also contributed to the collapse of schemes.

But all is not lost. The Council for Medical Schemes will continue to engage with relevant stakeholders with a view to ensuring appropriate protection of members through strengthening the current health policy structure or supporting any proposed health policy reforms. ■

By Patrick Matshidze
ACTING REGISTRAR
OF MEDICAL
SCHEMES AND
HEAD: RESEARCH
& MONITORING

“
Medical schemes continue to discriminate against their members.
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Risk selection: a short history

Until recently medical schemes in South Africa were allowed to pick and choose who they would admit as members and who would be turned away: they welcomed you on board if you were young and healthy but rejected you if you were not. The Medical Schemes Act has rectified the situation to a large extent but members remain vulnerable to schemes who try to cherry-pick the healthiest South Africans.

**By Thulani
Matsebula**
SENIOR POLICY
ANALYST

It is obvious why the ability to select “good risks” while eliminating high claimers from cover would appeal to medical schemes: they would be able to keep contribution levels low for the young and healthy, thus attracting them to enrol in even greater numbers.

Some stakeholders use this argument to consistently advance for more deregulation of the industry: to make risk selection legal again.

But are calls to permit risk selection realistic?

The argument that risk selection leads to affordable contributions for low-risk members disregards the

(negative) impact of risk selection on those most likely to need and therefore seek cover for healthcare: the older and sicker would be faced with higher contributions and would ultimately be forced out of the medical schemes environment.

This is exactly what happened in South Africa between 1989 and 1999 when the industry underwent significant changes allowing risk selection to occur. Overall membership remained stagnant. Restricted schemes were losing members

to open schemes. And instead of implementing efficiency improvement measures, schemes were simply “dumping” high-risk members onto the public health sector.

The negative consequences of risk selection during the 1990s gave a huge thrust to initiatives to revise the Medical Schemes Act. It was amended in 1998 to reintroduce risk-

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**Measures to
eliminate risk
selection have
unfortunately
not resulted
in a complete
eradication of
the practice.**
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pooling. Since then schemes are allowed to take into account only two factors when setting their contribution levels: the number of dependants, and income.

But schemes found a way to persist with the discriminatory practice.

In 2006, the Council for Medical Schemes (CMS) alerted several schemes to the fact that the manner in which they had structured their medical savings accounts was in fact resulting in the risk-rating of contributions for out-of-hospital expenses based on the age and health status of their members. The possibility to vary contributions to medical savings accounts was subsequently removed.

Later that same year, the CMS made further, perhaps radical, proposals to implement a basic package of healthcare services that would be uniform across all medical scheme options in preparation for the implementation of risk equalisation across all schemes to ensure that no scheme was prejudiced by the healthcare profile of its members in terms of financial performance. The amended Act requires that all schemes provide full cover for this defined list of conditions, referred to collectively as prescribed minimum benefits (PMBs).

The proposed changes to benefit design are contained in the latest Medical Schemes Amendment Bill. It promotes income cross-subsidisation between medical schemes. The revised benefit structure hopes to remove the existing scenario where schemes are still able to risk-rate PMBs by structuring some options to contain more comprehensive benefits while others provide only the PMB package.

Significant strides have been made towards eliminating risk selection in the medical schemes environment, but without the benefit design restructuring as envisaged in the Medical Schemes Amendment Bill, several avenues are still open for schemes to circumvent the Act by implementing risk selection in more subtle ways. ■

What is risk selection?

Schemes view potential members as “risks”. You are a “good risk” if you are young and healthy because you will claim less and therefore cost the scheme less. The older and sicker you are, the more you will need to claim – which makes you a “bad” or high risk. But schemes are not allowed to choose their members based on their age and/or health status; the principle of open enrolment protects potential members against unfair discrimination.

What is risk-pooling?

All members of a particular medical scheme belong to the same “risk pool”. They all contribute to this risk pool and their claims are covered from this risk pool. No distinctions are made between members on the different options of the scheme.

The risk profiles of medical scheme options

The current arrangement whereby community rating is required only at option level and not at scheme level results in de facto risk-rating within schemes. Consequently, older people pay much more for medical aid than younger people do.

The Council for Medical Schemes (CMS) receives two kinds of quarterly submissions from medical schemes: data for the Risk Equalisation Fund (REF) project as well as statutory returns prescribed by the Medical Schemes Act.

Having analysed both for a number of years now, we have developed the graph below. We find it quite interesting.

The graph shows that there are marked differences between the risk profiles of benefit options in registered medical schemes. Each benefit option seems to attract members similar in age and health status.

Look again at the graph. It visually demonstrates the relationship between the average age of beneficiaries on a particular option and the contributions charged to these beneficiaries to belong to this option.

