



October 2007

CMS NEWS

Newsletter of the Council For Medical Schemes

LET'S TALK PMB's



CONTENTS

| | Page |
|---|------|
| Expenditure in 2006 | 1 |
| Developments in Health Service Pricing | 2 |
| Driving Demand for Healthcare | 3 |
| Publication of the report on the analysis of the Shadow returns for 2006. | 3 |
| The Registrar of Medical Schemes Receives the SAIHCM Award | 4 |
| The Industry's views on REF Entry and Verification Criteria | 4 |
| Let's Talk PMBs: The idea of PMBs and the PMB Communication Campaign | 6 |
| Let's Talk ICD10 | 7 |
| Tackling Fraud | 8 |
| Solvency | 10 |
| Requirements for 2008 Rules Submissions | 11 |
| Consumer Asks | 11 |

Editor's Note

The positive feedback received from readers after publication of the June edition of CMS News is much appreciated. In this edition, we look at the issue of fraud in our ongoing series on the fit and proper status of officers of medical schemes. We also highlight some key issues around the topical concern of rising health care costs, and provide some updates on the REF shadow process. Some insights are also provided into regulatory processes around rule approvals and solvency regulation. Once again, please email ideas and suggestions for articles you would like to see appearing in CMS News to p.khanyile@medicalschemes.com

Erratum:

In our June copy of CMS News we wrote: "Professor William Pick held Senior academic positions at UCT, Wits and John Hopkins University." We apologize for the error, Professor Pick had at no time held a senior position at Johns Hopkins; however he was nominated for the deanship of the Johns Hopkins Bloomberg School of Public Health. At the time, he was both a Fellow and a Visiting Fellow in International Health at Harvard.

Analysis Of Expenditure On Benefits For The 2006 Annual Report

Mncendisi Michael Willie –
Research & Monitoring Analyst

What started as an easy analysis of the benefits for 2006 Annual Report, ultimately proved to be a challenging and daunting task. This is according to Michael Willie, a CMS Research Analyst who was involved in the analysis process.

Willie says the major challenge was to understand the reasons for an apparent lack of comparability between the 2005 and 2006 expenditure trends. The outcome of the initial analysis of statutory return data appeared to show growth in expenditure for provincial hospitals and medicines of 91.1% and 21.5% respectively. In rand terms this would have translated into growth in expenditure on provincial hospitals from R243 million in 2005 to R464 million in 2006 and on medicines from R7.2bn in 2005 to R8.7bn in 2006. These outcomes were outliers and did not conform to the expected results. When the team investigated possible causal factors for such huge increases they could not find any.

The secondary step was to verify the data and try to identify which schemes might have contributed to these irregularities. The results of this verification process pointed to misallocation of expenditure as well as under-reporting for some of the variables by certain schemes, principally on the 2005 data. 17% of the 124 registered schemes in 2006 were identified as having presented incomplete data. All the identified schemes were administered by the Metropolitan Health Group (MHG). On approaching MHG with the findings, the administrator confirmed the misallocation and under-reporting.

Another challenging factor was the fact that both the 2005 and 2006 financial results had already been audited. The team was therefore in a dilemma whether to publish the inaccurate results as provided in the statutory returns, or to adjust the audited results. In the end, a decision was made for the affected

schemes to resend their 2005 and 2006 annual statutory returns data, reflecting a corrected allocation of expenditure.

The 21 schemes accordingly correctly submitted their data in accordance with the guidelines and specifications for submitting statutory returns. The team had to rerun the analysis, resulting in a report of better quality and reliability. The results for all the MHG administered schemes were restated; however this did not influence the total audited financial data (as the problems related to allocation of spend). It should be noted that medicine expenditure for the aggregated data was underestimated in the 2005 annual report due to the inaccurate information submitted by some of the MHG administered schemes.

The results of the final report were more comparable for both years. Expenditure on provincial hospitals actually increased by 12.5% to R274 million from R243 million reported in 2005. Expenditure on medicines dispensed by pharmacists and providers other than hospitals increased by 8.8% to R8.7bn from R8.0bn reported in 2005 (accounting for 17% of schemes benefits in 2006).

The other findings of the final version of the report was that expenditure on hospital services accounted for R17.9bn, or 35% of the total benefits paid to providers. Of the R17.9bn spent on hospitals, private hospitals expenditure accounted for R17.7bn – an increase of 13.6%. Payments to medical specialists accounted for R11bn, representing a year on year increase of 17%. Medical specialists received 21% of benefits paid in 2006.

General practitioners received R4.4bn, or 8.6% of total benefits paid. The amount spent on GPs was an increase of 17.2% compared with 2005. Expenditure on medicines dispensed by

pharmacists and providers other than hospitals increased by 8.8% to R8.7bn.. Dental specialists were paid 17.6% more to R434 million, while benefits paid to dentists accounted for R1.7bn.

Going back to data issues, it can be clearly seen that the submission of poor and incomplete data in statutory returns can have significant undesirable impact. Had we based our Annual Report on the data initially supplied in the statutory returns, we would have reported an expenditure increase of 91.1% for provincial hospitals and 21.5% for medicines, as opposed to the corrected figures of 12.5% and 8.8% respectively. Given the fact that these figures are used for policy review and other purposes, these errors are unacceptable. And the examples of provincial hospital and medicine expenditure were not the only expenditure items on which poor data quality was identified. In addition, there remain concerns with the reliability of some of the utilisation data supplied by schemes.

