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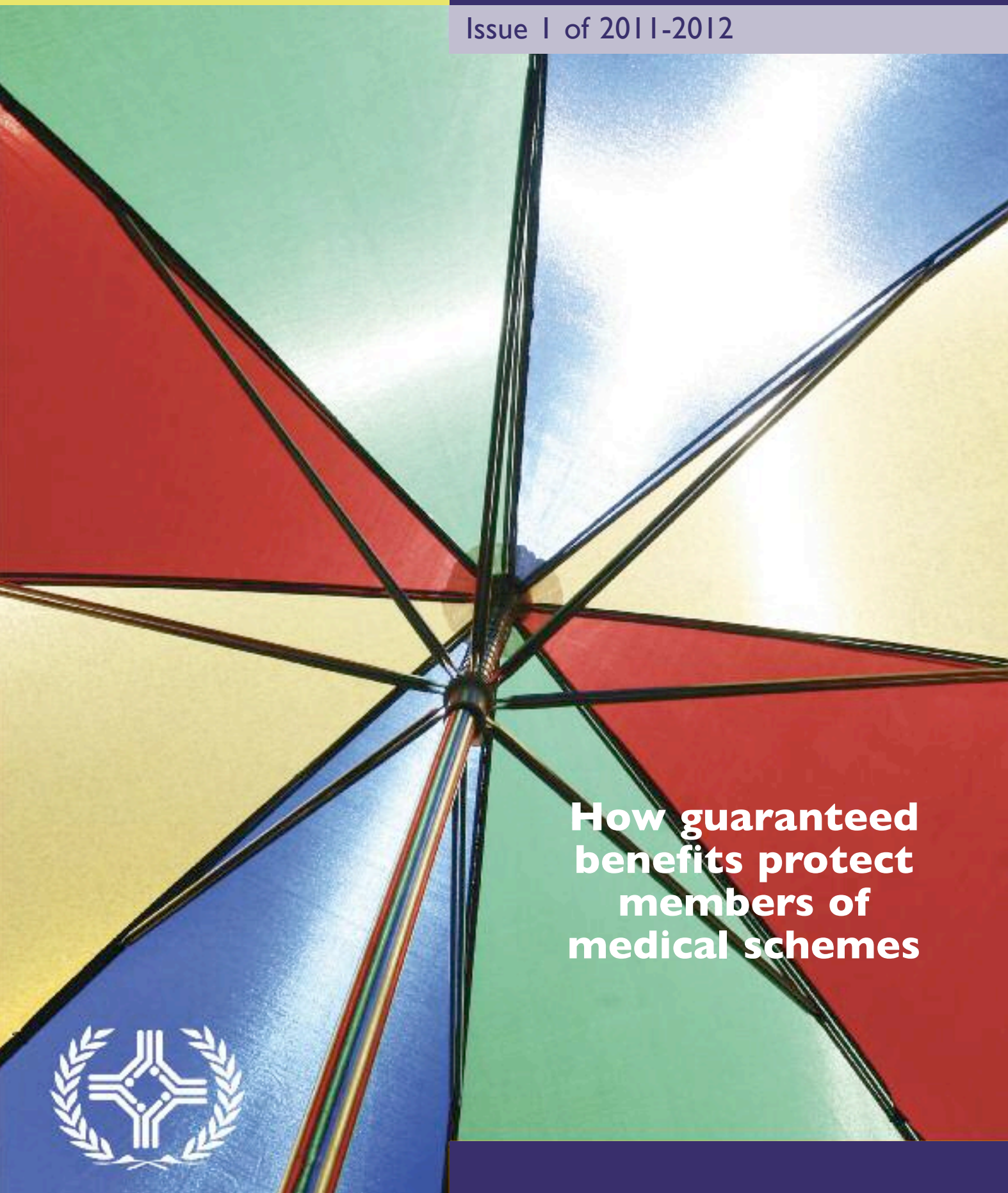

How guaranteed benefits protect members of medical schemes

Perspective

The most recent Medical Schemes Act – namely 131 of 1998 – guarantees certain benefits to members of medical schemes with certain health conditions. These benefits are widely known as PMBs, or prescribed minimum benefits. There are 300 PMB conditions at the moment, including 27 chronic diseases.

PMBs serve two very important functions. Not only do they protect members against unforeseen health events which may have ruined them financially, such as emergency hospitalisation, cancer or a rare chronic condition.

PMBs also teach us something about social solidarity. Young and healthy members contribute to the same PMB-intended pool of funds as their older and sicker counterparts. As a result, all benefit options can provide PMBs.

PMBs protect risk pools by preventing that they be split. Members with predictable and high health-care costs, such as the chronically ill and the elderly (who frequently suffer from PMB conditions), can belong to the same benefit options as younger and healthier members. Had PMBs not existed, schemes would have been able to create low-cost options consisting of day-to-day benefits and very limited catastrophic cover. Such options may seem commercially attractive but they offer no solution for older and sicker members; these members would have to join other options with other older and sicker members, and would not be able to enjoy cross-subsidies from younger and healthier members of the population. This would amount to unfair discrimination.

This issue of *CMS News* invites you to consider real-life examples of how PMBs have assisted both members and medical schemes. All the stories you are about to read are based on cases which were heard by the CMS's Appeals Committee. Members' names have been changed to protect their privacy and schemes' names have not been mentioned. We also profile our Legal Services Unit.

Editorial Committee

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You may have to wait for your guaranteed benefits

Your guaranteed benefits as a member of a medical scheme – the prescribed minimum benefits or PMBs – are not covered at all times; you may be subjected to a waiting period of up to 12 months during which you will have to fund your PMB condition yourself.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

John* had never belonged to a medical scheme and when he signed up for the first time in 2007, the scheme applied a 3-month general waiting period on his membership.

