Career Ready Academy

TEXTBOOK

Medical Aid Benefits

Final Module for COB 9

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INTRODUCTION

An FSP must ensure that it, its key individuals and representatives are proficient in respect of, understand, and have completed adequate and appropriate class of business training and product specific training relevant to, the particular financial products in respect of which they render financial services or manages or oversees the rendering of financial services.

Class of business training, where appropriate must include training on the following:

The range of financial products within the class of business.

The general characteristics, terms and features of financial products in the class of business and any specialist characteristics, terms and features in respect of financial products in the class of business.

The typical fee structures, charges and other costs associated with products in the class of business.

General risk associated with investing, purchasing or transacting in the products in the class of business.

Investment and risk principles, options and strategies in respect of products in the class of business.

The appropriateness of different products or product features in the class of business for different types of clients or group of clients.

The typical role players or market participants in respect of products in the class of business, including their legal structure.

The impact of applicable legislation, including taxation laws, on product in the class of business.

The impact of applicable economic and environmental factors on the products in the class of business and the performance of those products including:

- The economic and business environment and cycles.
- Inflation.
- Government monetary and fiscal policy.
- Interest rates and exchange rates.

Any inter-relationship within and between particular classes of business.

Industry standards and codes of conduct relevant to class of business

This module is the final module in order to be certified for COB Class 9: Health Services Benefits

To be certified, complete all of the required modules:

- COB General Module: All Classes of Business
- COB Final Module: Class 9

Topic 1 Overview of Health Care Industry

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Describe the South African health-care industry.
- Outline private funding mechanisms.
- Understand the legislative environment pertaining to health care.
- Describe the function of the Council for medical schemes.

1.1 INTRODUCTION

The first medical scheme in South Africa was established by the employees of the De Beers Consolidated Mines in 1889. Since that time there have been a proliferation of medical scheme-type entities in various forms.

From 1956, schemes had to register as "friendly societies" under the Minister of Finance in terms of the Friendly Societies Act 25 of 1956, but there was no statutory control or coordination of these entities by the Ministry of Health from a perspective of health policy.

The "old" Medical Schemes Act, 1967 was approved by Parliament, there were 256 such schemes. This Act sought to regulate and coordinate the functioning of the two most important medical scheme-type entities providing financial protection in respect of health services, namely medical aid schemes and medical benefit schemes. 1993 saw major changes to the Act with a primary focus on deregulation in the industry.

The 1998 "new" Medical Schemes Act was legislated and introduced significant changes regarding benefits, risk management methodologies and regulatory control. The new legislation is aligned with national health policy and is concerned with increased equity of access to medical scheme membership within a cross-subsidised environment of contributions between the elderly and the young, the healthy and the sick and between low- and high-income earners.

The 1998 Act provides for the Council for Medical Schemes to be more purposeful and client-oriented in its functions with a defined focus on the protection of the interests of medical scheme members.

The Act also introduced the concept of the business of a medical scheme and that of relevant health services.

1.2 THE SOUTH AFRICAN HEALTH CARE INDUSTRY

The South African health system consists of a combination of two systems to serve the health needs of the country:

- ☐ Large public sector: This sector mainly caters for all people who do not have access to private sector health care. The public health care sector is mainly funded from the national budget. User fees are also raised by the public sector for people with the financial means to but electing not be a member of a medical scheme and to use the public health sector.

- ☐ Private sector: The private sector looks after the health needs of people having access to private sector health care. The private sector only provides health care services to approximately 8 million people or 16% of the population. This sector is funded privately or mostly through medical schemes.

There is currently an equity debate surrounding the funding proportion of the two sectors as 55% of total health care expenditure is used to serve 84% of the population who are mainly dependent on the services provided by the public sector.

In other words, the inequitable distribution of financial resources to the private sector serving only 16% of the population has always been questioned by policymakers and forms the basis around which health reform is motivated.

This inequitable distribution of resources favouring the private health care sector does not only refer to financial resources, but extends to human resources, including doctors, nurses, pharmacists and technology, which also includes high-tech diagnostic equipment.

1.3 PRIVATE FUNDING MECHANISMS

Private individuals access health care in the private sector mainly through the following methods:

- ☐ Medical scheme
- ☐ Health insurance products
- ☐ Gap cover
- ☐ Travel insurance
- ☐ Disability insurance
- ☐ Self-funding

The subsections following considers these funding mechanisms briefly.

1.3.1 Medical Schemes

The funding through medical schemes is based on a voluntary membership to a medical scheme and entails the following:

- ☐ The member pays monthly contributions to the medical scheme.
- ☐ The member is eligible to receive certain benefits to fund the cost of receiving health care in either the public or private sector, although medical scheme members usually utilise the private sector doctors and facilities.
- ☐ The specific benefits a member is entitled to are determined by the rules of the medical scheme.
- ☐ The monthly contribution carries a capped tax rebate.

Members can still have out-of-pocket costs, as benefits often do not cover the total costs of the health services received or fees charged by health professionals.

1.3.2 Health insurance products

Certain individuals choose not to contribute towards a medical scheme but elect to manage their personal financial risk through a health insurance product. This alternative is to provide for the financial risk associated with an adverse health situation through purchasing a health insurance product. These products are very different from medical scheme products. The benefits of these products cover certain health events, which are clearly stipulated in the contract. The policy may pay out a percentage of the sum for which a policyholder is assured depending on the severity of the health event and may pay the benefit on a periodic basis.

Health insurance policies are provided by short-term and long-term insurers.

Health insurance products are not permitted the following actions:

- ☐ Pay a benefit and there may not be a link between benefits paid to the client and actual medical expenses incurred.
- ☐ Provide benefits that are linked to lists of procedure codes or a list of tariffs associated with the procedure codes.
- ☐ Pay benefits directly to a service provider.

The core differences between a medical scheme and health insurance policies are as follows:

- ☐ Medical schemes reimburse their members for actual expenditure on receiving relevant health services from registered health professionals (indemnity business).
- ☐ Health insurance policies may not indemnify policyholders against actual medical expenses incurred for relevant health services but must offer a sum assured defined in advance of any health care provision.
- ☐ Health insurance products operate under the Long-term and Short-term Insurance Act whereas medical schemes operate under the Medical Schemes Act.

The table following summarises the main differences between Medical Scheme benefits and Health insurance products.

	Health insurance product	**Medical Scheme Benefits**
Relevant legislation	Long-term and short-term insurance Act	Medical Schemes Act
Benefits	Triggered by a diagnosis of a health condition	Triggered by obtaining a relevant health service
Policy benefit	One or more sums of money, services or other benefits including an annuity	Reimbursement for actual expenditure or part thereof for health services obtained (indemnity business)
Underwriting	Allowed – can risk rate	Not allowed – cannot risk rate
Pay-out	Based on health event	Based on service obtained

Table 1.3.1: Difference between Health Insurance Products and Medical Scheme Benefits

A health event is defined as an event relating to the health of the mind or body of a person or an unborn.

A policy benefit is defined as one or more sums of money, services or other benefits, including an annuity.

1.3.3 Gap Cover

The National Health Reference Price List (NHRPL) is commonly used by medical schemes as the standard for payment or the medical scheme tariff. This tariff is the benefit available to members as reimbursement for services provided by doctors and other service providers.

Service providers frequently charge fees that are substantially higher than the NHRPL or medical scheme rate. The difference in the case of a specialist's account during a period of hospitalisation can be significant.

Members of medical schemes have to self-fund this difference or insurance known as gap cover can be taken to cover such a difference.

Gap cover is made available by short-term insurers and is regulated in terms of the Short-term Insurance Act as it is not regarded as a Health Service Benefit.

1.3.4 Self-Funding

The reality is that many individuals don't have any type of medical scheme or insurance cover for health care and access care in the private sector by personally carrying the financial burden. This is mainly restricted to out-of-hospital or ambulatory primary care services. This represents a level of self-funding.

1.3.5 Travel Insurance

Travel insurance is short term insurance that provides cover for health event occurring outside South Africa whilst travelling abroad.

1.3.6 Disability Insurance

Disability insurance is a long-term insurance product that cover disability events. Such pay-outs can be used to cover medical expenses related to the disability, but the pay-out is not linked to medical costs.