One of the major objectives of the Council for Medical Schemes is to inform policymakers, medical schemes, members and other stakeholders of key demographic and financial trends in the private health financing industry. It is therefore important that schemes and administrators put forward accurate information to the Registrar's office as required by the Act. It is not enough for schemes and administrators to have the infrastructure and processes in place to function properly, but it is equally important that these processes are monitored to ensure good quality standards in producing adequate and most reliable information. Going forward, we will be reviewing our legal remedies in the case of the submission of erroneous data. The need for this of course becomes even more compelling as we prepare for the implementation of the risk equalisation fund.

DEVELOPMENTS IN HEALTH SERVICE PRICING

Stephen Harrison –
Senior Specialist: Strategy

The Council for Medical Schemes has been increasingly concerned at uncontrolled cost escalation in the private health sector with consequent devaluing of medical scheme benefits and increased balance-billing of members, and the absence of effective negotiation between providers and funders of health care.

At its meeting on 25 May 2007, the Council set up a committee to further develop some preliminary proposals for consideration by the Department and Minister of Health, but wanted those proposals first to be informed by input from the Board of Healthcare Funders (BHF) and some other key stakeholders. A meeting was held with BHF on 14 June 2007 to discuss the proposals, with a view to informing a position that could be presented to the Minister of Health and the Department for consideration.

At the meeting, the idea was canvassed for statutory provision to be made for the development of a no-balanced billing tariff for health services provided to members of medical schemes, by means of a collective bargaining process between sufficiently representative bodies of funders and providers. Individual providers and funders would be able to negotiate alternative funding arrangements outside of this no-balance billing tariff, provided that this extraneous negotiation did not involve collusion, and resulted in a discount off the centrally negotiated tariff (essentially volume-related discounts).

In terms of this proposal, a detailed statutorily defined set of criteria for the tariffs would be set out in the enabling legislation – these would be criteria against which any negotiated or Ministerially determined tariff structure and

pricing would need to comply with (hereinafter referred to as “certification criteria”). Separate processes would be established for the negotiation and gazetting of the tariff structure (coding, descriptors, billing rules) and the negotiation and gazetting of the prices attached to that structure.

Provision would be made for Ministerial determinations in the event that: there were no “sufficiently representative” bodies of funders or providers to participate in the negotiation (“sufficiently representative” would be defined in the legislation); the negotiating parties failed to reach agreement within statutorily prescribed timeframes; or the agreement reached did not comply with the certification criteria.

Discussions at the meeting were productive, and highlighted various areas that would need to be expanded upon or modified in the further development of the proposals. Various suggestions were made in relation to other entities that would need to be consulted on the proposals, including the competition authorities; training authorities; HPCSA; provider associations etc.

BHF also agreed to take the proposals back to its constituency for input, and to revert with an industry position.

Following consultation between BHF and medical schemes, BHF provided feedback that the funders were very supportive of the framework in principle, and that they were keen to engage further on development of the proposals.

Some of the areas raised by certain medical schemes for further consideration included potentially defining circumstances when it may be appropriate to negotiate reimbursement levels above the

the idea was canvassed for statutory provision to be made for the development of a no-balanced billing tariff for health services provided to members of medical schemes, by means of a collective bargaining process between sufficiently representative bodies of funders and providers.

generally agreed tariff, and limited circumstances in which balanced billing may be permissible. Further meetings between the Council committee and BHF are planned to take this discussion forward, with a view to making proposals to the Minister and Department of Health as expeditiously as possible.

In the meantime, various other significant developments have taken place affecting the determination of health service pricing. On 23 July 2007, the Minister of Health published the final set of regulations relating to the obtaining of information and the processes for determination and publication of the National Health Reference Price List by the Department of Health. In addition, following significant media exposés of kickbacks in charging for medical consumables by hospitals, the Minister of Health convened a meeting of representatives of private health funders and providers – and the Council – to discuss issues of cost escalation and unethical pricing in the private health sector. This meeting took place on 7 August 2007. At the meeting, the Minister announced her intention to establish a representative task team to look into the issues, develop recommendations for remedial measures and organise an indaba to take the matter forward.

This was followed by a Private Health Indaba on 21 September 2007, to which the Minister invited representatives from a broad spectrum of stakeholders in the health care industry to make proposals on how to contain costs in the private health sector. At this meeting, the Minister made it clear that she would be pursuing a regulatory agenda to address these issues.

DRIVING DEMAND FOR HEALTH CARE

Thulani Matsebula –Researcher

Private hospitals have increased market concentration and also deliberately strengthened relationships with medical specialists.

A growing body of evidence points to supplier-induced demand (SID) being a major contributing factor to the cost escalation problem currently experienced in the South African private healthcare sector...this was the main thrust of a presentation given by Thulani Matsebula, the CMS Researcher during the International Health Economics Association 6th World Congress held from 8–11 July at Copenhagen, Denmark.

The CMS presentation formed part of a session on physician utilisation with other presenters from the United States, Ireland and Norway. The other presentations demonstrated that other countries are grappling with similar pressures to contain costs. Participants were keen to share experiences on tackling the inducement problem.

Matsebula pointed that since the doctor often possesses privileged access to information that would help restore the patient to health, a hypothesis has therefore emerged that the doctor is able to directly influence the patient to consume more healthcare services than are necessary to return to a healthy state. This practice is defined by health economists as SID. The potential for SID is a concern in the medical schemes environment because it can contribute to failure to contain costs.

In his presentation Matsebula looked specifically at demand for private hospital services with the

aim of: exploring the relevance of the inducement as a hypothesis in the South African health system; examining factors that drive inducement, focusing on specialists; assessing the role of inducement on cost escalation and adding a low middle income country perspective on the inducement debate.