This means that for the first three months of his membership, John was not covered for his prescribed minimum benefit (PMB) conditions, which include medical emergencies.

> "Your guaranteed benefits are not covered at all times."

The Medical Schemes Act 131 of 1998 allows schemes to impose a general waiting period of up to three months and/or a condition-specific waiting period of up to 12 months on new members, depending on how long they have belonged to a previous medical scheme.

What happened?

Some two months after joining the scheme, in other words still within the waiting period, John experienced severe pain in his abdomen. His partner called the scheme's emergency number and asked if John had to wait until the waiting period expired before she could call an ambulance but was told that she could call an ambulance.

John understood this to mean that the scheme was agreeing to pay for the hospitalisation which he required.

But the scheme pointed out that even PMBs are not funded during the 3-month general waiting period.

When John took the matter up with the Council for Medical Schemes (CMS), the Registrar found in the scheme's favour but John appealed the ruling with the CMS's Appeals Committee.

What was the final verdict?

The Appeals Committee agreed with the Registrar's ruling; here is why.

The registered definition of the scheme's waiting period is based on Section 29A(1) of the Medical Schemes Act which says that a scheme may impose a general waiting period of up to three months and/or a condition-specific waiting period of up to 12 months on an applicant who was not a beneficiary (neither the principal member nor a dependant) of a medical scheme for 90 days or more before applying for membership.

The only difference between the scheme's definition of the waiting period and Section 29A(1) is that the Section is silent on PMBs while the definition in the registered rules of the scheme expressly excludes funding for PMB conditions.

The Appeals Committee compared Section 29A(1) with Sections 29A(2)(a) and 29A(3). (See the table on page 2-3 which summarises how schemes can apply waiting periods.)

Section 29A(2)(a) says that a medical scheme may impose a condition-specific waiting period of up to 12 months on an applicant who belonged to a scheme for two years or less and whose membership with the previous scheme had ended less than 90 days before date of application. But this condition-specific waiting period may not exclude PMBs; all PMB conditions must be covered in full.

Section 29A(3) says that a medical scheme may impose a general waiting period of up to three months on an applicant who belonged to a scheme for more than two years and whose membership with the previous scheme had ended less than 90 days before date of application. But, again, PMBs may not be excluded during this waiting period.

So while Sections 29A(2)(a) and 29A(3) provide that the waiting period does not apply to PMBs, Section 29A(1) does not mention PMBs at all.

Why are waiting periods allowed?

The provisions on open enrolment (anyone can join a scheme) and community rating (everyone pays the same amount for the same benefits) in the Medical Schemes Act 131 of 1998 ensure that the public has access to medical schemes and that their contributions are not risk-rated (based on your health status or age etc.). Waiting periods protect members of medical schemes against "free riders", people who do not join medical schemes while they are young and healthy but only join later when they become older and sicker.

* *Not his real name*

On a plain reading of Section 29A(1), applicants who had not been members of a medical scheme for at least 90 days before date of application are not covered for PMBs during either the general waiting period (three months) or the condition-specific waiting period (12 months). But in terms of Sections 29A(2)(a) and 29A(3), those who have previously been members are covered for PMB conditions.

Just because the scheme covers the cost of the ambulance, do not assume that it will cover all the other treatment that you may require, including hospitalisation.

The reason for this distinction is that the medical history of an applicant who had previously belonged to a medical scheme is easier to obtain than that of an applicant who had not been a member for at least three months preceding application.

Do not assume that your medical scheme will cover all your conditions at all times.

(Schemes usually destroy the records of former members after three months.)

But it is also true that while schemes need to know your medical history, they cannot discriminate against you based on your health status; this is clear in Sections 24(2)(e) and 29(1)(n) of the Medical Schemes Act.

> "Schemes can impose a general waiting period of up to three months and/or a condition-specific waiting period of up to 12 months on new members."

Section 24(2)(e) says that medical schemes may not "unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds, including race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health".

And Section 29(1)(n) prescribes that medical schemes may determine their monthly contributions only on the basis of the household's income and/or the number of dependants, and not on the basis of "any other grounds, including age, sex, past or present state of health of the applicant or one or more of the applicant's dependants, [or] the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants".

In summary

The Medical Schemes Act 131 of 1998 makes allowance for a general waiting period of up to three months and/or a condition-specific waiting period of up to 12 months in certain circumstances, and the registered rule of the medical scheme in question makes it clear that PMBs will not be covered during the waiting period.

Depending on your situation, you may have to wait for up to 12 months before your medical scheme gives you access to guaranteed benefits.

The Medical Schemes Act supersedes the registered rules of a medical scheme where the two contradict each other.

But where legislation is silent on a disputed matter, a reasonable interpretation and conclusion must be reached. ■

How schemes apply waiting periods

Medical schemes check for two things when they decide whether to apply waiting periods on new members.

First, they determine how long you have been without medical cover (i.e. how long you did not belong to a medical scheme) up to the day on which you applied for membership with them.

If you have been without cover for 90 days or longer, the scheme may impose both general and condition-specific waiting periods and exclude cover for prescribed minimum benefits (PMBs) as well.

If you had no cover for less than 90 days up to the day of applying for membership, the new scheme will look at how long you belonged to the previous scheme and apply either a general or a condition-specific waiting period. Either way, it may not exclude cover for PMBs in this instance.

If your employer decided to leave a scheme or join a new scheme, or if you had to change schemes because you changed jobs, the new scheme may not impose any waiting periods on you.