Benefit options face risk. This risk can be presented in many ways but in this graph it is presented as the estimated cost of the prescribed minimum benefits (PMBs) in the various options as well as the risk claim costs*. The numbers represent the expected cost per member for PMBs, and the expected average cost for risk benefits.

On one extreme, the graph shows that where contributions are between R200 and R299 pbpm:

- PMB costs are estimated at R212 pbpm (per

beneficiary per month);

- the average age of beneficiaries in these low-cost options is 27 years; and
- risk claim costs are R301 pbpm.

The graph also shows that average age, contribution levels, PMB costs, and risk claims increase progressively. The older you are, the more you pay for medical aid based on the option you are indirectly forced to choose, the more you end up paying for PMBs, and the more likely you are to claim.

At the point where contributions exceed R2 500 pbpm, the average age is 64 years and PMBs cost almost R700 pbpm.

If older people pay more for PMBs than younger people do, this means that the current benefit design does not support inter-generational cross-subsidisation from young and healthy members to older and sicker members; de facto risk-rating is taking place. Yet a key objective of the Act is to prevent risk-rating.

Other research done at the CMS supports the view that option design allows for an unequal distribution of risk, whereby lower risks (presented by lower average age and low PMB costs) are risk-pooled separately from higher risk groups.

The uneven distribution of risk between options is the motivation behind the suggested amendments to the Act, whereby a stricter version of community rating will be implemented. (Community rating says that all members on a particular option should be paying equal contributions.) The Medical Schemes Amendment Bill proposes revisions to the benefit structure as well as the implementation of the Risk Equalisation Fund (REF).

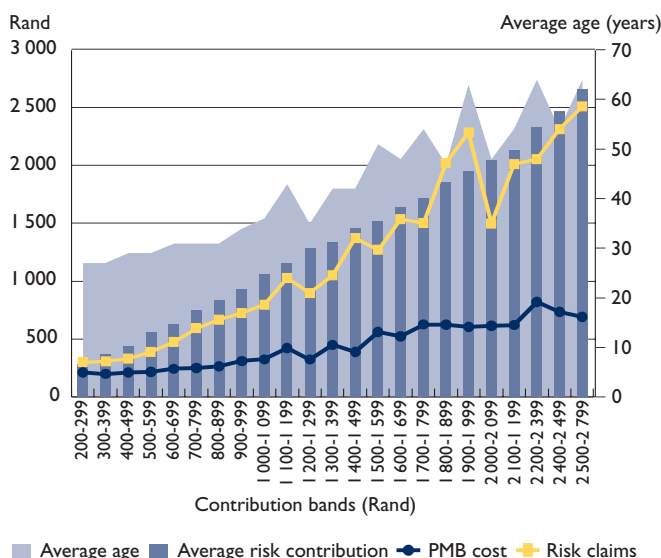
The suggested revised benefit design will require all beneficiaries to be risk-pooled together in each individual scheme in respect of PMBs, and all beneficiaries will then pay a community-rated contribution (i.e. the same contribution for access to PMBs). This arrangement will remove the current differences associated with age, and will ensure inter-age cross-subsidies within schemes.

REF will introduce a system of financial transfers between schemes, whereby all medical schemes will face the same risk in respect of PMBs, regardless of the risk profile of that particular scheme. ■

By Dr Boshoff
Steenekamp
REF PROJECT
SPECIALIST

“The current benefit design is inappropriate; it does not support inter-generational cross-subsidisation from young and healthy members to older and sicker members of the same scheme.”

The distribution of risk through option design**



* The risk claim costs represent the amount of money that a scheme pays for medical benefits that are paid from the risk pool. This amount excludes benefits paid from medical savings accounts and other expenses of the scheme.

** The data is based on December 2007 REF and statutory returns.

Unfair discrimination is all too real

Risk selection is sometimes just a euphemism for a form of unfair discrimination. And despite it being outlawed by our Constitution and the Medical Schemes Act, it continues to plague the private health sector.

By Marli Weldhagen
FORMERLY A
CLINICAL ANALYST
AT THE COUNCIL
FOR MEDICAL
SCHEMES

The illegal practice of risk selection in the medical schemes environment manifests itself in many different ways. It infiltrates scheme rules and benefit design, marketing material, and the application of benefits by the scheme and/or its contracted agents. The deliberate misinterpretation of benefits can also constitute a form of risk selection where it is targeted at sick people who need access to healthcare services.

The scenarios described below are examples of how schemes continue to risk-select against actual and prospective members.