The findings for the presentation were based on documents from the Council for Medical Schemes and Competition authorities covering the period 2001-2006. A substantial amount of consolidation has occurred in the private hospital sector during this period which has concentrated market power in the hands of a small group of players in the market. This has placed funders in a weaker market position than the hospital groups. Funders are increasingly reporting that they are unable to implement effective strategies that affect utilization of hospital services.

The Herfindhal-Hirschman Index (HHI), a measure used internationally to determine concentration within a market, has increased steadily since 2001 and is now consistently above 2000. The HHI rises to more than 3500 for all the major private hospital catchment areas. This means that the private hospital market has consolidated significantly during a short period of time. During the same period, the proportion of the medical scheme contributions going to expenditure on hospitals has increased substantially largely

due to increased utilization. Private hospitals have increased market concentration and also deliberately strengthened relationships with medical specialists. This has had the impact of increasing utilization since specialists are key drivers of hospital utilization and cost. Private hospitals offer incentives to attract specialists, including the acquisition of numbers or types of expensive technologies that may not ordinarily be sustained in an efficient market.

A consequence of such incentives may be that patients with medical scheme cover may obtain care over and above what is necessary to return to a healthy state. This is one of the factors that is believed to have fueled cost-escalation in the medical scheme driven private health care sector in South Africa.

Also the presentation identified specific factors that are driving supplier-inducement and these are:

- the fee-for-service reimbursement system;
- some of the benefit designs of medical schemes;
- an excess supply of certain resources in the private healthcare sector; and
- a disempowered medical scheme population.

The CMS Research and Monitoring Unit is currently continuing with further research on these issues as part of a broader programme to improve cost-containment in the medical scheme environment.

The Registrar of Medical Schemes Receives the SAIHCM Award

Q: What is the purpose of the award?

A: The award recognises leadership in the public and private sector, and is given to the Top 25 most influential leaders in health care in South Africa.

Quote from the Registrar: Patrick Masobe

"I thank the SAIHCM and I am honoured to receive this award. It is a recognition, not only of me personally, but of the critical role that the Council for Medical Schemes and its staff have played in influencing developments in health care in the country over the last few years. I am very grateful for the hard work by the staff of the Council, and it is this dedication that has been rewarded by the SAIHCM."



Patrick Masobe

Publication of the report on the analysis of the Shadow returns for 2006.

By Mondli Govuzela –
REF Analyst

The CMS recently published a report on the analysis of the Shadow returns for 2006, the second calendar year for which REF data has been submitted during the REF shadow period. Through these submissions CMS is preparing for a system of risk equalisation, during which the impact of the REF formula is evaluated and systems and skills are being developed.

The report indicated 99.5% of the beneficiaries were represented in data submitted by schemes for quarter 4 of 2006. In the previous report, a marked improvement in the quality of data was observed between December 2005 and June 2006. On review, this report indicates that this improvement was not sustained for the rest of 2006.

The report shows that, similar to the experience in 2005, there was a gradual increase in the level of reporting of REF risk factors. At the beginning of 2006, total CDL's were reported at levels 3% below the expected, this changed to levels 17% higher than expected at the end of 2006.

Schemes are categorised in one of nine categories, of which category 9 represents data sets that are clearly inadequate, incomplete or inappropriate. By December 2006, there were 17 (14%) category 9 schemes; the report presents scheme categories by administrator.

In the section on the clinical credibility of data submissions, the report lists the CDL conditions that have particularly unrealistic submissions, and lists schemes with unreliable

data submissions. Particular conditions that were reported at higher than expected levels include hypertension, hyperlipidaemia, diabetes mellitus and multiple chronic conditions. Maternity again appears erratic.

The report concludes that:

- in spite of the identified problems, there is further improvement in the REF price by age curves, indicating convergence to the same standards by schemes;
- there is increased stability in the estimation of the scheme community rate and the financial impact on schemes;
- more work needs to be done before the financial impact of the REF could be estimated accurately.

The Industry's views on REF Entry and Verification Criteria

Roschelle Singh – REF Analyst

In the Risk Equalization Fund (REF) workshop held with industry stakeholders on 15 June 2007, five main issues were raised in relation to Version 2.1 of the REF Entry and Verification Criteria, which required further industry comment.

Extensive feedback on the above issues was received from representatives of Cape Medical Plan, Medscheme, Cheiron Health Technologies, Medihelp, MediKredit, MIP and Mediscor. Below are the issues and a summary of the responses.

Issue 1: To qualify as proof of treatment, scripts must be issued in separate calendar dates.

This could cause problems in the following circumstances:

a. If a member receives treatment in advance because the beneficiary might go on extended holiday etc.

Summary of feedback from industry:

- Supporting documentation should be used to corroborate the extended supply.
- Use the days of therapy calculation to determine amount supplied per month.
- Split claim payment per month.
- Reconcile REF at the end of each quarter and not per month.
- Conduct industry study to determine impact.

b. Most chronic scripts are re-issued within 25 days by courier pharmacies, resulting in 2 scripts in one month.

Summary of feedback from industry:

- Change REF interval to 21 days to facilitate qualification.

- Non-issue as there will be at least 2 claims in 3 months.

Issue 2: The guidelines are still ambiguous on what constitutes an authorization.

a. Must it explicitly state that automatic authorization based on autochronic techniques must be excluded?

Summary of feedback from industry:

- State explicitly the non-use of autochronic techniques to identify REF beneficiaries.

b. In how much detail must the authorization process be defined in the guidelines?

Summary feedback from industry:

- Define authorization in more detail and in terms of proof of diagnosis and ICD-10 codes.