Uncovered period

(from your last day with the previous scheme to the date of application for membership with the new scheme)

Break in cover of at least 90 days	Break in cover of less than 90 days (0-89 days)		
Membership period with previous scheme			
Regardless of previous membership	**Longer than 24 months**	**24 months or shorter**	**Regardless of previous membership** Change of employment, or employer leaving or changing a scheme
• General waiting period of up to 3 months • Condition-specific waiting period of up to 12 months • Waiting period applies to PMBs (i.e. the scheme may exclude cover for PMBs during this waiting period)	• General waiting period of up to 3 months • Waiting period does not apply to PMBs (i.e. the scheme may exclude cover for all benefits except PMBs)	• Condition-specific waiting period of up to 12 months • Waiting period does not apply to PMBs (i.e. the scheme may exclude cover for all benefits except PMBs) • General and/or condition-specific waiting period imposed by your previous medical scheme may be continued by the new medical scheme until the original expiry date	• No general or condition-specific waiting periods may be imposed

It is an emergency only if you need immediate treatment

It is not enough for a medical emergency to be diagnosed; the condition must also require immediate treatment before it can qualify as an emergency and, subsequently, a prescribed minimum benefit, or PMB.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

The Appeals Committee of the Council for Medical Schemes (CMS) has ruled that diagnosis is not enough to conclude that a condition is a medical emergency; the condition must require immediate treatment as well.

At the same time, all emergencies are prescribed minimum benefits (PMBs) which require full payment from your medical scheme.

What happened?

Robert's* medical scheme determined that his condition – "chest pains" after a golf game – was not an emergency and therefore also not a PMB condition, and refused to pay for the diagnosis.

When Robert challenged this decision with the CMS, the Registrar of Medical Schemes agreed with the scheme.

Robert then took the matter to the CMS's Appeals Committee. He argued that his condition was potentially an emergency, and said the fact that he was put through an ECG (electrocardiogram) twice indicated that "something far more serious was suspected" than just "chest pains".

The definition of an "emergency" in the Medical Schemes Act 131 of 1998 requires that the need for immediate treatment be present.

The fundamental question

The Appeals Committee was faced with a difficult question: when is a medical condition an emergency? Is mere suspicion that the condition is serious, enough? Or should one wait for the retrospective diagnosis and only then make a pronouncement on whether the condition was sufficiently serious to warrant emergency treatment? The definition of an "emergency medical condition" in the Medical Schemes Act 131 of 1998 begs the very question it should be answering.

> An emergency medical condition does not arise every time people merely "suspect" that someone's life is in serious jeopardy.

What is an emergency?

The Medical Schemes Act defines an "emergency medical condition" as "the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a body organ or part, or would place the person's life in serious jeopardy".

If we were to take a closer look at the definition, we could break it down as follows:

1. There must be an onset of a health condition.
2. This onset must be sudden and unexpected.
3. The health condition must require immediate medical or surgical treatment.
4. The health condition must be of such a nature that, if not immediately treated, one of three things would result, namely: serious impairment to a bodily function, or serious dysfunction of a body part or organ, or death.

In Robert's case, there was no doubt that "chest pains" was a health condition and that it had started suddenly and unexpectedly (points 1 and 2 above).

You may be diagnosed with an emergency medical condition but if your condition does not require immediate treatment, your condition is not an emergency.

But did Robert's chest pains require immediate treatment (point 3)? And would he have died or lost bodily function if immediate treatment had not been provided (point 4)?

These two questions were answered only after Robert's diagnosis.

The diagnostic tools that were used (ECG and blood tests) showed that no immediate treatment was necessary. So Robert asked the scheme to pay for the tests only.

All emergencies are prescribed minimum benefits (PMBs). PMBs cover diagnosis, treatment and care costs in full.

How the final verdict was reached

A plain reading of the definition seems to allow payment for the treatment of a health condition. But Robert was not treated for his chest pains. Blood tests were conducted and he was put through ECG twice but these are diagnostic measures which are not covered by the definition.

> Diagnosis is not enough to conclude that a condition is a medical emergency; the condition must require immediate treatment as well.

Had Robert been treated for his chest pains, he would have been entitled to claim the cost of treatment because it cannot reasonably be argued that a health condition is an emergency only if the diagnosis says so, the Appeals Committee found.

For a medical condition to qualify as an emergency, diagnosis is not enough; the person must require immediate treatment.

Diagnosis may in any case come too late for any treatment to save a person's life or bodily function or use of a body part.

An emergency medical condition does not arise every time people merely "suspect" that someone's life is in serious jeopardy. Each case must be considered on its own merits and its own circumstances.

Robert's appeal failed because what he claimed for (diagnostic costs) is not countenanced by the definition of an emergency. ■

** Not his real name*

Treatment does not have to be explicitly listed

Provided it is medically necessary, any and all treatment for a prescribed minimum benefit (PMB) condition must be covered, even when it is not expressly listed in the Medical Schemes Act or the rules of your scheme.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

13 July 2007 proved a terrible day for Jenny*. She was attacked by three large dogs while out on a walk. An ambulance took her to a provincial hospital where she was treated for a dislocated knee and kneecap, and severed knee ligaments.

But because the hospital did not have MRI scan facilities, Jenny was transferred to another hospital where the full extent of her injuries was discovered after an MRI scan was performed. Surgery was performed on her knee on 18 July 2007. Two months later she also received physiotherapy treatment.

The problem

Jenny's scheme refused to fund some accounts. Its basis for refusing was two-fold.