1.4 LEGISLATIVE ENVIRONMENT IN HEALTH CARE

The health care industry is a complex and highly-regulated environment. The subsections following considers the different legislation regulating health care in South Africa.

1.4.1 National Health Act, 2003 (Act 61 of 2003)

The National Health Act, 2003, provides a framework for a single health system for South Africa. It highlights the rights and responsibilities of health providers and health care users and ensures broader community participation in health care delivery from a health facility level up to national level. It establishes provincial health services and outlines the general functions of provincial health departments.

The National Health Act provides for the following rights to all people in South Africa:

- ☐ The right toto emergency medical treatment.
- ☐ The right to have full knowledge of one's health condition.
- ☐ The right to exercise one's informed consent.

- ☐ The right to participate in decisions regarding one's health.
- ☐ The right to be informed when one is participating in research.
- ☐ The right to confidentiality and access to health records.
- ☐ The right to complain about service.
- ☐ The right of health workers to be treated with respect.

1.4.2 Medicines and Related Substances Control Act

The Medicines and Related Substances Control Act makes provision for the establishment of the Medicines Control Council (MCC).

The MCC is a statutory body with a purpose to oversee the regulation of medicines in South Africa. It is appointed by the Minister of Health and its main purpose is to safeguard and protect the public through ensuring that all medicines that are sold and used in South Africa are safe, therapeutically-effective and consistently meet acceptable standards of quality.

1.4.3 Acts Regulating Health Professions

There is different act that makes provision for the registration and regulation of health professionals. To be able to provide relevant health services within the context of these acts, professionals need to be registered with the appropriate professional board as is legislated for in the different acts. These acts include the following:

- ☐ Medical, Dental and Supplementary Health Services Professions Act (No. 89 of 1997)
- ☐ Pharmacy Act (No. 88 of 1997)
- ☐ Nursing Act (No. 5 of 1995)

1.4.4 The Medical Schemes Act

The Medical Schemes Act was passed in November 1998. The new Act repeals in full the Medical Schemes Act, 72 of 1967, and all the Amendments to that Act which followed. The new Act has been in effect since January 2000.

The Medical Schemes Act and Regulations aim to widen access to private health care, which is consistent with the aims of government policy.

The Medical Schemes Act's provisions are mainly about the ways and means of establishing oversight and regulatory mechanisms and structures to better monitor and control the activities of medical schemes. Provisions in this respect are concerned with broadening the capacity, functions and powers of the Council for Medical Schemes; appointing a Registrar and Deputy Registrar and providing for stricter terms of reference for auditors and brokers. The Act also sets out all the mandatory procedures for the registration and operation of individual medical schemes.

The regulations in terms of the Medical Schemes Act deal more specifically with provisions for contribution and benefit structures of medical schemes.

I) Objective of the Act

The main objectives of the Act are as follows:

- ☐ Make provision for the registration and control of medical schemes.

- ☐ To create an environment that will protect the interest of members of medical schemes by dealing with regulatory control of-
  - Medical schemes
  - Third-party administrators
  - Managed care organisations
  - Medical scheme brokers

1.4.5 Key Organisation of the Act

The Act consists of 12 chapters and 2 schedules. The main focus areas are follows:

- ☐ To consolidate the laws relating to registered medical schemes.
- ☐ To provide for the establishment of the Council for Medical Schemes.
- ☐ To provide for the appointment of a Registrar.
- ☐ To make provision for the registration and control of medical schemes.
- ☐ To protect the interest of members.
- ☐ To provide for measures for the co-ordination of medical schemes.
- ☐ To provide for incidental matters.

The regulations issued in terms of the Medical Schemes Act addresses the following:

- ☐ Administrative requirements for medical schemes.
- ☐ Contributions and benefits.
- ☐ Waiting periods and penalties.
- ☐ Provision of managed care.
- ☐ Administrators of medical schemes.
- ☐ Conditions to be complied with by brokers.
- ☐ Accumulated funds and assets.

The annexures to the Regulations deal with the following:

- ☐ Prescribed Minimum Benefits (PMB's)
- ☐ Limitation on assets to be held in South Africa
- ☐ Audit reports for purpose of regulation 25

The impact of some of these provisions are to be considered in detail in later topics.

1.5 COUNCIL FOR MEDICAL SCHEMES

The Medical Schemes Act makes provision for the establishment of the Council for Medical Schemes. The alignment with the objectives of the National Health Policy is clearly evidenced in the functions of the Council for Medical Schemes.

The functions of the Council for Medical Schemes are as follows:

- ☐ Protect the interests of medical scheme members at all times.

- ☐ Control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy.
- ☐ Make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes and such other services as the Council may from time to time determine.
- ☐ Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Medical Schemes Act.
- ☐ Collect and disseminate information about medical schemes but also private health care in general.
- ☐ Make rules, not inconsistent with the provisions of Medical Schemes Act, for the purpose of the performance of its functions and the exercise of the Council for Medical Scheme's powers.
- ☐ Advise the Minister on any matter concerning medical schemes.

The Medical Schemes Act provides that the Council for Medical Schemes will have the powers necessary to carry out its statutory functions.

1.5.1 Governance of the Council for Medical Schemes

The governance of the Council for Medical Schemes is vested in a board appointed by the Minister of Health, consisting of a non-executive Chairman, a Deputy Chairman and 13 members. The Council for Medical Schemes members are elected based on their skills and expertise, which include disciplines of law, accounting, medicine, actuarial sciences, economics and consumer affairs.

The names of those appointed are published in the Government Gazette, also indicating the period of the term of appointment. The Minister also appoints the Chairperson of the Council for Medical Schemes. The period of office is stipulated as the minister deems necessary but will not be for more than 3 years. Council members can be re-appointed for a further term.

1.5.2 Management of Council for Medical Schemes

The executive head of the Council for Medical Schemes is the Registrar, also appointed by the Minister in terms of the Medical Schemes Act.

The Council for Medical Schemes determines overall policy, but the day-to-day decisions and management of staff, the appointment of the necessary staff to support the operations of the Council for Medical Schemes and the control and evaluation of performance, are the responsibilities of the Registrar and the executive managers.

The Registrar will fulfil his function within the provisions of the Medical Schemes Act and policy guidelines from the Council for Medical Schemes. The powers of the Registrar include the following:

- ☐ The registration of medical schemes.
- ☐ Inspection of reports and documents of medical schemes.
- ☐ Address enquiries to medical schemes with regard its business.
- ☐ Investigate the business of any entity not registered as a medical scheme, to establish whether that entity constitutes the business of a medical scheme.
- ☐ Removal of members of the Board of Trustees from a medical scheme if there is sufficient reason to suspect that such a person is not fit and proper.

Topic 2 Regulation of Medical Schemes

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Define the business of a medical scheme.
- Outline the registration process for a medical scheme.
- Understand how the rules of a medical scheme impacts on members.
- Outline the approval of medical scheme options process.
- Outline the management of a medical scheme.

2.1 INTRODUCTION

A medical scheme is a legal entity for the purpose of providing access to health care services for its members.

Medical schemes are registered in accordance with the provisions made within the Medical Schemes Act, Act 131 of 1998 as amended.

A medical scheme operates as a non-profit organisation. This means that it does not have shareholders, and therefore does not pay dividends or distribute its profits.

Should the claims experience for a given benefit year result in a surplus and the scheme make a profit, that money must be carried forward to the following year in its entirety to the benefit of the members of the medical scheme. It will increase the solvency ratio or reserves of the medical scheme. The opposite is also true – should a medical scheme make an operating loss during a benefit year, it will reduce the reserve level of the scheme.

To put it in perspective, a medical scheme can be seen as a community of people with different ages, different health needs and different disease profiles. It could be viewed as a trust fund whose only beneficiaries are the members within the defined community.

The revenue of a medical scheme comes from members' monthly contributions and the investment income.

The expenses are represented by claims representing cost of care (±85%) and the cost of managing the medical scheme (±15%).

The Medical Schemes Act states that no person shall carry on the business of a medical scheme unless that person is registered as medical scheme under section 24 of the Act. Therefore, no financial product that offers financial cover for health needs or events may be positioned as being a medical scheme.