Issue 3: Version control

a. How must the guidelines be more specific on version control in terms of previous diagnoses?

Summary of feedback from industry:

- Define version control in terms of proof of diagnosis and proof of treatment.
- Store effective date history for diagnosis codes and ATC codes.
- No more clarity needed on version control; only on implementation date.
- IT systems must be able to accommodate "versioning".

b. What happens if ATC codes are deleted or added with proof of treatment scripts that were processed in the previous year (that has an impact on an individual's REF eligibility status in the current year)?

Summary of feedback from industry:

- Ensure that REF implementation dates do not conflict with deleted codes.

Issue 4: Differences between the status of PMB's and REF E&V criteria

a. How could this be explained more clearly in the guidelines?

Summary of feedback from industry:

- PMB is patient specific while REF is communal.
- Clarify benefit entitlements for REF and PMB's.
- PMB and REF are mutually exclusive.
- Qualifying criteria are different for REF and PMB's.
- No further clarity required.

Issue 5: Provider communication – what must be communicated to providers and how?

Summary feedback from industry

- Involve HPCSA in arranging workshops about REF and how providers can facilitate this process especially with regard to ICD-10 coding and the supply of diagnostic information.

All comments were investigated and evaluated and recommendations were made to the Steering Committee of CMS. Changes based on the feedback will be incorporated into a draft Version 3 of the Guidelines for the Identification of Beneficiaries with REF Risk Factors in Accordance with the REF Entry and Verification Criteria. The draft Version 3 has been supplied to the Risk Equalisation Technical Advisory Panel (RETAP) in order to elicit final stakeholder input on the proposed changes.

LET'S TALK PMBs

*Professor Jan van der Merwe and Marli Weldhagen, Clinical Unit
Phumla Khanyile, Communications Officer*

Minimum benefits are a key element in health care reform internationally.

The prescribed minimum benefits (PMBs) refer to a scope and level of benefits that are to be made available to beneficiaries as may be prescribed.

They cover diagnosis, treatment and care costs (Section 29(1)(o) read with Regulation 7 of the Medical Schemes Act 131 of 1998). The introduction of the PMBs responded to the need to promote consumer protection and to deal with the problem of “free riders” on the public health system.

From a consumer protection perspective, consumers do not always have the knowledge of the range of catastrophic health events for which they may need to protect themselves when choosing cover, and medical schemes do not necessarily voluntarily provide (adequate) coverage for these events.

The PMBs ensured that medical scheme benefit design first covered the more essential, non-discretionary benefits, and only then allocated resources to more discretionary services.

The “free rider” issue arose from the fact that state hospitals effectively acted as a ‘last-resort’ insurer. Public facilities cannot turn away patients with immediate and serious health care needs, regardless of their ability to pay. They have also generally been unable to collect fees for services rendered to patients who are able to pay. Consequently medical schemes sometimes took advantage of the *de facto* free services at public hospitals, and medical scheme members were “dumped” unfunded on the public sector when benefits had been exhausted in the private sector. In a speech to Parliament, the then Minister of Health, Dr NC Dlamini-Zuma, in 1997 announced that the Department considered the introduction of a prescribed set of minimum benefits

that would apply to all registered medical schemes. There were several intentions with the establishment of the Prescribed Minimum Benefits (PMBs). These intentions included:

- to provide a framework for essential and cost-effective healthcare,
- to prevent selective exclusion of health care benefits in a manner that is not transparent to members,
- to determine a set of benefits that, if covered by medical schemes, would largely eliminate unfunded dumping of members into public sector hospitals,
- to ensure efficient allocation of private health care resources, and
- to create a platform for the future development of social health insurance.

Minimum benefits are a key element in health care reform internationally. They refer to a determination of the minimum health services that should be generally and uniformly available in order to assure adequate health status and protection of the population from disease. It is imperative that it should be representative of essential health care needs of the insured health care population.

The Council for Medical Schemes is, however, receiving reports of abuse of the regulations which provides for full coverage of the PMBs in at least one designated provider setting. This regulation is not intended to increase provider reimbursement, but to ensure that members retain access to PMBs in some setting without financial obstacle. However, we understand that an “open chequebook” interpretation of PMBs has sometimes been propagated among some providers. This attitude on the part of some providers is a misinterpretation

of the regulations. We welcome proposals for developments to the policy framework which will allow the policy objectives of PMBs to continue to be met while curbing this abuse of the system.

An immediate strategy that we are deploying to ensure a proper understanding of PMBs among providers, funders and consumers is the launch of a PMB communication strategy. During the course of the campaign issues such as PMBs coverage, voluntary vs. involuntary access to PMBs, designated service providers (DSPs), formulary drugs and many more issues will be addressed through key communication messages directed to members, medical schemes and service providers.

The Council for Medical Schemes has entered into a one year contract with Gold Quill Publishing cc, a consulting company in Johannesburg, to assist with the drawing up and running of the PMB communication campaign. The campaign is expected to have a strong consumer media focus aimed at stimulating debate and discussion around health care provision and the imperative for consumers to take firmer control of their personal health and the costs associated with care. It will also generate awareness in the form of key messages to medical schemes and healthcare service providers.

The campaign aims to make members of medical schemes aware of the existence of PMBs and how these rights benefit them. It will encourage healthcare providers to provide basic PMB information to patients, while seeking to dispel the perceptions that PMBs create an “open chequebook” for providers.

continued from pg 06

It will also seek to generate an awareness of the potential advantages for medical schemes of better information sharing and greater accessibility of DSPs.