Deductibles, co-payments, and sub-limits

For some time we have been noticing an increase in the number of scheme options that have either introduced or increased co-payments, deductibles and/or sub-limits on various medical interventions. When a scheme makes these penalties unaffordable, its beneficiaries either purchase a more comprehensive (and hence more expensive) option or remain on the current option and face the penalties.

But co-payments and deductibles do not apply to prescribed minimum benefit (PMB) conditions and their related services.

Benefit limitations and exclusions

Scheme A submitted its annual rule and benefit amendments to the Council for Medical Schemes (CMS) for registration. While reviewing its benefit schedules, we discovered that the maternity benefits section stated there were “no benefits for caesarean section”. This vague exclusion was not registered; it was removed from the benefit sched-

ules. “Delivery” falls under PMB 52N: pregnancy. The public sector protocol/practice is the minimum standard for PMB entitlements if there is a significant difference between the public and private sector practice – and the public sector protocol does include caesarean sections where

they are clinically indicated. Some indications are known in advance; consequently, a planned caesarean section is then clinically appropriate and is part of the PMB entitlement.

But if a patient asks for a caesarean section for social and not clinical reasons, this is not accommodated in the protocol/practice in the public sector and the scheme is allowed to impose a co-payment in such instances; this should be clearly stated in its rules.

Chronic medication for PMB conditions

The public sector protocol/practice does include chronic medication as part of the treatment and care of a few PMB conditions listed in the Diagnosis and Treatment Pair (DTP) table in the Medical Schemes Act. Some schemes, however, list these conditions only in their high-cost options and tell members that they qualify for chronic medication benefits only if they upgrade to one of these expensive options.

Mr X underwent a heart transplant. His scheme paid for the procedure. He now needs anti-rejection medication on a chronic basis. He also requires consultations, investigations and specific services at regular intervals to monitor his condition post-operatively. Mr X is on the second most expensive option of his scheme. He applied for chronic medication but the scheme declined his request, arguing that his current scheme option does not

“Incorrect, false or deceptive marketing material which does not accurately reflect the registered rules of a scheme allows the scheme to risk-select against prospective members as well as current members who need to make decisions about their annual benefit option subscriptions.”

Continued on page 9

The next time you speak to your broker ...

Healthcare brokers carry a huge responsibility on their shoulders: they have the power to either promote or mitigate risk selection in the medical schemes environment. It is a complex issue.

Medical schemes contract brokers to sell healthcare cover to their clients. There are two kinds of healthcare brokers in South Africa: the independent brokers and the tied agents. Independent brokers usually have contracts with more than one scheme and give their clients a choice of cover amongst the schemes they are contracted to. But tied agents are contracted to market one scheme only and as such, must disclose this fact to their prospective clients.

Both kinds of brokers must be accredited. They are also required to have contracts with schemes and both must be licensed by the Financial Services Board to provide services in a lawfully correct manner.

Healthcare brokers and risk selection

Some brokers promote risk selection. When advising their clients, many seem to put the interests of schemes and administrators above the concerns of their clients by favouring the admission of the young and healthy over the sicker and older and so adding fuel to the fire of unfair discrimination based on age and health status instead of trying to put out the blaze.

Brokers are there to advise both prospective and current members of schemes on the extent of the cover available to them. They need to add value to their clients by making them aware of the best possible cover at the most affordable rates. The selection of health cover offered must balance with the extent to which the employer is willing to subsidise the contributions of their employees and the effect of out-of-pocket payments made by employees for such cover. Employer subsidies of contributions constitute a substantial portion of staff expenditure and have an impact on the bottom line for employers. Conflict may arise where the broker is paid by the scheme for advising the member whilst pandering to the wishes of the employer.

The potential income of healthcare brokers

depends on the prescribed fees that schemes are lawfully permitted to pay them. Their income can also be driven by the contributions for a richer benefit option where contributions are more expensive than for lower-cost benefit options. This may have an impact on risk selection if the client's real need for cover is more aligned to reduced benefits. The higher the contribution, the higher the commission paid to the broker, though still subject to a legal maximum.

Consider the costs that brokers incur to advise their clients or to move them from one scheme to another. Brokers are required to educate their clients about new benefits and changes in benefit design, and they should conduct regular and proper analyses of their clients' needs and changes in financial circumstances; a client may need to buy up or down from occasionally. The decision to move the client to another scheme may be influenced by the cost the broker will have to incur for doing so. An enormous amount of work is involved in moving clients between schemes. Leaving them where they are is often cheaper for the broker – although not always in the best interest of the clients.

Many brokers fail to properly assess the well-being of the scheme to which their clients belong. Where schemes do not meet the required solvency levels or fail to produce financially sound results, brokers ought to advise their clients accordingly and seek alternative schemes to ensure that their clients do not suffer financial loss should their scheme be unable to turn the tide. The risk of waiting periods for the client should be weighed against the risk of loss of cover should the current scheme have to liquidate.