2.2 BUSINESS OF A MEDICAL SCHEME

In terms of the Medical Schemes Act, the business of a medical scheme is defined as the business of undertaking liability in return for a premium or contribution to-

- ☐ Make provision for the obtaining of any relevant health service.

- ☐ Grant assistance in defraying expenditure incurred in connection with the rendering of any health service.
- ☐ To render a relevant health service (where applicable), either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

This definition of the business of a medical scheme is important in the context of protecting an environment of cross-subsidised, community-rated medical schemes. If the membership is diluted by alternative products that compete with medical schemes, the broader objectives of the medical schemes policy will be defeated.

It is important that members and prospective members understand the extent of the benefits available to them from the specific benefit option recommended and chosen. Also important is for members to understand that the Medical Schemes Act makes provision for the payment of benefits for only relevant health services.

Relevant health services are defined in the Medical Schemes Act as any health care treatment of any person by a person registered in terms of any law, which treatment has the following objective:

- ☐ The physical or mental examination of that person.
- ☐ The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency.
- ☐ The giving of advice in relation to any such defect, illness or deficiency.
- ☐ The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof.
- ☐ The prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy including the termination thereof.
- ☐ Nursing or midwifery.

2.3 REGISTRATION OF A MEDICAL SCHEME

Any entity that wants to do the business of a medical scheme, needs to be registered as such through following the proper procedures as stipulated in the Medical Schemes Act and Regulation 2 of the Regulations to the Act.

An application to register a medical scheme must be submitted in writing to the Registrar for Medical Schemes and signed by the person wanting to register the scheme

The application needs to be accompanied by all documents and information as required, including the following:

- ☐ The name of the medical scheme.
- ☐ The rules of the proposed medical scheme that will come into effect at the date of commencement of operations of the proposed medical scheme.
- ☐ Guarantees and guarantee deposits as required by the Registrar.
- ☐ Full details of the Principal Officer and trustees of the proposed scheme
- ☐ Details of the person who will administrator the proposed scheme as well as a copy of the administration agreement.
- ☐ A detailed business plan.

Once the Registrar is satisfied that the person who applied for registration will be able to comply with the provisions of the Medical Schemes Act, the medical scheme will be registered, and a registration certificate will be issued with a copy of the rules and date of registration. A notification with regards to the registration will be published in the Government Gazette.

The Registrar can also reject an application for registration. The applicant will be informed in what respect the proposed medical scheme does not comply with the provisions of the Medical Schemes Act.

The regulation further stipulates that the minimum number of members required by the proposed scheme is 6 000 and this number of members must be admitted within 3 months of the date of registration of the scheme.

A medical scheme must also have a registered office in South Africa and may not carry out any other business other than the business of a medical scheme.

After a medical has been registered it can assume liability for and guarantee the benefits offered to its members and their dependants in terms of the rules of that medical scheme.

2.3.1 Restricted Membership Schemes

A medical scheme can be registered as an open or a restricted membership scheme. Open schemes are open to the general public.

A restricted medical scheme is one not open to the general public for membership: it is often restricted to groups of people such as employees of a particular company or industry. These schemes are subject to the same regulations as open schemes, and also are governed by the Medical Schemes Act.

2.4 RULES OF MEDICAL SCHEMES

2.4.1 Introduction

Whereas medical schemes in South Africa are governed and managed in terms of the Medical Schemes Act, each scheme is also governed in terms of its rules, which are also called its constitution, and which form the basis of the contract that members conclude with their medical scheme.

Section 29 of the Medical Schemes Act stipulates what should be provided for in the rules. The list includes the following:

- ☐ The appointment or election of a Board of Trustees to govern the scheme.
- ☐ The appointment of a Principal Officer by the Board of Trustees.
- ☐ The removal of officers.
- ☐ The manner in which complaints and disputes are to be settled.
- ☐ The terms and conditions applicable to the admission of a person as a principal member and his/her dependant(s).
- ☐ The scope and level of benefits.
- ☐ The scale or tariff for the payment of benefits.

Rules of schemes become valid only once they have been registered by the Office of the Registrar at the Council for Medical Schemes. They must conform to the provisions of the Medical Schemes Act at all times.

2.3.2 Model Rules

Subject to the Medical Schemes Act and Prescribed Minimum Benefits, scheme rules may restrict benefits covered and limit amounts payable in respect of particular benefits.

A medical scheme will only be registered if its rules provide for specific matters that are set out in the Medical Schemes Act. The model rules provide this guideline.

Every medical scheme must provide the member with a detailed summary of its rules specifying the rights of and obligations to members when that member joins the medical scheme.

It is of utmost importance that brokers know these rules when they advise clients and make sure that members understand the rules once joined.

In the event of the amendment of the rules of the medical scheme, members must be given advanced written notice of any change in contributions and/or benefits or any other condition affecting their membership. This usually occurs towards the end of a benefit year where both contributions and benefits are evaluated by the medical scheme management and approved by the board.

It is again of utmost importance that brokers keep themselves informed regarding these changes and as part of the ongoing services to their clients, to make sure that the impact of rules, contributions or any other changes are taken into account with regards to clients' changing health care needs. They are also to ensure that members understand the changes in rules and their impact.

The areas that the rules address are considered in the subsections following.

I) The Governance and Management

The governance and management of the medical scheme, i.e. the appointment or election of a Board of Trustees, the appointment of a Principal Officer by the Board of Trustees and other management issues.

II) Rules Regarding Membership

The rules must state the terms and conditions for admission to a scheme, including the member contribution (premium). Contribution costs are to be determined only on the grounds of income, richness of benefits or number of dependants of the member, or on a combination of these factors. Dependants of a member of a scheme are entitled to participate in the same benefit option as the member.

Members and dependants are only permitted to join one medical scheme and can only claim or accept benefits from the medical scheme of which they are members.

Members must be given advanced written notice of any changes that will affect their membership. For example, changes in contributions, membership fees or benefits.

III) Continuation Membership

This is important for restricted membership schemes only. Members must be informed about rules for continued cover for themselves and their dependants after a member's employment is terminated.

IV) Suspension and Cancellation of Membership

Medical schemes must set out the grounds under which they can cancel or suspend a member's membership.

Regulation 4 also determines that a medical scheme that provides more than one benefit option may not preclude any member from choosing any benefit option offered by the medical scheme, although a member or a dependant shall have the right to participate in only one benefit option at a time.

A medical scheme may in its rules provide that a member may only change to any benefit option at the beginning of the month of January each year, and by giving written notice of at least 3 months before such a change is made.

V) Rules Regarding Benefits

The minimum benefits available to members and their dependants as is legislated in terms of the Prescribed Minimum Benefits must be included in a scheme's rules.

VI) Personal Savings Accounts

Personal savings accounts are deposits made by individual members, held by a medical scheme and used by members to pay for medical scheme expenses without risk pooling.

The rules of a scheme must stipulate how personal savings accounts will be handled by the scheme.

VII) Rules Regarding Reimbursement for Services

The rules of a scheme must provide that no limitation shall apply to the reimbursement of any relevant health service obtained by a member from a public hospital where this service complies with the general scope and level as contemplated in the Prescribed Minimum Benefits.

The rules must provide for a clear benefit for the payment of any services rendered by service providers according to a scale, tariff or recommended guide, or specific directives prescribed in the rules of the medical scheme.

VIII) Rules Regarding the Mechanisms to Settle Complaints or Disputes

The medical scheme needs to make provision in its rules for the resolution of complaints or disputes by members or providers of care.

2.5 APPROVAL OF MEDICAL SCHEME OPTIONS

Every option within a medical scheme represents a unique product with a specific range of benefits for a particular segment of the market. Every option has a set of benefits and a customised contribution rate for that particular option.

Section 33 of the Medical Schemes Act allows for a medical scheme to apply to the Registrar for the approval of additional benefit option/s. This application will only be approved if the following conditions are met:

- ☐ Every such contemplated option includes the Prescribed Minimum Benefits.
- ☐ The option will be self-supporting in terms of membership and financial performance.
- ☐ Every such option is financially sound.
- ☐ The option will not jeopardise the financial soundness of any existing benefit option within the medical scheme.