Firstly, the scheme claimed that Jenny had not obtained pre-authorisation for certain treatments; those were consequently not covered in full as required by Regulation 8 of the Medical Schemes Act and the scheme wanted Jenny to pay the outstanding difference.

Use your scheme's preferred network of healthcare providers to avoid co-payments for guaranteed benefits.

Secondly, the scheme said that the surgery performed on 18 July 2007 and the physiotherapy which Jenny received later were elective procedures and thus did not qualify as PMBs.

Too literal a reading of the law may lead to absurdity. What is reasonable?

Jenny brought the matter to the attention of the Council for Medical Schemes (CMS) and asked that the scheme pay all her accounts in full. The Registrar found in her favour, confirming that the diagnosis, treatment and care for PMB conditions must be covered in full in compliance with the Medical Schemes Act.

The scheme appealed against the Registrar's decision.

Let reason prevail

Do not take the law too literally. The Medical Schemes Act prescribes certain treatment regimes for certain health conditions but just because a specific intervention (such as surgery) is not explicitly stated does not mean that it falls outside the prescribed treatment.

> The literal meaning of an Act [...] is not always the true one.

What was the final verdict?

The Appeals Committee of the CMS ruled that the scheme was not obliged to pay for the physiotherapy treatment but that it must cover (in full) the surgery and all the other diagnosis, treatment and care costs that preceded the physiotherapy.

The arguments

The scheme accepted that Jenny's was a PMB condition that falls under code 902H in the Regulations of the Medical Schemes Act.

The diagnosis prescribed under this code is "closed fractures/dislocations of limb bones/epiphyses – excluding fingers and toes", and the treatment is "reduction/relocation".

But the scheme insisted that surgery and aftercare – which Jenny had undergone – are not part of this PMB treatment.

When too literal is absurd

The Appeals Committee ruled that the scheme's reading of the code was too literal. Our courts have consistently held that where a literal meaning of a legislative provision would lead to absurdity, one could depart from the literal meaning of the provision.

Even the Supreme Court of Appeal pointed out in a unanimous judgment in 2009 that "the literal meaning of an Act [...] is not always the true one". It pronounced that where a literal meaning would result in "absurdity so glaring that it could never have been intended by the [l]egislature" or in "absurdity, inconsistency, hardship or anomaly which [...] the [l]egislature could not have intended", a court would be justified in differing from the clear and unambiguous meaning of the provision.

In Jenny's case, code 902H may not explicitly prescribe "surgical intervention" or "aftercare" for a dislocated knee, but the Appeals Committee felt that it would be absurd to suggest that such interventions will never be required to treat such an injury – and that the legislature could never have intended such an interpretation. "The [treatment] of a dislocated knee may very well require surgical intervention, and physiotherapy may very well be required as part of that process," said the Appeals Committee in its ruling. "The legislature could not reasonably be required, as the scheme clearly does, to have included under the code every conceivable treatment for a dislocated knee, so that what is not included is taken to have been deliberately omitted."

Managed care interventions such as pre-authorisation are allowed but the requirement that you obtain pre-authorisation may never be used to deny you a benefit which you are entitled to.

Use DSPs for PMBs

The scheme then argued that Jenny was not entitled to this PMB anyway because she had allegedly freely and knowingly chosen to obtain the surgical intervention and physiotherapy from a non-designated service provider (non-DSP) – when the Medical Schemes Act clearly states that members must obtain PMBs from their scheme's preferred service providers or DSPs.

But the Act also stipulates that no co-payment may be charged to a member who had no choice but to use a non-DSP, and that a scheme can charge a co-payment for a PMB condition only where the member voluntarily used the services of a non-DSP.

Jenny did not choose to be transferred to the second hospital for the MRI scan and further treatment. She was taken there because the first hospital (the scheme's DSP) did not have MRI scan facilities. The Act is also clear that where a service is not available from the scheme's DSP or cannot be provided without unreasonable delay, no co-payment is payable by a member who obtains that service from a non-DSP.

Obtain pre-authorisation within a reasonable amount of time.

Pre-authorisation and other managed care interventions

Pre-authorisation of treatment is a managed care measure intended to improve the scheme's "efficiency and effectiveness" when providing healthcare to its members; it is not meant to prevent members from accessing benefits, including PMBs.

Regulation 8(4), which allows for pre-authorisation and other managed care interventions, is not intended to enable medical schemes to put measures in place that would have the effect of depriving members of appropriate treatment and care if they do not follow such measures. The purpose of this provision is to allow schemes to ensure that cost-effective, evidence-based healthcare is provided to members.

> A scheme rule which claims that you will be charged a co-payment if you do not obtain pre-authorisation is inconsistent with the Medical Schemes Act.

A scheme rule which claims that you will be charged a co-payment if you do not obtain pre-authorisation is inconsistent with the Medical Schemes Act. And it does not matter that the rule was registered; a rule that is inconsistent with applicable legislation cannot trump that legislation by reason only of registration. It remains invalid.

At the same time the Appeals Committee decided that the efficiency and effectiveness of the scheme's provision of healthcare to its members would be compromised if members were free to submit claims months after the onset of the condition without a pre-authorisation. Jenny sustained her injuries on 13 July 2007 and underwent surgery five days later because MRI facilities were not available at the scheme's DSP; the Appeals Committee agreed that this delay was justifiable. The surgical intervention was obtained involuntarily.

But the same could not be said of the physiotherapy treatment which Jenny obtained two months after the surgery. She should at least have obtained pre-authorisation for the physiotherapy because of the time lag since the surgical intervention. This is why the scheme did not have to cover her physiotherapy treatment. ■

Reduction

The medical meaning of the term "reduction/relocation" refers to both "open" and "closed" reductions. An open reduction is a surgical reduction and is performed where a closed reduction (the manipulation of a dislocation without surgery) has failed or would not succeed.