Please also note that incentives beyond the commission prescribed by law are forbidden (except for a professional fee negotiation and direct payment from the client to the broker). Yet certain brokers are likely to receive additional remuneration disguised in many different forms. Such additional incentives

make it difficult for brokers to advise their clients with a clean conscience on issues that may have a direct bearing on the brokers' income and consequently, material well-being. ■

By Danie Kolver
HEAD:
ACCREDITATION

“Many healthcare brokers seem to put the interests of medical schemes and administrators above the concerns of their clients.”

Waiting periods: preventing anti-selection by members

The advent of the Medical Schemes Act (Act 131 of 1998) at the start of the new millennium heralded a significant shift in the way that medical schemes were entitled to conduct their business.

By **Craig Burton-Durham**
HEAD: LEGAL
SERVICES

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There was a need to address the risk of abusive and opportunistic behaviour on the part of certain medical scheme members.

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** Waiting periods are clearly defined in the Medical Schemes Act. This ensures that members of medical schemes are protected against risk selection in the form of the arbitrary application of waiting periods when joining medical schemes.*

Prior to the introduction of the “new” Medical Schemes Act in 2000, schemes had been able to legitimately influence the risk profile of their membership bases via mechanisms such as risk-rating (the determination of the contribution which a member was required to pay on the basis of his or her age and/or health status).

But the introduction into the medical schemes environment of open enrolment and community rating (see sidebars for definitions) by the “new” Act resulted in these practices being outlawed.

Medical schemes were now obliged to deal with new applicants and members of medical schemes on a basis free from discrimination on grounds such as age and health status.

While these legislative interventions have resulted in improved right of access to medical schemes on a non-discriminatory basis, there was nevertheless a need to address the risk of abusive and opportunistic behaviour on the part of certain members.

Such behaviour typically manifests itself by way of certain members engaging in what is commonly called “scheme-hopping”, which is the practice whereby an errant member exhausts his or her benefit entitlements on whichever scheme they belong to before seeking out a new scheme on which to perpetrate the same practice. In the absence of any check on such behaviour, the open enrolment provisions of the Act would of course result in medical schemes being selected against in a prejudicial manner – hence the term “anti-selection”.

Parliament has sought to address the practice of anti-selection by way of introducing a system whereby prospective members of medical schemes can be subjected to the imposition of discretionary waiting periods by any medical scheme which they are seeking to join.

These waiting periods fall into two categories, namely a three-month general waiting period and

what is termed a 12-month condition-specific waiting period*.

The imposition of waiting periods results in any member admitted to a medical scheme being excluded from accessing all benefits for three months (with the exception of the prescribed minimum benefits) and/or from accessing benefits relating to any specific condition from which

they were suffering for the 12 months prior to applying for their membership.

This sanction in effect aims to discourage those persons prone to the pernicious practice of opportunistically exhausting the benefits of medical schemes.

The legislature does, however, recognise that not all changes in medical scheme membership are motivated by opportunistic self-interest and accordingly prevents any waiting period from being imposed in circumstances where a change in medical scheme membership is occasioned by factors beyond a member's control,

such as in the instance of a change of employment where such a member was obliged to join another medical scheme as a condition of employment. ■

Risk-rating v community rating

The problem: risk-rating = when a medical scheme determines the contribution which a member is required to pay on the basis of his/her age and/or health status (outlawed in South Africa)

The solution to risk-rating: community rating = a principle enshrined in the Medical Schemes Act to prevent risk-rating by medical schemes by prescribing that members on the same benefit option must pay the same contribution, regardless of their age and/or health status

Risk selection v open enrolment

The problem: risk selection = when a medical scheme favours the young and healthy and unfairly discriminates against the older and sicker (outlawed in South Africa)

The solution to risk selection: open enrolment = a principle enshrined in the Medical Schemes Act to prevent risk selection by medical schemes by prescribing that anyone and everyone who wishes to join a medical scheme must be allowed to do so and be admitted to the open scheme of his/her choice (subject only to waiting periods)

Open enrolment does not necessarily mean open arms

The principle of open enrolment is enshrined in the Medical Schemes Act, yet prospective members are prevented from joining open schemes anyway.

The introduction of the Medical Schemes Act brought about several new legislative provisions, one of which was open enrolment.

Open enrolment allows all eligible members to join a medical scheme of their choice without facing any form of unfair discrimination. This is more relevant in the open schemes environment as opposed to the closed or employer-based schemes environment.