2.6 MANAGEMENT OF A MEDICAL SCHEME

2.6.1 Board of Trustees

Medical schemes are managed by a Board of Trustees. The Medical Schemes Act requires that 50% of board members need to be elected from scheme members. The Medical Schemes Act also provides for people disqualified to be elected, for example, a person who is a director or an employee of an administrator or managed care company contracted to the scheme.

The duties of the Board of Trustees are to manage the business of the scheme in accordance with the applicable laws and the rules of the scheme.

The Board is also responsible to appoint a Principal Officer who is responsible for the day-to-day running of the scheme and overseeing that the operational records of the scheme are kept accurately and that the scheme has proper systems and controls.

The trustees also need to ensure that adequate and appropriate information is available and communicated. All members need to understand their rights, benefits entitlement and contributions, as well as their responsibilities.

2.6.2 The Principal Officer

The Principal Officer is the executive officer of the scheme and must ensure the following:

- ☐ That he acts in the best interest of the members of the scheme at all times.
- ☐ The decisions and instructions of the Board are executed without unnecessary delay.
- ☐ Where necessary, there is proper and appropriate communication between the scheme and those parties affected by the decisions and instructions of the Board.
- ☐ That he keeps the Board sufficiently and timeously informed of the affairs of the scheme concerning any matter relating to the duties of the Board.
- ☐ That he keeps the Board sufficiently and timeously informed concerning the affairs of the scheme so as to enable the Board to comply with the provisions of the Medical Schemes Act.
- ☐ That he does not take any decisions concerning the affairs of the scheme without prior authorisation by the Board and that he at all times observes the authority of the Board in its governance of the scheme.

The Principal Officer is the accounting officer of the scheme charged with the collection of and accounting for all moneys received and payments authorised by and made on behalf of the scheme and must keep full and proper records of all moneys received and expenses incurred by, and of all assets, liabilities and financial transactions of the scheme. The Principal Officer must ensure that annual financial statements are prepared and must ensure compliance with all statutory requirements pertaining thereto.

The Principal Officer must ensure the carrying out of all of his duties as are necessary for the proper execution of the business of the scheme including the following:

- ☐ Attendance of all meetings of the Board.
- ☐ Attendance of any other duly appointed committee where his attendance may be required.
- ☐ Ensuring proper recording of the proceedings of all meetings.

The Principal Officer shall be responsible for the supervision of the staff employed by the scheme unless the Board decides otherwise.

Topic 3 Arrangements Between a Medical Scheme and Third Parties

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Describe the administration of medical scheme arrangements.
- Understand managed health care.
- Outline regulation surrounding health service brokers.

3.1 INTRODUCTION

The main agreements between medical schemes and third parties are the following:

- ☐ Administrators of medical schemes
- ☐ Managed care organisations
- ☐ Health service brokers
- ☐ Medical service providers
- ☐ Technology clinical support services

The sections following considers some of these arrangements.

3.2 ADMINISTRATION OF MEDICAL SCHEMES

The business of a medical scheme is complex and transaction-intensive and includes the following:

- ☐ Managing applications for membership and evaluating applications.
- ☐ Registration of membership and tracking growth, resignations and suspensions.
- ☐ Managing and collection, control and reconciliation of the contributions received from membership.
- ☐ Loading of the rules of the scheme and managing benefits to members according to those rules.
- ☐ Paying claims according to the rules of different benefit options.
- ☐ Interacting with members and managing member queries.
- ☐ Producing financial, operating and risk reports.
- ☐ Interacting with and reporting to the Medical Schemes Council.

To be able to manage the business requires a comprehensive technology, skilled people and infrastructure that may not be a feasible investment for a smaller scheme. Bigger schemes do create the infrastructure to administer the business themselves (self-administered schemes).

The Medical Schemes Act makes provision for medical schemes to outsource their administration to independent medical scheme administrators, often referred to as third party administrators. These administrators perform the administration functions as per contracted service levels on behalf of schemes and at a negotiated fee payable usually on a per-member-per-month basis.

The Medical Schemes Act requires that an organisation administering medical schemes must also be accredited by the Medical Schemes Council. The accreditation for an administration company is granted for a period of 24 months by the Medical Schemes Council and a certificate is issued to the administration company. The Medical Schemes Council. has the power to withdraw the accreditation if the administration company that does not comply with the provisions within the Medical Schemes Act.

Unlike medical schemes, the business of medical scheme administration is a for-profit business.

The following companies are some of the big players in the third-party administration market:

- ☐ Allcare Medical Scheme Administrators (Pty) Ltd
- ☐ Discovery Health (Pty) Ltd
- ☐ Medscheme Holdings (Pty) Ltd
- ☐ Metropolitan Health (Pty) Ltd
- ☐ Sanlam Health care Management (Pty) Ltd

3.3 MANAGED HEALTH CARE

Managed health care is the clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical management-based programmes.

The Medical Schemes Act defined rules-based and clinical management-based programmes as a set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy, and efficiency of, health care services, procedures or settings, on the basis of which appropriate managed health care interventions are made.

A medical scheme may decide to provide the managed care services internally. Thus, it will create an infrastructure with people and technology to self-manage the financial and clinical risk of the membership population. The alternative would be for the Board to elect to outsource the managed care services to a managed care organisation.

A managed health care organisation (MCO) refers to an organisation that -

- ☐ Has been accredited through the appropriate procedures by the Medical Schemes Council as an MCO and is doing the business of managed care.
- ☐ Has been contracted with a medical scheme in terms of Regulation 15A to provide a managed health care service.

A list of all accredited managed care organisations as well as the conditions attached to the accreditation of the entity, can be viewed on the Medical Schemes Council website. Accreditation to an MCO is granted for a period of 24 months.

2.9.3 Typical Services Provided by Managed Care Organisations

The main objective of the implementation of a managed health care programmes are to try and reduce the number of events and to reduce the cost of these events.

Typical services provided by Managed Care Organisations are as follows and are considered in the subsections following.

- ☐ Hospital Risk Management
- ☐ Disease management programmes
- ☐ Pharmacy Benefit Management
- ☐ Alternative reimbursement methods

I) Hospital Risk Management

Hospital Risk Management includes the pre-authorisation of any person that needs to be hospitalised. This event is then reviewed concurrently and retrospectively.

Level of care is managed through the case management process. This refers to a process of engaging with the treating doctor to assess whether the management is, for instance, intensive care in the hospital and whether the patient could not equally effectively be treated in a general ward without compromising the outcome of care.

It also refers to managing where the patients are best treated, i.e. at home with homecare nursing or in a step-down facility.

II) Disease Management Programmes

Disease management programmes focus on achieving optimal control of common, high financial impact, chronic diseases. The disease management protocols use evidence-based clinical treatment guidelines in the programmes.

Protocol is defined in the Medical Schemes Regulations as a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways.

Evidence-based clinical treatment is defined as the conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby individual clinical experience is integrated with the best available external clinical evidence from systematic research.

The Medical Schemes Act stipulates that if managed health care entails the use of an evidence-based protocol, the medical scheme and the managed health care organisation must provide such protocol to health care providers, beneficiaries and members of the public, upon request, and provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause harm to a beneficiary, without penalty to that beneficiary.

Examples of disease management programmes are the following:

- ☐ Diabetes programmes
- ☐ Asthma programmes
- ☐ HIV and AIDS programmes
- ☐ Oncology programmes

III) Pharmacy Benefit Management

Pharmacy Benefit Management provides for the authorisation of medicine for chronic diseases within the Prescribed Minimum Benefits and rules of the scheme. Medicine pricelists are used to manage the benefits available for drugs or classes of drugs.

Medicine formularies or a medicine list that would be used to stipulate approved drugs within the benefits for this programme are used. It usually stipulates the use of generic medicine when available. Certain drugs may not be available on the formulary. In those cases, the member will have to pay for the drug of choice or alternatively be willing to accept the formulary drug.

Generic medicine are copies of brand-name medicine that have exactly the same dosage, intended use, effects, side effects, route of administration, risks, safety, and strength as the original medicine.