The campaign is divided into short, medium and long term activities, allowing the matter to be dealt with in increasing depth and detail. There will be an official launch of the campaign through the launching of the PMB month in October 2007. The

timing is planned to coincide with that time of the year when medical scheme members traditionally reconsider their membership of a particular scheme for the following year.

Other activities within the year will include a PMB sub-site on the CMS website (www.medicalschemes.com) and on support organizations' websites, an electronic newsletter, radio broadcasts, production of information brochures, pamphlets and posters to be circulated to healthcare provision points, exhibitions at selected

hospitals and information sessions with human resources staff of large companies.

CMS urges all stakeholders involved (medical schemes, members, administrators, brokers, healthcare providers, employers, support organizations for specific organizations, national media, trade and specialist publications and consumer rights organizations) to come on board and be part of the campaign.

INTRODUCTION OF ICD 10 IN THE MEDICAL SCHEME ENVIRONMENT

*By Patrick Matshidze,
Head: Research and Monitoring*

The Council for Medical Schemes and the National Department of Health support the implementation of ICD 10 in the public and private health sectors. This is an international diagnostic code that was adopted by the National Health Information System of South Africa (NHISA), and forms part of the health information strategy of the Department of Health, outlined in the White Paper on the Transformation of the Health System of 1997. It was developed by the World Health Organisation to measure morbidity and mortality.

ICD 10 coding is important in that it lends itself well to the improvement of efficiency of healthcare through easy storage, retrieval and analysis of information for patient care, research, performance improvement, healthcare planning and facility management. It also facilitates fair reimbursement for health care services provided. In addition, coding enables reliable communication about healthcare data among many participants in the health care industry in a standardised manner.

Several processes led to the need to implement ICD 10 in the medical scheme environment.

When the Medical Schemes Act and regulations were introduced fully in 2000, they regulated the

manner of submitting claims to schemes by health care providers and also the contents required for such claims. Regulation 5 (f) prescribed that all health service providers must include a diagnosis code in their claim forms.

The introduction of Prescribed Minimum Benefits as part of legislation also meant that a monitoring system for these diagnosis-driven conditions should be put in place and this would require a standardised diagnosis code.

In 2000, the Council for Medical Schemes, at the request of the Minister of Health, held consultative meetings with providers and funders in an effort to address concerns raised by healthcare providers with regards to poor payment of claims submitted on behalf of medical scheme beneficiaries. At the core of the problem was the need for greater standardisation of data collection, IT systems, and billing practices.

A process to standardise data and billing practices in the industry was started in 2001 with the formation of a Committee on Standardisation of Data and

Billing practices. The Committee sought to address some of the concerns raised by providers and funders, and at the same time to give meaning to the recommendations made that focused primarily on appropriate coding standards for South Africa, taking into account other pertinent issues such as privacy, confidentiality and security of beneficiary information.

In addition to this exercise, the results of a survey conducted by the Council to determine the type of information medical schemes were collecting and the quality thereof, revealed serious gaps and poor standardisation.

A separate but complementary process was initiated by the Council for Medical Schemes aimed at accrediting all administrators in the environment. The purpose of the accreditation process was to ensure that an administrator is (1) fit and proper to provide administration services; (2) has the necessary resources, systems, skills and capacity to render the administration services which it wishes to provide; and (3) is financially sound.

At the beginning of 2005, the Council for Medical Schemes, the Department of Health and industry stakeholders formed a task team whose primary purpose was to develop a process for implementation of ICD 10 in the public and private health sector.

Essential Benefits of ICD 10

The benefits of ICD 10 are both administrative and statistical. Below is a list of possible benefits for a variety of stakeholders.

Members

- Better definition of member entitlements
- Reimbursement from the correct benefit pool
- Protection of PMBs

Providers

- Improved reimbursement of providers in line with section 59 of the MSA
- Resources planning

- Clinical audits
- Proper capitation fees
- Clinical excellence

Medical schemes and administrators

- Risk management
- Proper reimbursement
- Development of managed care interventions
- Claims adjudication

Department of Health and Regulatory Bodies

- Monitoring of PMBs
- Review of PMBs
- Measurement of quality
- Risk Equalisation Fund
- Development of a Basic Benefits Package
- Health planning
- Resource allocation
- Public private partnerships
- Capitation
- Assessment of the prevalence and incidence of diseases
- Development of Social Health Insurance

Privacy confidentiality and security

The final document on confidentiality on Patient Health Information (PHI) in the medical schemes environment has been completed and is available on the Council's website on www.medicalschemes.com.

Standards Advisory Body

The National Task Team on ICD-10 implementation has recommended that the Department of Health through the National Health Information Standards of South Africa (NHISA) sets up a National Health Standards Advisory Body – a standards body that will take over the functions of the implementation task team and subsequently, all the responsibilities of the standards body.

This body would ultimately be responsible for the continued maintenance and updating of ICD-10 codes, liaison with the World Health Organisation on coding related matters and the continued development of standards for privacy, confidentiality and security.

TACKLING FRAUD

By Jaco Lubbe – Compliance Senior Investigator

The Council for Medical Schemes will deal with all information received on a very sensitive basis and will go to all lengths to protect so-called whistleblowers.

“Fraud is the unlawful and intentional making of a misrepresentation with fraudulent intention so that the prejudiced person suffers actual or potential prejudice”. (Applied Law for Police Officials, Technikon SA, 1999).