Previously, most medical schemes practised risk-rating where the health status of the prospective member was a strong determinant of his or her contribution level. This practice served as a major barrier to entry to medical schemes for many potential members.

It was also common practice for medical schemes to accept a member but then to exclude certain important conditions (such as diabetes), which ultimately amounted to exclusion from cover.

Since the system at the time discriminated primarily against the sick and the elderly, there was a need to create a fair and just system – one that would, amongst other things, prohibit the exclusion of applicants from medical schemes on the basis of their age or health status and also allow anyone and everyone to join the open scheme environment, provided they were able to pay the average contribution.

Over time, the Council for Medical Schemes (CMS) has been monitoring the implementation of the legislation to ensure that it meets the broader policy objectives of government.

Monitoring is done actively and passively. Active monitoring entails stakeholder surveys and the assessment of whether or not marketing materials and application forms comply with legislation. Passive monitoring is conducted largely through the review of complaints that are submitted to the CMS. The monitoring system enables the CMS to develop a deeper understanding of the industry and to identify areas for possible regulatory intervention to ensure adequate protection of the interests of members.

According to Thembi Phaswane, Manager of our Complaints Adjudication Unit, the CMS has not received many complaints from prospective members who were being refused membership by medical schemes in the last couple of years. She believes this is because the CMS has been very effective in ensuring that schemes comply with the Medical Schemes Act in this regard.

A challenge that prospective members continue to face in many open schemes is that of the incorrect application of waiting periods which

tends to exclude members from cover. Section 29A of the Medical Schemes Act gives medical schemes the discretion to impose waiting periods to prevent anti-selection by members. This legislative provision applies primarily to individuals but excludes employer groups. The challenge for employer groups has been the arbitrary definition or quantification of a group by some medical schemes.

Closed or restricted schemes, on the other hand, tend to waive the application of waiting periods altogether as their focus is completely different to that of open schemes. The emphasis for most restricted schemes is on access to good quality healthcare for their employees. This has generally

translated into healthcare benefits that are in many instances richer than those of many open schemes.

Medical schemes also use other means to undermine the principle of open enrolment. One such strategy are rule amendments which include provisions allowing the medical scheme to refuse entry to prospective members whose membership with their previous scheme had been terminated because they had failed to pay their contributions within the time frame allowed in the rules of the scheme. Another strategy used to undermine open enrolment is denying access to the medical scheme on the grounds of non-disclosure of material information.

Such practices constitute unfairness to members and impact on their access to healthcare. ■

By Nolutkholo Phoshoko
SENIOR ANALYST:
BENEFITS
MANAGEMENT

“
Medical schemes
continue
to undermine
the principle of
open enrolment.
This is unfair
to prospective
members.”

PMBs, benefit design and risk selection

Prescribed minimum benefits appear self-explanatory: they are minimum benefits that are *prescribed* by law – and thus guaranteed. Medical schemes do not have a way out ... or do they?

By **Marli Weldhagen**
FORMERLY A
CLINICAL ANALYST
AT THE COUNCIL
FOR MEDICAL
SCHEMES

Medical schemes have a legal obligation to provide cover for prescribed minimum benefit (PMB) conditions in all their options.

The explanatory notes to Annexure A in the Medical Schemes Act provide more clarity on this provision when they refer to the protocols or practice in the public health sector as the minimum standard of care in resolving disputes where the private and public sector practices differ.

Explanatory note 2A also clearly states that the setting is not restricted: any PMB can be provided on an outpatient basis or in a setting other than a hospital (where this is clinically most appropriate).

A number of medical schemes have been extremely creative in crafting their benefit design;

it gives the impression that their low-cost options do not cover PMBs. This is especially evident in instances where the marketing material of a scheme does not adequately reflect the registered rules of the scheme.

Having reviewed both hard copy and electronic marketing material, we have observed

that some low-cost options go as far as indicating that all non-hospital treatment and care, and even chronic conditions, are either not covered at all or covered from the member's medical savings account, without making any reference to PMBs. This is false and misleading – and illegal.

Some services and limitations

described in benefit schedules can apply to both PMB and non-PMB conditions; these are the so-called “overlapping” benefits. Examples include oncology, dialysis, organ transplants, mental health, an internal and/or external prosthesis, appliances, and specialised radiology.

But because many schemes neither communicate with nor educate their members, it seems that most members who qualify for PMBs do not realise that the annual limit (e.g. R50 000 for renal dialysis) can only be applied to non-PMB conditions and that the scheme is not allowed to limit the benefit if the treatment is in

line with public sector protocols or practice and obtained from a designated service provider (DSP).