Where a formulary is used, the medical scheme and the managed health care organisation must-

- ☐ Provide such formulary or restricted list to health care providers, beneficiaries and members of the public, upon request.
- ☐ Provide for appropriate substitution of drugs where a formulary drug has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary. This means that where a product on the formulary does not have the desired effect of the treatment of the patient, the doctor can motivate to the Managed Health Care Organisation for a drug that is not on the formulary. If approved by the Managed Health Care Organisation, the member cannot be penalised.

IV) Provider Relations

This provider relation function is mainly responsible for setting up arrangements for the delivery of care by providers of care as well as tariff negotiations.

The Medical Scheme Regulations refers to a participating health care provider which means a health care provider who, by means of a contract directly between that provider and a medical scheme, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned.

In some instances, arrangements are made with provider groups (doctors, pharmacists or hospitals) to be the preferred providers or network for the scheme.

Examples of General Practitioner Groups are Primecure and CareCross. Whereas pharmacy groups include Click Pharmacies and Alphapharm.

V) Alternative Reimbursement Methods

In the negotiation of tariffs, the Managed Health Care Organisation also prefers to agree on an alternative to the fee-for-service tariff structure. One example is a capitation agreement.

A capitation agreement is defined as an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme.

In other words, under a capitation arrangement the doctor gets a fixed fee per month per registered member of the scheme in the doctor's practice, irrespective of how frequently the patient sees the doctor. This tariff may include certain other procedures that could be charged additionally under fee-for-service.

Capitation agreements eliminates the incentive created by doctors using a fee-for-service tariff system to keep the members sick so as to ensure frequent visits. The incentive for the doctor under capitation is to keep the members healthy to avoid unnecessary visits. In the tariffs he is also incentivised to use only what is necessary.

For hospitals in South Africa the *per diem* system is being used. This refers to a single rate per day for a specific level of care in a hospital. It usually includes consumables and therefore encourages the hospital to apply cost-efficiency in care of patients in the hospital setting.

3.3.2 Pre-Requisites for Managed Health Care Arrangements

If any managed health care is undertaken by the medical scheme itself or by a Managed Health Care Organisation, the medical scheme must ensure the following:

- ☐ The services and methodologies must be in writing and must describe all utilisation review activities and infrastructures including data-sources used in detail.
- ☐ For an appeals process to be in place to provide a mechanism for doctors and patients to appeal against any decision by the Managed Health Care Organisation that may adversely affect the entitlements of a beneficiary in terms of the rules of the medical scheme concerned.
- ☐ Provisions for ensuring confidentiality of clinical and proprietary information.
- ☐ The use of documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions.
- ☐ The managed health care programmes use transparent and verifiable criteria for any other decision-making factor affecting funding decisions and are evaluated periodically to ensure relevance for funding decisions.
- ☐ A participating health care provider may not be forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the health care provider's view, such care is consistent with medical necessity and medical appropriateness.

3.4 HEALTH SERVICE BROKERS

3.4.1 Definition

Broker services entails advising clients on their financial services needs and includes the following:

- ☐ Providing clients with a number of quotes from different financial services companies for comparison.
- ☐ Matching potential clients up with companies that can meet their client's unique needs.

The Medical Schemes Act defines a medical schemes broker as a person whose business or part thereof entails providing broker services but does not include the following unless the person elects to be accredited as a broker, or actively markets or canvasses for membership of a medical scheme.

- ☐ An employer or employer representative who provides service or advice exclusively to the employees of that employer.
- ☐ A trade union or trade union representative who provides service or advice exclusively to members of that trade union.
- ☐ A person who provides service or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of a medical scheme.

Broker services includes the ongoing provision of advice and services beyond introduction or admission of members to a medical scheme.

3.4.2 Legal Requirements for Acting as a Broker

The conduct of brokers advising clients on health care products are regulated by both the Medical Schemes Medical Schemes Act and the Financial Advisory and Intermediary Act (FAIS).

Compensation of brokers, however, is regulated by only the Medical Schemes Act.

The registration and conduct of business by medical scheme brokers is therefore jointly regulated by the Council for Medical Schemes and the Financial Sector Conduct Authority.

I) Accreditation as a Broker by the Council for Medical Schemes

The business that provides broker services is known as a brokerage whilst the person providing the services is known as a broker.

To be accredited as a health care brokerage, the business must submit an application for accreditation to the Council for Medical Schemes and must meet specified requirements and be managed by a person who meets the requirement set by the Council for Medical Schemes

To be accredited as a health care broker, a person must submit an application for accreditation to the Council for Medical Schemes, meet the fit and proper requirements in terms of qualifications and experience stipulated under the Financial Advisory and Intermediary Services (FAIS) Act and must pay the prescribed registration fees.

If the person does not meet some of the fit and proper requirement, the person can work under supervision under certain conditions and is accredited as an apprentice broker.

The fit and proper requirements in terms of the FAIS Act is considered in Module 1.

Upon accreditation, the brokerage and broker will receive an accreditation number.

Accreditation for brokerages and brokers are granted for a period of 24 months after which time the accreditation needs to be renewed. It needs to be noted that an application for renewal must be submitted to the CMS at least three 3 prior to the expiry date of the accreditation.

II) Accreditation as in Terms of the FAIS Act

Medical scheme broker services also falls within the definition of financial services as defined by the FAIS Act.

The brokerage needs to apply for authorisation as a financial services provider (FSP) in terms of category 1.16: Health Service Benefits and must meet the fit and proper requirements for an FSP. Such a license will only be issued if the brokerage already has been accredited by the Council for Medical Schemes.

A medical schemes broker needs to be appointed by an authorised FSP as a representative registered in category 1.16: Health Services Benefits. The person must meet the fit and proper requirement applicable to representatives for this category and must have the necessary accreditation by the Council for Medical Schemes before approval as representative.

3.4.3 Broking Agreement

Brokerages become eligible to be compensated only when the brokerage has a written agreement with a medical scheme or more than one scheme.

All agreements concluded between brokers and medical schemes must be in strict accordance with the Medical Schemes Act.

The provisions that must typically be contained in the broking agreement are considered in the subsections following.

I) Commencement Date

The broking agreement must specify the date of commencement and a continuation clause.

II) Appointment

The appointment clause usually considers the following:

- ☐ The undertaking by brokerage to ensure that all introducing brokers act in good faith towards the scheme.
- ☐ In the case of a brokerage, the brokerage will deliver to the scheme a list of introducing brokers and maintain that list.
- ☐ The requirements with regard to the scheme's marketing and administration standards as determined from time to time.
- ☐ The terms referring to the appointment on an exclusive or on a non-exclusive basis
- ☐ The right granted to the broker to market the scheme for the purpose of procuring prospective members to join the scheme.

III) Scope of Authority

The scope of authority usually focusses on the broker acting as an independent contractor and not deemed as representatives, employees or agents of the scheme. Most of the times, it also includes a stipulation that the brokerage or any broker shall not be entitled to contract on behalf of or bind the scheme or incur any liability or debt on its behalf.

Brokerages are not authorised to publish or cause to be published any advertisements, marketing material or other information relating to the scheme or its business without the prior written approval of the scheme.

IV) Collection and Remittance of Monies

Neither the brokerage nor its introducing brokers are authorised to collect any monies or issue any receipts in either the name of or on behalf of the medical scheme.

V) Undertakings by the Brokerage

The broking agreement places the following onus on the Broker:

- ☐ Ensuring that the broker is duly accredited by the Council for Medical Schemes.
- ☐ Ensuring that all brokers who market the scheme undertake to successfully complete all initial and ongoing training which shall be provided by the scheme or through its administrator or any other authorised person.
- ☐ Ensuring that all individuals and entities that are utilised by the broker is in compliance with the terms of the agreement, have all the required skills and accreditations required by the Medical Schemes Act and are fit and proper as required by the FAIS Act.
- ☐ To immediately inform the scheme in the event of the brokerage / broker accreditation by Medical Schemes Council being suspended, withdrawn or lapsed or in terms of the FAIS Act being suspended, withdrawn or lapsed

- ☐ Compensating any other individuals or entities employed by them to fulfil the obligations arising in terms of the agreement and ensuring that such individuals or entities comply with the provisions of the broker agreement.
- ☐ Not use any marketing material or information regarding the scheme with the intention of granting a competitive advantage to any health care competitor of the scheme.
- ☐ Defend, indemnify and hold harmless against any and all claims, liabilities, damages, judgments, including legal fees asserted against, imposed upon and/or incurred by the scheme that arise out of the acts or omissions, including negligence of the brokerage, its introducing brokers or any other persons under the brokerage's control, in the discharge of the brokerage's or the introducing broker's responsibilities in terms of the agreement.
- ☐ Effect and maintain professional indemnity insurance and other such insurance.