One of the main functions of Council for Medical Schemes is to protect the interests of the beneficiaries at all times. Ensuring that contributions received from members of medical schemes are dealt with in a proper and transparent manner, is one of the ways of preventing fraudulent activities that may occur in the medical schemes industry. In relation to a medical scheme, fraud occurs when a misrepresentation is made to the medical scheme with the intention of persuading that medical scheme to act to its

prejudice. Fraud becomes relevant to the Office of the Registrar of Medical Schemes when it is committed by the persons/entities dealing with the medical scheme and the commission of this act impacts on the perpetrator's fiduciary duties or his/her “fit and proper” status. It would be difficult if not impossible to describe all the circumstances in which fraud may be committed, and in each case one will have to look at the specific circumstances. The best way to illustrate this would be by using an example:

Mr X is the Chairman of the BoT of a medical scheme. He is also a director and shareholder of XYZ Administrators. He persuades the BoT to outsource the administration to XYZ Administrators and does not at any stage divulge his relationship with XYZ, nor does he

declare any conflict of interest. The matter is investigated by the Office of the Registrar, who establishes this relationship. The further outcome of the inspection is that the administration fees negotiated are far in excess of the industry benchmark for such fees.

From this example it is clear that the “fit and proper” requirements were not met, but also that Mr X contravened section 57(3) as well as section 57(6) of the Act. However, even more serious than this, Mr X committed fraud in that he misrepresented to the scheme that it was necessary to outsource the administration and that the best company to do this at the best price was XYZ, knowing that this was not the case and this resulted in the scheme acting to its prejudice.

continued from page 08

Furthermore, the rest of the Board might also be held liable in terms of their “fit and proper” status as well as section 57(6) in that a proper tender procedure was not followed. Apart from this, in the event of any of the rest of the trustees being found to have been aware of, involved in or having received any benefits from this deal, such trustees might be charged with fraud as accomplices or for corruption, depending on the circumstances.

Other forms of fraud that are seen in the medical schemes industry are:

- *Brokers paid extra amounts (in addition to the regulated commission) when they assign members to a specific medical scheme.*
- *Funeral policies or other insurance products included in the members’ contributions.*
- *Contracting with service providers whereby discounts or rebates are negotiated and such discounted amounts or rebates are paid separately after the fact and do not find its way back to the scheme but rather to individuals or companies involved in the dealings.*
- *The setting up of a “middle man” or intermediary to negotiate service delivery between a scheme and a service provider where such an intermediary is connected to any of the parties and/or adds no value other than to increase the base price of the service.*

The fiduciary duties of persons such as Board members are highlighted more often these days by the courts, and extend to all persons who deal with public funds. An example of this is the so-called “bulking” whereby pension fund administrators are now being forced to pay back all monies they accumulated, including interest. In these cases administrators have put different pension funds’ monies together in their investments and could therefore negotiate higher returns on such investments.

These “extra” returns were then pocketed as “profit”. However, the courts ruled that these administrators already received remuneration for their services and that any returns or profits made on investments must be passed onto the funds they were administering and therefore belonged to the individual members of such funds! These administrators now also face possible criminal prosecution.

It is not always easy to detect or uncover this type of fraud as it usually involves individuals who have a lot of control over the scheme and the parties involved to the exclusion of others. For this reason it is necessary for schemes, administrators and other parties to be totally transparent in their dealings and to have systems in place to prevent irregular or related-party dealings. Systems should be implemented and maintained whereby persons can report their concerns or irregularities without the fear of victimisation or losing their jobs. In this regard emphasis should also be placed on the police’s Crime Stop initiative whereby crime can be reported anonymously. People must also take cognisance of other Acts such as The Prevention and Combating of Corrupt Activities Act and The Prevention of Organised Crime Act, which compels certain persons or categories of persons to report certain irregular matters to the authorities.

It must be reiterated that it is specifically for the reason of preventing such irregularities as mentioned in the example above that the Medical Schemes Act prohibits Board members from being involved with any of the parties dealing with the scheme in its continuation of its business. The rationale for this is to ensure that Board members at all times act impartially and in the best interests of the scheme and its members, and that they should not benefit personally from any decision made on behalf of the scheme. The Council for Medical Schemes will also deal with all information received on a very sensitive basis and will go to all lengths to protect so-called whistleblowers. This will

be done over and above the protection given to such whistleblowers in other legislation.

Once any fraudulent acts have been established, section 16(b) of the Medical Schemes Act places an obligation on the Council to refer the matter to the National Prosecuting Authority for prosecution.

The consequences of committing fraud or being involved in it could be far-reaching. In terms of the criminal law, persons who are convicted of fraud or theft amounting to R500 000-00 or more face a minimum sentence of 15 years imprisonment. The court can only impose a lesser sentence if there are compelling reasons presented to the court that allows the court to move away from the prescribed minimum sentence. Apart from this, any person convicted of fraud, theft or a contravention of the Medical Schemes Act will be left with a criminal record. The further consequences of this are that such persons cannot be directors of companies and will not be “fit and proper” to serve on any committees or boards whatsoever, especially where this would entail them dealing with other people’s monies.

Apart from this, such persons’ belongings could also be seized to recover funds misappropriated. This could be done by way of civil proceedings or by way of the Asset Forfeiture Unit of the NPA whereby the proceeds of crime are recovered.

The criminal courts will also definitely take into account the position of trust that Board members and others dealing with public funds found themselves in if they are convicted, and this will most probably increase the sentence by some margin or, in the case of minimum sentences being applicable (15 years), fail to move the court to reduce the sentence!



082 411 1171

Solvency Of Medical Schemes

Paul Bosch – Senior Financial Analyst

Solvency can be best described as the ability of an entity to meet its financial obligations as they arise.