Several options apply deductibles and/or co-payments to specific procedures or admissions. These penalties cannot be applied to PMB conditions and their related services. Despite this, the specific procedures or admissions are often linked to groups of people identified by the scheme as “high risks”, e.g. joint replacements that are mostly

utilised by older members. The co-payment for a hip replacement can go up to R25 000. A member who fears a hip fracture and who cannot afford the co-payment or deductible might be erroneously advised to upgrade to an option which does not have these severe penalties – and the member will upgrade unnecessarily if s/he does not know that a hip fracture is a PMB condition.

The same principle applies to options with self-payment gaps for members who might need regular and/or costly access to health services.

Your savings account

Regulation 10(6) of the Medical Schemes Act 131 of 1998 is clear: the funds in a member's medical savings account shall not be used to pay for costs of a prescribed minimum benefit (PMB).

Prescribed minimum benefits

Prescribed minimum benefits (PMBs) are described in Section 29(1)(o) and Regulation 7 of the Medical Schemes Act 131 of 1998.

All medical schemes must pay in full for the PMB conditions of all their members, regardless of the benefit option to which they belong.

In terms of PMBs, schemes must cover all costs to diagnose, treat, and care for:

- 1 the ±270 Diagnosis and Treatment Pairs (DTPs);
- 2 the 25 chronic conditions on the Chronic Diseases List (CDL); and
- 3 any emergency medical condition.

“These benefits are prescribed by law – and thus guaranteed. Medical schemes have a legal obligation to provide cover for PMB conditions.”

Schemes are also generally very vague when indicating which chronic conditions qualify for PMBs, especially on low-cost options.

Numerous schemes list only the 25 conditions on the Chronic Diseases List (CDL) when they must in fact also mention the ± 270 chronic conditions that fall under the Diagnosis and Treatment Pair (DTP) section of PMBs.

Yet the first ruling of the Appeal Board of the Council for Medical Schemes regarding chronic medication benefits for a DTP condition was made back in 2001 (for Gaucher's Disease).

This ruling stipulated that where chronic medication forms part of the treatment and care

(medical management) of a DTP condition, as per the public sector protocols or practice, it also forms part of the PMB entitlement for it.

Your benefit option

Subject to the provisions of Regulation 8(1) of the Medical Schemes Act 131 of 1998, any and every benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, for the diagnosis, treatment and care costs of prescribed minimum benefit (PMB) conditions.

Many medical schemes continue to list only some DTP conditions in their high-cost options when they should be listing all; many tell their members that they qualify for chronic medication benefits only if they upgrade to a high-cost option.

Examples of such chronic DTP conditions that often go unmentioned include post-transplant medication, hormone replacement therapy, specific metabolic and endocrine conditions, anti-coagulant therapy, post-cardiac surgery, quadriplegia, and valvular heart disease. ■

Continued from page 4

cater for chronic medication after organ transplantation – and that he would obtain access to the medication if he upgraded his scheme option. Mr X was also informed that all costs of his medical management post-operatively would be covered from his medical savings account.

Scheme B got it wrong. It acted outside of clear legislative provisions and its registered rules and benefits.

Misleading marketing material

The registered rules and benefits of Scheme C adequately provide for cover for HIV infection, as per PMB code 168S. Its marketing material, however, incorrectly indicates that as far as out-of-hospital benefits are concerned, beneficiaries who suffer from HIV infection either have no benefits or their benefits are dependent on funds available in their medical savings account. A potential new member who is HIV-positive would review this marketing material and probably decide not to join the scheme due to the perceived inadequate coverage for out-of-hospital services. This is risk selection against prospective members.

Benefit limitations

The registered benefits of Scheme D reflect that it has a R30 000 hospitalisation benefit for mental illness/psychiatry and a separate out-of-hospital mental illness/psychiatry benefit of R5 000, both subject to PMBs.

Mrs Y suffers from bipolar mood disorder. The disorder falls under PMB code 902T. She suffered from a prolapse which required hospital-based medical management for 21 days in April.

Scheme D paid her hospital account of R27 200 from her mental illness/psychiatric hospital benefit. After being discharged from hospital, Mrs Y went for outpatient psychotherapy sessions at a treating psychiatrist at three weekly intervals. Her psychiatrist informed her that her scheme had refused to pay for his out-of-hospital claims on the basis that she had already exceeded her PMB for the year.

Scheme D had risk-selected against the member by reducing her benefits to the PMB entitlement only. The scheme acted incorrectly since Mrs Y still had a separate benefit of R5 000 for out-of-hospital mental illness/psychiatry. ■

Keeping the industry in shape

The mandate of our Compliance Unit is central to effective regulation. This team of dedicated professionals makes sure that medical schemes, administrators and healthcare brokers think long and hard about the Medical Schemes Act and its Regulations before making any decisions.