VI) Services

The brokering agreement provides for the brokerage and its introducing brokers, to, during the existence of the agreement, at their sole expense, solicit and enrol prospective members. The services to be provided include the following:

- ☐ The submission of proposals to prospective members in a form and only upon terms accepted in advance by the scheme, it being agreed that such proposals, including the amount of contributions payable, shall not be altered without the prior written approval of the scheme.
- ☐ The accurate and complete recording of information required by the scheme for the enrolment of prospective members.
- ☐ Absolute compliance with the policies and procedures of the scheme as per the agreement.
- ☐ The delivery and explanation of initial administrative forms and contract documentation to prospective members.
- ☐ The maintenance of accurate and complete records in respect of the enrolment of members to which the scheme shall be allowed access upon reasonable notice.

VII) Confidentiality

The scheme will allow the brokerage and its introducing consultants access to certain information and data relating to members in respect of whom the brokerage is responsible for servicing in terms of the agreement.

The data and information shall only be used for the purposes of meeting the servicing requirements of that member. The scheme may in its sole and absolute discretion and at any time, withdraw access to any such data and information during the period of the agreement.

VIII) Remuneration

This section deals with the compensation for the introduction of members to the scheme, including any disbursements and charges incurred.

The terms specify commission to be paid on contributions received by the scheme during the currency of the brokering agreement.

The clause also makes provision that commission can be changed at any time due to changes in statute or regulation or increases in contributions arising out of changes in plan types and benefit options.

Any change of plan type or benefit option or premium under or in respect of a contract shall entitle the scheme to adjust any commission in respect of such contract accordingly.

This clause could make provision that should a new membership issued pursuant to a proposal submitted by the brokerage be terminated due to non-payment of contributions by the member and not be reinstated within 3 months from the date of termination, no commission shall be paid to the brokerage after reinstatement of the contract, unless such reinstatement was the result of the sole efforts of the brokerage or its introducing broker.

Broking for Employer groups: Once the brokerage is no longer recognised by the participating employer as the servicing broker and such fact has been notified to the scheme in writing by the participating employer, the brokerage shall refund to the scheme any excess commission and any other remuneration which it may have received for the period during which it was not recognised.

If a contract is terminated for any reason whatsoever (other than the death of the member) prior to the payment of a minimum of 2 months premiums, no commission shall be paid, and if such commission has been received by the brokerage, it must be repaid.

If the scheme decides to repay any premium received by it in respect of a contract introduced by the brokerage (which the scheme shall be entitled to do for any reason which it, in its sole discretion, deems fit), then the brokerage shall not be entitled to any commission on such premium and shall refund to the scheme on demand any commission already paid thereon.

A statement issued by the scheme shall be conclusive evidence of the state of the account between the scheme and the brokerage, unless an error in such statement is reported in writing within 30 days of receipt of the statement.

This clause also includes a stipulation on how the scheme will deal with payment of continuing commission should the introducing broker die or terminate his affiliation with the brokerage.

IX) Payment Terms

A specification that broker fees are payable only on a monthly basis upon receipt of the monthly contributions from relevant members is usually included in the brokering agreement. Usually it also provides for payment to be made by the scheme by direct deposit into the brokerage's bank account.

If VAT is payable on the intermediary/broker's remuneration, the intermediary/broker is required to submit a VAT invoice against which payment will be made by the scheme.

X) Debts to the Scheme

The agreement may provide for amounts advanced to the brokerage at any time and for any other purpose whatsoever and the manner in which such constituted debts owed by the brokerage to the scheme will be dealt with.

XI) Termination

Terms of termination of a brokering agreement may include the following:

- ☐ The process of termination, i.e. in writing.
- ☐ The return of any scheme-specific records, information and documentation issued by the scheme.

A clause specifying an automatic termination in the event that the intermediary/broker ceases to be accredited by Medical Schemes Council for whatever reason.

A clause specifying automatic termination upon suspension, withdrawal or lapsing of the license as an FSP in terms of the FAIS Act.

3.4.4 Issuance of a Broker Code

A unique broker code must be allocated by the medical scheme to a specific broker for collection of commission purposes on conclusion of the brokering agreement. The broker code links all the broker's members to him. This allocation on the administrative system will calculate the commission.

Brokers must only have access to the information of members that are linked to their broker code for information purposes. All the provisions in terms of confidentiality of the client details linked to the broker code apply, in terms of the broker, the medical scheme and the administrator.

3.4.5 Compensation of Broker by Medical Schemes

I) Broker Commission

While brokers are regulated by both the Medical Schemes Act and the Financial Advisory and Intermediary Services Act (FAIS), compensation of brokers is regulated by only the Medical Schemes Act.

Brokers become eligible to be compensated only when the broker has a written agreement with the scheme.

The compensation to brokers is determined by the Minister of Health in terms of Section 65 of the Act and amended from time-to-time. The amendments are published in the Government Gazette and registered health brokers are informed by Council of such amendments.

The defined compensation is for the introduction of a new member to a medical scheme and the ongoing service and advice to that member.

The commission which a broker can earn on a medical aid is 3% of contribution (plus VAT) up to a maximum of R90.00 per month (plus VAT). (As at 1 January 2018)

II) The claiming of commission process

The medical scheme must appropriately manage the payment of broker commissions in full compliance with the Medical Schemes Act. A robust and transparent process that calculates and makes broker payments in full compliance with the Medical Schemes Act needs to be in place.

The process is to ensure payment to brokers from the monthly contributions that members make to their scheme.

The process must ensure that every broker to receive commission is duly accredited in terms of the Medical Schemes Act, from the first time of calculating the commission and have a broker code.

The scheme must ensure full details including bank details of the broker are on the system

The scheme must ensure that broker remuneration is calculated and paid for member-appointed brokers only, i.e. broker notes or appointment letters are in place.

The process is to terminate payment upon notice given by the client or employer, that further broker services will no longer be required.

The process must ensure delivery against all customer services as stipulated in the Agreement.

A fully detailed report of all broker commissions paid that confirms correct payment in terms of the Medical Schemes Act, must be produced.

If VAT is payable on the broker's remuneration, the broker is required to submit a VAT invoice against which payment will be made by the scheme.

III) Important issues related to compensation

The following statutory requirements related to the compensation of medical scheme brokers:

- ☐ A broker is not allowed to receive any form of compensation from an administrator or managed care organisation that stands to benefit from an increase in membership.
- ☐ A medical scheme is prohibited from compensating a broker in any way, directly or indirectly, other than as prescribed in the Medical Schemes Act.
- ☐ A medical scheme may not differentiate compensation based on anticipated claims experience that could be influenced by the prospective member's age or health status. In other words, no medical scheme may compensate a broker more to introduce healthy, young members and create a disincentive to introduce older people with chronic diseases. However, it can determine the compensation based on the size of group introduced by the broker to the medical scheme, i.e. a sliding scale based on the size of the membership.
- ☐ A medical scheme cannot prevent a member for applying for membership without a broker.
- ☐ A medical scheme may not compensate more than 1 broker at a time for a specific member.
- ☐ Should the conduct of the broker in any way constitute an unlawful act or material misrepresentation, the compensation could be claimed to be refunded in full by the person who paid the compensation.
- ☐ The agreement with the medical scheme does not have to fix compensation at the maximum amount as allowed by the Medical Schemes Act, in other words, the agreed fee for the introduction of a new member can be less than determined in the Act from time to time.
- ☐ Compensation can be on an ongoing basis.
- ☐ Compensation is discontinued if the member of the medical scheme/employer notifies the medical scheme that it no longer requires services from the broker.
- ☐ All expenses incurred by the /broker in the fulfilment of his/her obligations in terms of the agreement shall be borne by the broker.
- ☐ No additional compensation other than and over-and-above the compensation specified in the clause on compensation to the agreement, shall be payable by the scheme to the intermediary/broker.