Like any other business, a medical scheme needs to be properly managed if it is to survive and flourish. A medical scheme is a regulated business whose conduct is governed by the Medical Schemes Act, 1998 (“the Act”).

The introduction of the Act states that it is promulgated to “...make provision for the...control of certain activities of medical schemes; (and) to protect the interests of members of medical schemes...” One of the ways it ensures this is to prescribe that schemes have sufficient reserves to enable the scheme to handle any unexpected losses – generally known as solvency. Solvency can be best described as the ability of an entity to meet its financial obligations as they arise. An entity is considered solvent if the assets exceed the liabilities. The excess of assets over liabilities is also referred to as Nett Assets.

The solvency margins act as a cushion against adverse experience. It serves as a warning mechanism or indicator for stakeholders that the scheme is able to:

- face the risk it may experience;
- face any uncertainties in the future;
- protect members’ interests; and
- guarantee the continued operations of the scheme.

For medical schemes, solvency is measured in terms of section 35 read together with Regulation 29 of the Act. The Nett Assets, after deducting assets set aside for specific purpose and unrealized non-distributable reserves, are also referred to as “Accumulated Funds”.

Regulation 29 prescribes the “Minimum accumulated funds” that should be maintained by a medical scheme. The Accumulated Funds expressed as a percentage of “Gross Annual Contribution” is referred to as a solvency level. The required statutory solvency level for a medical scheme

is 25%. However, this was subject to phase-in provisions, starting from the year 2001 until 2005. Per Regulation 29(3A), the required solvency levels for new schemes registered after year 2000, is also subject to phase-in provisions. The table below shows the prescribed solvency levels per these phase-in provisions:

| Required Solvency Phase-in % | New Scheme – Regulation 29 (3A) |
|------------------------------|---------------------------------|
| 10% | 1st year |
| 13.5% | 2nd year |
| 17.5% | 3rd year |
| 22% | 4th year |
| 25% | 5th year |

By not meeting the solvency margins as set in the Act does not mean that the scheme is insolvent (bankrupt), but could indicate that the scheme is experiencing some form of financial difficulties.

The solvency of medical schemes is closely monitored by the Office of the Registrar to protect members against scheme insolvency. The medical schemes are monitored using the following tools:

- **Annual returns:** Schemes are required to annually submit audited financial statements together with a return. These returns provide useful information especially as they are based on audited figures, thus showing the true financial position of the scheme and the industry.
- **Quarterly returns:** During 2002, the quarterly returns system was introduced, whereby schemes submit to the Office their financial performance on a quarterly basis in the form of a return supported by management accounts. These returns are used by the Office as an “early warning system” so that corrective action may be implemented before a scheme reaches the position of insolvency. It should be noted that the quarterly documents are

not audited; however, the onus is on the scheme to provide accurate and reliable information to the Office.

- **Notifications from schemes:** Regulation 29(4) requires that schemes that fail to meet the required solvency level for a period of 90 days, to notify the Registrar in writing of such failure, and specify the course of action being adopted to ensure compliance.
- **Business plans:** The Act requires medical schemes that fail to meet the prescribed solvency level to submit a business plan to the Registrar, stating the reasons for such failure and the course of action to be adopted to ensure compliance with the solvency requirement.

On completion of review of the business plan, the Registrar may accept the business plan with the scheme agreeing to the time frames and key results to be met. The agreed plan is then monitored by the Office. The scheme will be required to submit monthly management accounts to the Office to monitor progress against the agreed plan. The plan may also be monitored through regular management meetings between the Office of the Registrar and the trustees of the scheme.

A number of factors can have a negative impact on a scheme’s ability to increase solvency levels:

- **Member profile:** The main determinant of the level of claims of a scheme is its membership profile. A scheme with an ageing membership will incur greater costs than a scheme with a younger profile. The introduction of REF may assist schemes with older and sicker members in the future.

- **Under pricing contributions:** Open schemes in particular could under-price options to attract members. By under-pricing the solvency requirements are also lower as solvency is calculated as a % of contributions. In the long term this is not sustainable and eventually it will require above average increases to correct the situation. It is advisable for schemes to obtain expert advice when reviewing contributions.
- **Claims experience:** Contributions are based on expected claims experience. In the event of this experience being worse than expected the scheme will need to take timeous corrective action to ensure reserves are not depleted.
- **Non-health expenditure:** This is an element often ignored by trustees when faced with an inability to build reserves. Non-health costs are the second highest expenditure item for many schemes, second only to hospital costs. The trustees need to review their contracting to ensure the services received are commensurate with the fees paid.
- **Risk management:** Schemes have many ways of managing risk and claims costs. These can include commercial reinsurance and various managed care initiatives. Again the value for money aspect of such contracts needs to be monitored constantly.
- **Loss making options:** Options need to be self-supporting in terms of membership and financial performance.
- **Rapid membership growth:** Schemes that aggressively chase new members often fail to take into account the effect this has on solvency levels. This may result in existing members having to pay higher contributions to make up the deficit.

Medical schemes require skill and experience to manage properly and trustees are responsible for this task. The first requirement is therefore trustees who are fit and proper to manage such a business and they need to make use of outsourced expertise and opinions where there is a lack of such skills within the board of trustees.

REQUIREMENTS FOR 2008 SCHEME RULE SUBMISSIONS

By Phakamile Nkomo,
Research Analyst: Finance

A regulatory objective of the Council for Medical Schemes is that all schemes rules are registered in terms of the Medical Schemes Act and its regulations, in the interest of scheme members.