** Not her real name*

The legal team of Burton-Durham, Tlali & Motloutsi

The Council for Medical Schemes (CMS) is a regulator whose operations are guided by the Medical Schemes Act and in such a complex environment, a dynamic legal team is a must. Meet the CMS Legal Services Unit whose mandate it is to render support to both internal and external stakeholders – all in the name of fairness.

By **Gugulethu Blose** (Communications Officer)

Craig Burton-Durham
(Head: Legal Services)

Craig describes himself as someone who has a sound belief in the principle of fairness, one who is passionate about the rights of others and what is proper. This is evident in the thread of public

service that runs through his significant legal career.

Craig joined the CMS at its inception in 2000 after a stint as Deputy Registrar at the Patent and Trademarks Copyright Office at the Department of Trade and Industry.

"I joined the CMS because I have always been interested in using my legal qualification to ensuring the fair treatment of others and assisting people in protecting their rights. I think it's also important that everyone who pays for healthcare is able to access it."

The Johannesburg boy says his decision to study law was informed by his love of debating. "Law is a discipline where you can enjoy a good and well-reasoned argument.

As Head of Legal Services, Craig ensures that his unit fulfils its mandate to both internal and external stakeholders.

"The unit has to ensure that the principles of the Medical Schemes Act are upheld in legal terms and that the operational units at the CMS have sound legal advice."

"Craig is a great boss," says Gugulethu Tlali, a member of his team who was recently appointed Council Secretary at the CMS. "He gives us room to grow and a lot of people who have worked in his team have risen in their careers because of his support."

Gugulethu Tlali
(Council Secretary)

Gugulethu is the newly appointed Council Secretary but she has served the CMS as Legal Advisor in the Legal Services Unit since 2008.

Born and bred in Durban, this passionate advocate realised very early on in life that she wanted to be a lawyer because of her persistence, good communication skills and ambitious nature.

"In grade 12 I organised an after-school study group for my classmates which ensured that we all got excellent grades that year. I realised then that I was influential to my peers and that I had leadership qualities."

After completing her tertiary studies, Gugulethu came to Pretoria to serve her articles. She says she enjoys law because it gives her flexibility to learn about any subject she chooses.

"I like to learn and with a legal qualification all you need to do is choose a field that interests you and apply your legal knowledge to that field. I have been in the medical schemes industry for five years now and I am still learning," she told *CMS News*.

Gugulethu believes that the role of the Council Secretary is a crucial one.

"The job involves giving guidance to Council on the Medical Schemes Act and governance, and

assisting with general legal advice. This ultimately means that I assist Council in affording beneficiaries the protection that they expect from us."

Mamose Motloutsi
(Executive Assistant: Legal Services)

Mamose is the soft-spoken, diligent gatekeeper to the Legal Services Unit.

But do not let her quiet demeanour fool you; she brooks no nonsense.

This newest addition to the unit has been with the CMS since late 2010 but she is no stranger to either the medical or the legal field.

"I have worked in the legal field for eight years now; some of this time was in the legal unit at the Health Professions Council of South Africa."

Why did she join the CMS? "I saw the CMS as an opportunity to learn more about the medical schemes industry and to grow."

Mamose gets to arrange a number of activities which keep the unit running smoothly, including committee meetings and Council meetings, but there is much more to what she does.

"I get involved in all facets of the unit's running, from strategic planning to budget management. It's almost as if you are pulling the strings behind the scenes."

Mamose says that her love for coordinating

and multi-tasking and attention to details are important in performing her duties effectively and efficiently.

"The CMS is very different to where I have worked before. A lot of things pop up that I have to accommodate, so I have to be flexible in my planning and prioritise accordingly and make sure that whatever I put on the back-burner is not forgotten." ■

Keeping it local

Your medical scheme is not obliged to pay for treatment that was obtained in another country, even when the treatment is not available in South Africa.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

Sharon* took on her medical scheme when it refused to reimburse her for treatment she had to obtain overseas due to it not being available in South Africa.

No pronouncement was made on the matter and the Appeals Committee of the Council for Medical Schemes (CMS) merely recorded the agreement that was eventually reached between the parties.

Boards with absolute discretion and ex gratia committees serve different purposes.

What happened?

Sharon's scheme refused to reimburse her for almost R2.5 million which she had spent on a surgery to treat her husband's cancer.

Do not assume that your scheme will pay for all the expenses associated with your prescribed minimum benefit (PMB) condition(s).

The procedure was performed in the United States of America as the treatment is not available in South Africa.

The Registrar of Medical Schemes ruled that the scheme had "acted within its rights" by refusing reimbursement and Sharon appealed the decision to the CMS's Appeals Committee.

> "Absolute discretion can only be exercised properly within the unique context of each case."

The crux of the matter

Cancer is a prescribed minimum benefit (PMB) condition. Your medical scheme is therefore obliged by law to pay in full for its diagnosis, treatment and care.

But medical schemes registered and operating in South Africa are not required to pay for the diagnosis, treatment or care obtained outside our country's borders, even in instances where the required medical interventions are not available locally and even when the condition is a PMB.

Ex gratia committees deal with benefits which are not listed in the rules of the scheme, or which are expressly excluded.

Some details

The registered and relevant rule of the scheme in question says that "benefits [...] shall be provided only within the borders of [...] South Africa, provided the Board [of Trustees] may, in its absolute discretion, pay for benefits in respect of health services obtained outside such borders".

The same rule further states that the scheme "shall not be required to make special arrangements to obtain foreign services or medicines for special conditions [...] and any medicines or medical services o[f] any kind available only outside South Africa".