Topic 1 Concepts Relating to Health Service Benefits

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Understand the fundamental concept relating to health service benefits.

1.1 LEGIBILITY OF MEMBERSHIP OF A SCHEME

Every person who wants to join a medical scheme and can afford to pay the contributions can become a member of an open medical scheme.

The principle of open enrolment means that any open medical scheme must admit any person who applies to be a member of that medical scheme.

The practical implication is that a medical scheme cannot deny membership based on:

- ☐ A prospective member's age.
- ☐ A prospective member's health status.
- ☐ A prospective member's previous claims experience with another medical scheme.

This means, that in line with the principles of open enrolment, cross-subsidisation and community rating in the medical scheme business, schemes cannot risk rate and underwrite the risk associated with a prospective member's age or health status.

In other words, the contribution paid towards membership cannot be increased because of older age or a sicker member. This is contrary to the practice and rules that apply when an applicant is assessed and underwritten for an insurance product.

To give protection to medical schemes against prospective members who wait until they are older or develop an ailment before joining, the Medical Schemes Act however makes provision that medical schemes, at the time of evaluating an application for membership, can apply: late joiner penalties and a waiting period.

1.2 PRINCIPLE MEMBER

The principle member is the main member on the medical aid scheme. Either one person or someone who has registered one or more dependants.

The principal member pays a larger contribution than the dependants do. Medical schemes refer to dependants as beneficiaries.

1.3 PROVIDER PRACTICE CODES

The Practice Code Numbering System (PCNS) is managed by the Board of Health care Funders. It is a list of unique practice billing codes for providers of health care services in South Africa, Namibia and Lesotho.

The practice number allocated to all registered health care providers is a legal requirement for the process of reimbursement of a claim to either a medical scheme member or service provider.

The codes identify different disciplines. For example, code 14 or 15 is a General Practitioner.

1.4 ICD 10 CODES

ICD 10 stands for International Classification of Diseases and Related Health Problems (10th revision).

It is a coding system developed by the World Health Organisation (WHO) and translates the written description of medical and health information into standard codes.

These codes are used to inform medical schemes of the conditions for which members sought health care services so that claims can be settled correctly. The inclusion of ICD-10 codes on claims from health care providers to medical schemes is now a mandatory requirement.

Because ICD 10 codes provide accurate information on the condition the patient has been diagnosed with, the codes help the medical scheme to determine what benefits the member is entitled to and how these benefits could be paid. This becomes very important if the patient has a PMB condition, as these can only be identified by the correct ICD 10 codes.

Therefore, if the incorrect ICD 10 codes are provided, the PMB-related services might be paid from the wrong benefit (e.g. medical savings account) or it might not be paid at all if the day-to-day or hospital benefits limits have been exhausted.

ICD 10 codes must also be provided on medicine prescriptions and referral notes to other health care providers (e.g. pathologists and radiologists) who are not all able to make a diagnosis. Therefore, they require the diagnosis information from the referring doctor so that their claim to the medical scheme can also be paid out of the correct pool of money.

The table following provides an example of the ICD codes

Condition	ICD 10 Code
Acute tonsillitis	JO3.9
Epilepsy	G41.0

Table 1.4.1: ICD 10 Code

1.5 PROCEDURE CODES

Procedure codes are numeric or alphanumeric codes that are used to identify medical services, treatment and procedures performed by health care professionals.

Every claim must have a procedure code linked to a tariff. In South Africa the procedure codes used are listed in the National Health Reference Price List (NHRPL).

1.6 NATIONAL HEALTH REFERENCE PRICE LIST

The National Health Reference Price List (NHRPL) is a list of procedure codes with tariffs linked to it. These tariffs are annually revised and published by the National Department of Health.

The NHRPL is intended to serve as a baseline against which medical schemes can individually determine benefit levels and health service providers can individually determine fees charged to patients. Medical schemes may, for example, determine in their rules that their benefit in respect of a particular health service is equivalent to a specified percentage of the National Health Reference Price List.

The NHRPL is especially intended to serve as a basis for negotiation between individual funders and individual health care providers with a view to facilitating agreements which will minimise balance billing against members of medical schemes.

Should individual medical schemes wish to determine benefit structures, and individual providers determine fee structures, on some other basis without reference to this list, they may do so as well.

Practitioners are allowed to charge patients at the rate at which medical schemes are prepared to reimburse their claims. However, charges by practitioners above the rate at which medical schemes are prepared to reimburse their claims must be done with the patient's informed consent.

Examples of the procedure codes and tariffs in the NHRPL are listed in the table following.

Procedure Code	Description	Tariff
0191	New and established patient: Consultation/visit of new or established patient of an average duration and/or complexity. Includes counselling with the patient and/or family and co-ordination with other health care providers or liaison with third parties on behalf of the patient	RXX.XX
0300	Stitching of soft-tissue injuries: Stitching of wound (with or without local anaesthesia): (including normal aftercare)	RXX.XX

Table 1.6.1: Example of Procedure Codes and Tariffs in the NHRPL

1.7 TARIFFS AS BENEFITS

The medical scheme in its rules clearly states what the medical scheme rates for different disciplines of service providers will be. Medical expenses in South Africa are not regulated. Health professionals and hospitals can charge what they want, provided that the fees are deemed fair value to the client.

However, guidelines has been issued. There are basically two rates that serve as a guideline for health professionals to use:

- ☐ **The National Health Reference Price List (NHRPL):** This is a price list for health services published by the National Department of Health and is used to reimburse service providers.
- ☐ **Professional Association Guidelines:** These tariffs are developed and maintained by the professional provider associations like the South African Medical Association, the Dental Association of South Africa and the South African Optometry Association. The tariff structures use the same procedure codes as the NHRPL but assign a different monetary value to the service provided. The tariffs are significantly higher than the NHRPL, sometimes up to 3 times the value of the NHRPL.

The medical scheme decides what rate of reimbursement will be paid for services rendered by a health professional. That rate may be the equivalent of the NHRPL or a percentage of the tariff – this rate is known as the medical scheme rate or tariff and differ from scheme to scheme.

It is essential that members be informed what the medical scheme rate of an option is.

Because health care providers are free to determine their own tariffs based on the guidelines in the NHRPL or their Professional Association, the account rendered to the medical scheme may only be partially paid. This would mean that the member will be responsible for the balance of the account. For specialist services, this amount could be substantial.

1.8 CO-PAYMENTS

A medical scheme may provide in its rules that a member is required to pay a charge to the provider for certain health care services received. The co-payment can be a fixed rand amount or a percentage of the cost.

1.9 PRESCRIBED MINIMUM BENEFITS

A familiarity with the prescribed minimum benefits is necessary to advise clients with regards to their entitlement to benefits in the medical scheme and specific option for which they are a member.

The Council for Medical Schemes introduced the PMB in 2000 to define the minimum levels of cover. These minimum benefits are a safety net and ensure that members are not without care for certain major medical expenses because they cannot afford it or have exhausted their benefits.

Prescribed Minimum Benefits are minimum benefits which, by law, must be provided to all medical scheme members of all medical scheme options and include the provision of diagnosis, treatment and care costs of the following:

- ☐ Any emergency medical condition.
- ☐ A limited set of ±270 medical conditions called the Diagnosis and Treatment Pairs (DTPs)
- ☐ The 25 Chronic Diseases List (CDL) conditions.

An emergency medical condition as referred to in the Medical Schemes Act Regulations 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 bodily organ or part or would place the person's life in serious jeopardy.

The list of the PMB Diagnosis and Treatment Pairs (DTP) is set out in Annexure A to the Medical Schemes Act Regulations and consists of ±270 conditions and the suggested so-called treatment algorithms.

A treatment algorithm refers to step-by-step problem-solving procedures and guidelines applied to the treatment of a specific disease.

The CDL list follows at the end of the DTP-list. This list includes some of the most common chronic diseases for including the following:

- High blood pressure – Hypertension
- Diabetes mellitus
- High cholesterol – Hyperlipidaemia
- Angina – coronary artery disease
- Asthma
- Epilepsy

There are chronic diseases that are not part of the CDL but that fall under the ±270 conditions of the PMBs.