Since its inception the Council has operationalised a process for evaluating the fairness of contribution and benefit entitlement changes in benefit options. This has given rise to the development of a questionnaire for the standardized submission of scheme rules relating to benefit entitlements and contributions. The questionnaire's purpose is to enhance the regulator's ability to assess the impact of contribution changes, benefit amendments and benefit design adjustments within a consistent and equitable framework across all schemes in the industry. The questionnaire is in the form of an excel based template, which must accompany scheme rule submissions.

The assessment process applies regulatory tools criteria informed by the Act and regulations, taking into consideration factors such as: the scheme's financial performance and risk profile; evidence of compliance with prescribed minimum benefit entitlements; the consumer price index (CPIX) as a soft benchmark target for contribution increases; directives on benefit configuration and contribution table structuring; and fairness in the cost sharing between members and schemes.

Rule submissions will be considered complete if they include the following:

- a memorandum identifying areas of amendment to the rules and page numbers where such amendments have been documented (section 33(2) of the Act);
- a certification of the Board resolution as per section 31(3);
- two sets of rules to be lodged at the Office of the Registrar as per regulation 2 of the Act;
- two sets of a populated and certified hard copy of the benefit and contribution questionnaire, which is also to be mailed to the Registrar's Office in electronic format;
- business plans as per the circularized format distributed by the Financial Supervision Unit – these are required for the registration of new schemes, options and restructuring of benefit offerings, in order to comply with the requirements of section 33(2); and
- any motivations required in terms of circularized requirements communicated to schemes.

All rules have to be registered before they are implemented and marketed



“When the scheme found out, they accused me of committing fraud, cancelled my membership and demanded a repayment of R600 for services rendered to my daughter.”

Consumer Asks:

My doctor tells me that my medical scheme has declined to pay part of my medical bill for my prescribed minimum benefit (PMB) condition because the medication he prescribed was not in the scheme's formulary list, therefore I should pay the difference from my pocket. Is my medical scheme not supposed to pay my bills in full since my condition is a PMB?

CMS Responds:

What you have just referred to known as co-payment – a process whereby a member of a scheme shares the payment of the medical bill with the scheme for the service rendered.

If the scheme imposes co-payments, provision for this must be made in the scheme's registered rules. In terms of the Medical Schemes Act, the use of co-payments for PMB condition can be applied where a member voluntarily makes use of a non-designated service provider or if a member knowingly chooses to

make use of an off-formulary drug. In the case whereby your doctor has decided to put you on medication other than that which is in the formulary list due to ineffectiveness or side effects, you should obtain a motivation from your doctor explaining reasons to your scheme as to why he prescribes medication other than that which is on the scheme's formulary list.

Contact your scheme for more information about its designated service providers and formularies.

Consumer Asks:

My daughter who is now over 21 years and no longer qualified as my beneficiary stole and used my medical aid card without my knowledge. The doctor treated her and did not check whether she was still a beneficiary or not. When the scheme found out, they accused me of committing fraud, cancelled my membership and demanded a repayment of R600 for services

rendered to my daughter.

I was not aware of my daughter's activities and I do not feel that I have been fairly treated. Please advise.

CMS Responds:

On the facts, a fraudulent act was committed by your daughter without your knowledge or involvement. You are not guilty of fraud nor were you an accomplice. Unless the scheme has evidence to the contrary,

it cannot cancel your membership for fraud you did not commit and nor can it institute proceedings against you for the recovery of monies paid for health services rendered to your daughter, who has reached the age of majority. The proper recourse for the scheme would be to institute fraud charges against your daughter and reverse the payment or institute proceedings to recover the amount paid from your daughter.

Information Directory

1. Reception:

Tel: +27 (0) 12 431 0500
Fax: +27 (0) 12 430 7644

2. Call Centre:

ShareCall: 0861 123 267 / 0861 123cms

3. Resource Centre:

Tel: 012 431 0500
Fax: 012 430 7644
E-mail: information@medicalschemes.com

4. Communications Desk: (Media Enquiries)

Tel: 012 431 0581
Fax: 012 431 0681
E-mail: mediadesk@medicalschemes.com

5. Use our website: www.medicalschemes.com to view:

- o List of registered schemes in South Africa
- o List of accredited brokers
- o List of accredited managed care organizations
- o List of accredited scheme administrators
- o Download information (forms, Act and Regulations)
- o Read latest news, developments and upcoming workshops
- o Lodge a complaint on-line

6. Complaints:

Tel: 012 431 0500/ 0861 123 0861
Fax: 012 431 0560/ 012 430 7644
E-mail: complaints@medicalschemes.com

6.1. Complaints Procedures:

- o Complain to your scheme: contact the scheme by phone or write to the Principal Officer giving full details of your complaint as well as any supporting documents relating to your complaint.
- o Complain to the Registrar of Medical Schemes: if you are not satisfied with the outcome of your complaint with the scheme, you can complain in writing to the Registrar's office.
- o Appeal to the Council: If you are aggrieved by the decision of the Registrar or by the decision of the scheme's disputes Committee or any decision relating to the settlement of your complaint.
- o Appeal to the Appeal board: if you are aggrieved by the decision of the Council.

6.2. You can avoid complaints by:

- o Making sure that you know and understand the rules of your medical scheme.
- o Reading all correspondence from your scheme.
- o Studying your benefits guide and familiarize yourself with the terms and conditions of the benefit option that you have chosen
- o Making sure that you contributions are paid in full and on time every month.



Council For Medical Schemes

Private Bag X34, Hatfield 0028

Hadefields Block E
1267 Pretorius Street, Hatfield, Pretoria

Tel: +27 (0) 12 431 0500
Fax: +27 (0) 12 430 7644