During the hearing the Appeals Committee expressed the view that the matter was broader than just deciding whether the scheme had indeed acted justifiably in declining to reimburse Sharon; this matter was also about whether the scheme's Board of Trustees had exercised the "absolute discretion" conferred on it by the scheme's rule and, if so, whether it had done so properly.

Unfortunately, neither a member of the Board (which is required to exercise the discretion) nor a member of the scheme's Ex Gratia Committee (which had made the initial decision that was subsequently confirmed by the Board) attended the hearing of Sharon's appeal.

The Appeals Committee found that only the Board could shed light on the issue of discretion and asked that the scheme provide minutes recording the Board's discussions on whether to reimburse Sharon, and whether to reimburse her in part or in whole.

An unfounded fear

The scheme in question expressed the fear of creating a dangerous precedent if it reimbursed Sharon, but the Appeals Committee ruled that "absolute discretion" can only be exercised properly within the unique context of each case, and that there is thus hardly room for setting a precedent for subsequent cases that may appear similar.

Boards must exercise absolute discretion, and they must do so properly.

"The fear [of creating a precedent] would impermissibly constitute a fetter to the exercise of discretion and that would in turn lead inexorably to the conclusion that the discretion has not been exercised properly," said the Appeals Committee in its ruling.

Where a Board has absolute discretion, there is no danger of setting a precedent.

The Board and the Ex Gratia Committee

The Appeals Committee expressed the view that an ex gratia committee and the Board's absolute discretion are two very different things.

Ex gratia committees deal with matters which fall outside the scope of scheme rules. For example, had the funding for benefits obtained outside South Africa been barred absolutely, Sharon's only hope would have lied with the Ex Gratia Committee of her scheme.

But the rule in question requires the Board of the scheme to exercise its absolute discretion to "pay for benefits in respect of health services obtained outside [South Africa]".

In other words, discretion is peremptory while the actual payment for benefits obtained offshore depends on the particular facts of each case – that is, the proper exercise of discretion.

Put differently, the Board's exercise of discretion is not an exercise of ex gratia power.

Rather, it is exercise of a power conferred on the Board by the rules of the scheme.

The Ex Gratia Committee exercises a different discretion; it exercises a discretionary power not in relation to benefits for which the scheme rules provide but in relation to benefits for which the rules either do not provide or expressly exclude.

> "Medical schemes registered in South Africa are not required to pay for the diagnosis, treatment or care obtained outside our country's borders."

No pronouncement

The Appeals Committee did not rule on the matter but merely recorded the agreement that the parties had reached. The scheme agreed to provide all the documents pertaining to the decisions of its Board and Ex Gratia Committee to refuse to reimburse Sharon. ■

** Not her real name*

Your scheme's agreement with state facilities

Your medical scheme can ask you to have certain conditions diagnosed and treated at a state facility. And it does not have to fund treatment which is not available in the public sector.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

True to provisions in the Medical Schemes Act 131 of 1998, the Registrar of Medical Schemes instructed the scheme to pay in full for the diagnosis, treatment and care of the medical conditions of Julia's* daughter because these were prescribed minimum benefit (PMB) conditions.

But the Appeals Committee tweaked the ruling; the scheme had to fund the diagnosis, treatment and care only up to the level that it costs in the public sector.

Some background

Julia's daughter required external prostheses. During the course of one year, three Taylor Spatial Frames were fitted to her leg, all at private hospitals.

But the rules of the scheme provide only for internal prostheses.

The scheme had paid for the first two external prostheses because the healthcare providers had made coding mistakes on their invoices.

Your medical scheme must ensure that its designated service providers (DSPs) are available and accessible to you.

But by the time a claim for the third external prosthesis arrived, the scheme had established that these were not internal prostheses, reversed payment for the first two, and refused to pay for the third.

What the scheme argued

The scheme's applicable rule is based on the Medical Schemes Act 131 of 1998 and allows payment for a PMB condition at "100% of actual costing [...] when obtained from a public or state hospital or designated service provider".

Your medical scheme must ensure that its designated service providers are available and accessible to you.

The scheme argued that it did not have to pay for the daughter's PMB condition because she had been treated at private and not public hospitals. The Appeals Committee agreed.

According to the Medical Schemes Act, schemes are allowed to employ managed care interventions to keep the costs of healthcare affordable.

> "Your scheme can ask you to have certain conditions diagnosed and treated at a state facility."

One such intervention is the use of preferred or designated service providers (doctors, hospitals, pharmacies etc.) which are your scheme's first choice for obtaining PMBs. Designated service providers (DSPs) can include state facilities.

In this case, the medical scheme had indicated in its rules that you must obtain treatment for PMB conditions at one of its DSPs or a public hospital to qualify for 100% cover.

So the rule in question does what Regulation 8(2)(a) of the Medical Schemes Act prescribes, but instead of "designated service provider", the rule says "public or state hospital or designated service provider".

In other words, the Regulation says that the rules of a medical scheme may provide that the diagnosis, treatment and care costs for a PMB condition will only be paid in full "if those services are obtained from a designated service provider", and the rule of the scheme says "when obtained from a public or state hospital or designated service provider".

If you want your prescribed minimum benefit (PMB) condition to be covered in full, use your scheme's designated service provider (DSP). If you choose to use a non-DSP, you will have to pay a part of the amount yourself.

Both the Regulation and the rule envisage payment in full but only to the extent that a state hospital or the scheme's DSP would charge.

The scheme was therefore found not liable to cover the daughter's PMB condition in full at the rate of a private hospital, but at the rate of a public hospital.