By **Phumla Khanyile**
COMMUNICATIONS
OFFICER

Conceptually and practically, compliance covers many grounds. Stephen and his team deal with the often tricky issues of non-health expenditure, corporate governance, demarcation between schemes and traditional insurers, and general non-compliance. They enforce the rulings made by the Office of the Registrar. They also educate consumers and train trustees.

Stephen Mmatli (Head of Compliance)

Armed with many years of experience in many areas of the law and a cultivated knowledge of the medical schemes industry, Stephen is the admitted Attorney at the helm of the Unit.

"I have been a Senior Legal Advisor at the Council for years. I have also actively participated in numerous policy developments in the industry. These experiences have moulded and prepared me for the role of strategically taking the Unit to yet another level of proper coordination between enforcement and compliance," Stephen told CMS News.

Stephen is known for his commitment, but he draws a line between work and leisure. His closer colleagues describe him as "that guy who does not

shy away from trading his tie for an apron and braai-ing and dancing up a storm whenever the occasion calls for it".

Jaco Lubbe (Senior Investigator)

Jaco is a husband and a father of two who enjoys golfing, a challenging game of tennis and biking if he is not travelling to interesting places with his family.

Jaco has been with the Council for almost four years. He used to be with the Scorpions Special Investigations Unit and the SAPS Office for Serious Economic Offences.



Despite the gruelling demands of his job, Jaco oozes positivity and optimism. His sense of humour never leaves him. He prides himself on being dedicated to playing the role of a protector and guardian to society. It gives him a sense of accomplishment and satisfaction.

Loyiso Mdlalose (Compliance Officer)

Loyiso is a self-confessed book worm who finds pleasure in studying old newspapers and fixing old computers. Before he joined the Compliance Unit in February this year, he was a computer technician, a sales person, and a forensic investigator. Loyiso values the company of friends and enjoys playing chess.



Milly Viljoen (Manager: Education and Training)

"I am literally as old as the Council," says Milly. She joined the Council shortly after its establishment in 2000 as an Education Officer.

Her job has taken her to places across the country. "I have spent countless days and nights



away from my pride and joy, my soon-to-turn-three son, but I draw inspiration and drive from the knowledge that I make a difference in people's lives and empower beneficiaries by telling them about their rights and obligations."

Milly is a well-travelled lady; she has visited numerous countries in Africa and Europe. She also likes hiking, going to the theatre, and reading inspirational books.

Gugu Ngutshana (Education and Training Officer)

Gugu loves to read, travel, play scrabble and shop, but when it is time to step up to the podium and preach member rights, she does it with passion.



Gugu, who got married recently, has been with the Council for almost two years. She has worked as a call centre agent and at a healthcare brokerage. She may not have ended up fulfilling her childhood dream – that of nursing people back to health – but "I have discovered a love for empowering people with knowledge".

She reckons a lot more still needs to be done in this regard.

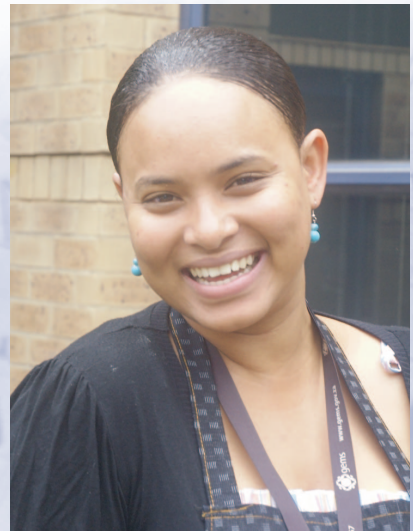
Luicia Leander (Education and Training Coordinator)

Give Luicia a happy and content world and you would have given her the greatest gift of all.

This joyful soul joined us last year:

"I enjoy promoting the Council for Medical Schemes through education and training activities."

Luicia also has a love for animals, which she shares with her husband. They spend most of their leisure time exploring nature and reading fiction.



Stella Matolweni (Personal Assistant)

Stella is the chatterbox who is Personal Assistant to both our Compliance and Legal Services Units.

She joined the Council four years ago as a receptionist before being promoted to a Call Centre Agent.

"I love spending time with my adorable four-year-old daughter, Mpho." ■



Insurance products and medical schemes

Medical schemes are under threat. Yet all that is needed to ensure their existence is a clear distinction between traditional insurance and medical schemes.

By **Dr Boshoff Steenekamp**
REF PROJECT
SPECIALIST

“

The 2008 changes to the Insurance Acts include provisions for the Minister of Finance to make regulations to ensure that insurance products do not undermine the objectives of the Medical Schemes Act.