Other lessons

Your scheme's designated service providers (DSPs) can include state facilities.

The scheme's compliance with Regulations 6(2), 6(3) and 6(4) was also raised.

Regulation 6(2) states that "[i]f a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform both the member and the relevant healthcare provider within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion".

If you have no choice but to use a non-designated service provider (non-DSP), you will not face a co-payment.

Regulation 6(3) states that "[a]fter the member and the relevant healthcare provider have been informed as referred to in subregulation (2), such member and provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction".

> "Your scheme does not have to fund treatment which is not available in the public sector."

And Regulation 6(4) states that "[i]f a medical scheme fails to notify the member and the relevant healthcare provider within 30 days that an account, statement or claim is erroneous or unacceptable for payment in terms of subregulation (2) or fails to provide an opportunity for correction and resubmission in terms of subregulation (3), the medical scheme shall bear the onus of proving that such account, statement or claim is in fact erroneous or unacceptable for payment in the event of a dispute".

Schemes can use designated service providers (DSPs) to be their first choice for providing prescribed minimum benefits (PMBs).

The scheme had contravened all three Regulations.

Prescribed minimum benefits (PMBs) are limited to what is available in the public health sector. If it is not available in the public sector, your medical scheme does not have to provide it either.

It had not responded to an erroneous claim in time. It had informed neither Julia nor the healthcare providers of the incorrect invoices, and it had given neither party the opportunity to correct the error.

Had the scheme discharged its administrative duties responsibly, Julia would have known several months earlier that various prostheses were not covered in the private sector and could have sought further care for her daughter from a public hospital.

What was the final verdict?

The Appeals Committee ruled that the scheme was liable to pay for the costs of the diagnosis, treatment and care that Julia's daughter would have received at a public hospital. ■

** Not her real name*

Get your benefits from designated providers

Prescribed minimum benefits (PMBs) should be obtained from your scheme's designated service providers (DSPs) – and it is your responsibility to find out who and where your DSPs are.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

Prescribed minimum benefits (PMBs) go hand in hand with designated service providers (DSPs); use your scheme's designated service providers to avoid co-payments for your prescribed minimum benefit conditions.

The Registrar of Medical Schemes had ruled in Caroline's* favour but the scheme brought the matter to the Appeals Committee which overturned the Registrar's ruling.

What the regulator said

The Registrar ruled that the scheme had to pay for a surgical procedure on Caroline's dependant who had sustained an open head wound.

The basis for the finding was that an open head wound is a prescribed minimum benefit (PMB) condition, and that Caroline and her son had used a non-designated service provider (non-DSP) involuntarily.

The Appeals Committee agreed that this was a PMB matter but said that Caroline and her son had voluntarily chosen to use a non-DSP which meant that they had to cover some of the costs out of their own pocket.

The Medical Schemes Act 131 of 1998 prescribes that members must use their scheme's DSPs for their PMB conditions if they want to qualify for 100% cover.

> "It is your responsibility to find out who and where your scheme's designated service providers are."

What the member said

Caroline identified her son's condition as PMB code 373J in the PMB Diagnosis and Treatment Pairs list in the Medical Schemes Act. The diagnosis is described as "non-superficial open wounds – non life-threatening" and the recommended treatment is "repair".

Communicate with your scheme before you undergo treatment at a non-designated service provider (non-DSP).

Surgery was performed some eight hours after diagnosis. Caroline said this was because no other plastic surgeon was available at the time of her son's diagnosis and admission to hospital and that the available surgeon could only perform the procedure the following morning. Caroline also said there were no DSPs in the area where she and her son lived.

What the law says

An open head wound is a PMB condition.

But Regulations 8(2) and 8(3) of the Medical Schemes Act make provision for the management of PMB costs through the use of DSPs.

So when a member voluntarily uses a non-DSP while a DSP is available, the scheme is allowed to impose a co-payment for the diagnosis, treatment and/or care of the member's PMB condition.

In summary

This was a PMB case but the condition was not life-threatening. It was treated only the following morning, some eight hours after diagnosis. It could therefore not have been an emergency medical condition which would have made it a PMB condition a second time over – and which would have required immediate treatment.

If you have no choice but to use a non-designated service provider (non-DSP), you will not face a co-payment.

It is your scheme's responsibility to ensure that its designated service providers (DSPs) provide the services needed for prescribed minimum benefit (PMB) conditions. It must also make sure that its DSPs are available and accessible. If they are not, you must use non-DSPs without fearing co-payments.

The scheme's DSP hospital should have been used to obtain treatment – and to avoid co-payment.

If Caroline did not know of the DSPs in her city, she could have made enquiries with the scheme. ■

* *Not her real name*

When you need different medicine

Medical schemes are allowed to use formularies to treat your prescribed minimum benefit (PMB) conditions. But when a drug on the formulary proves ineffective or harmful, your scheme must provide an alternative – also free of charge.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

The Registrar of Medical Schemes found in favour of the member, Paul*, and instructed the scheme to fund in full the drug Revellex for the treatment of ulcerative colitis, which is a type of inflammatory bowel disease. His ruling was later upheld by the Appeals Committee of the Council for Medical Schemes (CMS).

Some background

Everyone agreed that ulcerative colitis is a prescribed minimum benefit (PMB) condition.

Everyone also agreed that the condition in this case was severe.

When the condition is severe, the recommended treatment according to the Medical Schemes Act 131 of 1998 is intravenous corticosteroids (a class of chemicals) and, if there is no improvement, a "review for further medication or surgery".

What the scheme argued

The scheme agreed that Paul's son had exhausted all the other drugs on its formulary but refused to fund Revellex in full citing a number of reasons, including:

- Revellex is "not specifically included [on its] formulary".
- The alternative of surgery had not been considered.
- Revellex is not available at state hospitals for the treatment of ulcerative colitis.
- The scheme had funded 80% of the drug and required Paul to make only a 20% co-payment.
- The scheme could allegedly not afford to fund the drug in full.
- The scheme would consider an ex gratia application.

The crux of the matter

The Appeals Committee decided to focus on the proper interpretation of "review for further medication or surgery" within the meaning of the therapeutic algorithm for ulcerative colitis in the Medical Schemes Act.

The basis of its argument was Regulation 15H of the Medical Schemes Act which requires that:

- treatment protocols be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and
- appropriate exceptions be provided for in instances where the protocol has been ineffective or harmful.

Everyone agreed that the intravenous corticosteroids had shown no improvement in Paul's son.

The matter thus fell in the "appropriate exceptions" category envisaged in Regulation 15H. These "appropriate exceptions" come in the form of "further medication or surgery", as envisaged in the therapeutic algorithm.

How the final verdict was reached

The scheme's main argument was that it could not afford to fund the drug in full. But it provided no evidence to prove its assertion.

Your scheme's formulary is a list of the medicines which the scheme provides free of charge to treat your prescribed minimum benefit (PMB) conditions.

The fact that a drug – any drug – is not readily available at a public hospital cannot be used to argue that the drug is unaffordable, both for the state and for a medical scheme. There can be many reasons, having nothing to do with affordability, why a drug is not used at state facilities. It cannot be assumed that the reason is unaffordability.

When a drug on the formulary proves ineffective or harmful, your scheme must provide an alternative – also free of charge.

The scheme's relevant benefit being premised on the prevailing practice at public hospitals, the Appeals Committe ruled that both the scheme's rule and the affordability argument were insufficient reasons to deny Paul funding for the drug. The scheme needed to prove (and not simply assume) that the reason why the drug is not available at state hospitals is because it is unaffordable.

The argument that *both* further medication and surgery must be considered was dismissed.

By the way

The basis for this ruling was Regulation 15H of the Medical Schemes Act.

This ruling does not intend to suggest that Revellex is a first-line drug for the treatment of ulcerative colitis, or that it should be added to the therapeutic algorithm. ■

* *Not his real name*

No guaranteed benefits during waiting periods

Even the most basic benefits can be excluded for up to 12 months when you join a medical scheme. So the earlier you join, and the fewer and shorter your periods without cover, the better the cover from your medical scheme will be.

By **Dr Boshoff Steenekamp** (Strategist) & **Aleksandra Serwa** (Communications Manager)

George* was unsuccessful in appealing a ruling of the Registrar of Medical Schemes in which the regulator had ruled in favour of the medical scheme.

A simple story

George's scheme refused to fund his wife's heart surgery and hospitalisation costs.

The scheme had imposed a 12-month condition-specific waiting period for the condition in question.

George argued that schemes are not allowed to impose condition-specific waiting periods in respect of prescribed minimum benefit (PMB) conditions.

Even prescribed minimum benefits (PMBs) can be excluded during a waiting period.

But this is true only where the member or his/her dependent had belonged to another medical scheme for a continuous period of at least two years ending less than three months before application for current membership (Section 29A(2) of the Medical Schemes Act 131 of 1998).

> "The earlier you join, and the fewer and shorter your periods without cover, the better the cover from your medical scheme will be."

In this case, the wife had not been a beneficiary of a medical scheme for more than three months prior to application for current membership, so the condition-specific waiting period that was imposed on her excluded cover even for her PMB condition (Section 29A(1) of the Medical Schemes Act).

There are general waiting periods (of up to three months), and condition-specific waiting periods (of up to 12 months). Your scheme can apply either or both, depending on your previous scheme membership.

Go to the table on page 2-3 to see how your medical scheme can apply waiting periods.

Moreover, George had agreed to the imposition of this waiting period in writing.

His appeal to the Appeals Committee was unsuccessful. ■

** Not his real name*

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Use our website to:

- See whether your medical scheme is registered.
- Check if your healthcare broker is accredited.
- View lists of accredited administrators and managed care organisations.
- Find information relevant to the medical schemes industry, including forms, discussion documents and the Medical Schemes Act.

Complaints

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Reading matter

Between 1 April and 31 December 2011, we continued to publish various documents on our website, including:

- CMScript, our e-newsletter on prescribed minimum benefits (PMBs)
- Judgements of the Appeals Committee and the independent Appeal Board
- Our Annual Report 2010-2011, which includes detailed statistics on the medical schemes industry in South Africa
- Quarterly reports on the financial performance of medical schemes
- Circulars and guidelines for industry, including our recommended range for contribution increases for 2012 and a discussion document on trustee remuneration
- Press releases

Visit www.medicalschemes.com for more information and to subscribe to our publications.

How to avoid disputes

- Understand the rules of your medical scheme.
- Read all correspondence from your scheme.
- Study your benefits guide.
- Familiarise yourself with the terms and conditions of the benefit option you have chosen.
- Pay your contributions in full and on time every month.

How to resolve disputes

- Speak with your medical scheme first. The law requires all schemes to establish dispute resolution committees. 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, lodge a written complaint to the Registrar of Medical Schemes at the Council for Medical Schemes. You can send us a letter or e-mail us. All the contact details can be found on this page and the back cover.
- If you are aggrieved by the decision of the Registrar, appeal his/her decision to the Appeals Committee of the Council.
- If you are aggrieved by the decision of the Appeals Committee, appeal to the independent Appeal Board.

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