”

In the absence of clear demarcation between health insurance products and medical schemes, young and healthy members of schemes are tempted to discontinue their membership, leaving the older and sicker people behind. This might threaten the sustainability of the industry. National Treasury has established a working group to make recommendations on how regulations made in terms of the insurance laws must prevent this from happening (see the article on the history of risk selection on page 2).

The Insurance Laws Amendment Act of 2008 states that the Minister of Finance can make regulations that will identify insurance policies that would be regulated by the insurance laws and not by the Medical Schemes Act. Insurance policies identified as such would therefore be exempted from the provisions of the Medical Schemes Act.

The Insurance Laws Amendment Act further specifies that regulations must be made in consultation with the Minister of Health, Treasury, and the Registrars of Medical Schemes and Insurance, and that they must have regard for the objectives and purpose of the Medical Schemes Act, specifically the principles of community rating, open enrolment, and cross-subsidisation.

These regulations must also specify how often information must be submitted to the Registrars of Medical Schemes and Insurance, and may regulate the design and marketing of insurance products.

Earlier this year, Treasury established a working group that includes representatives of the insurance industry, the Financial Services Board, and the Council for Medical Schemes (CMS).

In a draft document submitted to the working group, the CMS presented the underlying reasons why some insurance products might undermine the purposes of the Medical Schemes Act, and proposed criteria that could be used to identify a specific insurance product as being harmful to the medical schemes industry.

Health insurance products would be harmful to the medical schemes environment if they caused medical scheme contributions to rise systematically for poor risks (older and/or sicker members) covered by schemes by prompting the good risks (the younger and/or healthier) either to leave schemes while they are good risks or to buy down from comprehensive cover options.

Similarly, insurance products are harmful if they encourage good risks to remain on insurance products and only join medical schemes when

they need better health cover.

Products that undermine the life-cycle protection offered by the medical scheme system or that cause schemes to reduce their benefit offerings as a direct consequence of health insurance product offerings, are also harmful.

Naturally, an insurance product is unacceptable if it has been specifically designed to circumvent the Medical Schemes Act.

Insurance products should not mislead the public into believing that they offer the same protection as a medical scheme, when their protection is in fact partial and conditional.

Members of the public may also not be misled into thinking that a scheme does not already cover what is offered as insurance. If misled, consumers end up paying more for the same level of cover. An insurance product is not the same as medical aid.

Insurance products should not aim to attract people who are healthy at the time of application and unable to assess the lifetime implications of opting out of medical scheme cover for themselves and their families.

Information gathered on medical scheme members must not be shared with insurance companies. Neither may it be used to underwrite access to top-up health insurance (or any insurance) through close linkages between medical schemes and insurers.

Care must be taken to ensure that the environment that results from the existence of insurance products does not lead to any group or individual being systematically excluded from cover who would otherwise have had comprehensive lifetime cover in a medical scheme.

Mechanisms must be put in place to prevent the incentivisation of brokers to mislead the public concerning the relative risks of opting for insurance versus medical scheme cover and/or to mislead the public into purchasing insurance products needlessly. In addition, interventions must prevent brokers from assisting in the circumvention of the Medical Schemes Act by providing a coordination mechanism for insurance products deliberately tailored to fill structured gaps in cover created by a scheme in collusion with an insurer.

Because insurance products are not subject to the managed care provisions in the Medical Schemes Act, buying healthcare services may become inefficient. This could result in system-wide cost increases. ■

Reception

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Call Centre

ShareCall: 0861 123 CMS (267)

Resource Centre

t: +27 (0)12 431 0500
f: +27 (0)12 430 7644
e: information@medicalschemes.com

Use our website to:

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

Complaints

t: +27 (0)12 431 0500 / 0861 123 CMS (267)
f: +27 (0)12 431 0560 / +27 (0)12 430 7644
e: complaints@medicalschemes.com

Complaints procedure

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

How to avoid complaints

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

Reading matter

Between 1 March and 31 May 2009, we published on our website:

- Our Regulatory Plan and Budget for the financial year 2009-10
- One invite to tender (for the development of our Corporate Identity manual and new website)
- March 2009 edition of *CMS News*, our paper-based quarterly external newsletter
- 2 issues of *CMScript*, our e-newsletter dedicated to prescribed minimum benefits (PMBs)
- 3rd draft of the PMB review consultation document
- Comments from external stakeholders on this consultation document (74)
- 11 documents relating to the Risk Equalisation Fund (REF) project and the Risk Equalisation Technical Advisory Panel (RETAP)
- 2 press releases
- 9 Circulars
- 5 guidelines and manuals

Visit www.medicalschemes.com for so much more.



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