1.9.1 Implications for Medical Schemes

The implications of these Prescribed Minimum Benefits (PMB) for medical schemes are as follows:

- ☐ Medical schemes must provide as minimum benefits for the full range of PMB in every option.
- ☐ No payment for PMB conditions may be paid from the member's medical savings account.
- ☐ Medical schemes have to pay the cost associated with services rendered for PMB conditions from the insured risk pool.
- ☐ The medical scheme may, however, apply certain risk management techniques to mitigate the risk of providing these comprehensive benefits to members.

1.9.2 Payments Made with Regard to Prescribed Minimum Benefits

Schemes are obliged to pay for PMB in full and without co-payments or deductibles where members obtained such services from a designated service provider (DSP) or involuntarily from a non-DSP.

Co-payments may be levied where a member voluntarily obtains services for PMBs from a non-DSP (usually 25%). Such a co-payment not result in an effective denial of a PMB. A scheme only applies the co-payment as provided for in their registered rules.

Designated service providers (DSP) means a health care provider or group of providers selected by the medical scheme as the preferred provider(s) to provide PMB services to member. This arrangement usually includes a tariff agreement for the management of PMB. The DSP needs to manage the health condition according to the rules of the medical scheme.

No treatment for a PMB may be paid from the medical savings account – not even co-payments.

The Medical Schemes Regulations makes provision for instances, where the health service was involuntarily obtained from a provider other than a DSP. In such an event, no co-payment is applicable.

Involuntary obtained services refer to one of the following situations:

- A health service that was not available from the DSP or would not be provided without unreasonable delay.
- Immediate medical or surgical treatment for a PMB condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a DSP.
- There was no DSP provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

The Medical Schemes Act also provides that no limitation shall apply on the re-imbursement of any relevant health service that a member obtained from a public hospital where this service complies with PMB.

1.9.3 Medical Scheme Interventions to Manage Financial Risk Associated with PMB

Medical schemes can employ various methodologies to improve the efficiency and effectiveness of health care so as to limit the financial impact of PMB on the financial performance of the scheme. The Designated Service Providers arrangement is one such strategy.

Other strategies to manage financial risks associated with the PMB are as follows:

- ☐ Contractual arrangements with public sector facilities to act as DSP for hospitalisation or for members with chronic diseases.
- ☐ The requirements for pre-authorisation for hospitalisation and high-cost diagnostic tests.
- ☐ the registration of members with CDL conditions or other chronic PMB conditions on the PMB programme for chronic diseases.
- ☐ The use of a medicine formulary (or list of medicines available to treat chronic diseases) that determines the medicine benefits of the medical scheme. If a member or beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.
- ☐ The use of treatment protocols or algorithms.

1.10 MEDICINE FORMULARY

A medical scheme may draw up what is known as a formulary – a list of safe and effective medicines that can be prescribed to treat certain conditions. The scheme may state in its rules that it will only cover medication in full if your doctor prescribes a drug on that formulary.

1.11 LIMITS

Every scheme's hospital plans and medical aid plans will have unique levels of cover – and unique medical hospital cover limits.

The limits can either be specified per event, per member or per family.

1.12 THRESHOLD LIMITS

Some medical scheme plans have a day-to-day benefit made up of a savings account followed by a self-payment gap until a pre-determined threshold is reached. Once the threshold is reached, the scheme will start paying for day-to-day claims again.

Some plans have unlimited above threshold limits, which essentially means that once you have paid the self-payment gap, the scheme will cover all day-to-day expenses until the end of the year, subject to scheme rules.

1.13 LATE JOINER PENALTIES

The Medical Schemes Act provides that a medical scheme may apply premium penalties to an applicant or dependant of a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant who qualifies for late joiner penalties.

A late joiner means an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older, but excludes any beneficiary who enjoyed coverage with one or more medical schemes as from a date preceding 1 April 2001, without a break in coverage exceeding 3 consecutive months since 1 April 2001.

A late-joiner penalty refers to a penalty by way of additional contributions, imposed on persons joining a scheme for the first time only late in life and is intended to encourage earlier and continuous membership of a medical scheme.

Thus, if a member or dependant is over 35 years of age and has not been a member of a medical scheme for a period of 3 months prior to the application, a late-joiner penalty will be calculated, and the premium of the medical scheme adjusted with that penalty.

The penalties are applied as a surcharge on the scheme (or loaded) contribution.

Schemes have the discretion to waive late-joiner penalties, but some apply them strictly regardless of the reason for which members join a scheme late in life.

1.13.1 Prove of Former Membership

Regulation 2 and 3 determines that a medical scheme must, within thirty (30) days of the termination of membership or at any time at the request of any former member, or dependant, provide that member or dependant with a certificate, stating the period of cover, type of cover and whether or not the person qualified for late joiner status.

The regulation also makes provision that the certificate of membership must be forwarded on request to any medical scheme to which the former member or dependant subsequently applies for membership.

The applicant is also entitled to produce a sworn affidavit in those instances where reasonable efforts to obtain documentary evidence of previous membership were unsuccessful.

1.13.2 Determination of the Surcharge

The additional contribution payable by a late joiner to a medical scheme, is calculated using the following formula:

$$\textit{Penalty Band} = \textit{Age of later joiner} - (35 + \textit{Credible coverage})$$

Credible coverage is the determination of any qualifying periods of membership of a registered medical scheme since 1 April 2001.

The formula used to determine whether a late-joiner penalty will apply needs to be used with the penalty table.

Penalty Band	Maximum penalty
1 - 4 years	Contribution x 1.05
5 - 14 years	Contribution x 1.25
15 - 24 years	Contribution x 1.5
25+ years	Contribution x 1.75

Table 1.13.1: Penalty Table

1.14 WAITING PERIOD

A waiting period refers to a period during which the member pays a contribution towards the medical scheme joined but during which time the member and/or dependants are not entitled to benefits.

There are two kinds of waiting periods:

- ☐ A general waiting period of up to three 3 months.
- ☐ A condition-specific waiting period of up to 12 months.

Medical schemes should use waiting periods only as a tool to mitigating adverse selection, and not to treat applicants unfairly.

Condition-specific waiting periods can accordingly be imposed in respect of conditions that an applicant suffered from or sought medical treatment for during the twelve-month (12-month) period before an application for membership of the scheme was made.

While medical schemes may be entitled to request health-related information from members for disease management purposes, condition-specific waiting periods may under no circumstances be imposed on members for conditions falling outside of the twelve-month period.

Waiting periods do not apply in respect of the following:

- ☐ Prescribed Minimum Benefits other than waiting periods that may be imposed on those applicants who have never belonged to a medical scheme, or have not been beneficiaries for the preceding ninety (90) days.
- ☐ A child dependant born during the period of membership.
- ☐ A member moving between benefit options, unless he has to complete the remaining period of previously imposed waiting periods
- ☐ When an individual has to involuntarily transfer to another scheme due to a change of employment.
- ☐ In instances where an employer changes the medical scheme of his employees with effect from the beginning of the financial year.

The table following serves as a summary and reference guide for waiting periods.

Category	3 months general	12 months condition-specific	Waiting period Applies to PMB
Application, with no membership 90 days prior to application, regardless of previous membership	Yes	Yes	Yes
Application, with break in cover of less than 90 days, from a member who was member of a different scheme for less than 2 years	No	Yes	No
Application, with break in cover of less than ninety 90 days, from a member who was a member of a different scheme for more than 2 years	Yes	No	No
Employer changing medical schemes	No	No	No
Application for change of scheme because of change of employment	No	No	No

Table 1.14.1: Reference Guide for Waiting Periods

Topic 2 Product Specific Features and Benefits

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Describe the benefit categories.
- Describe the standard options available in South Africa.
- Outline how contribution is determined.
- Describe the tax treatment of medical scheme contributions and the medical savings account.
- Outline the typical exclusions applicable to benefits.

2.1 BENEFIT CATEGORIES

Benefit categories are used to design a product option. Most important is that each option, however limited in benefits, will include the Prescribed Minimum Benefits (PMB).

There are distinct categories of benefits used in benefit design. It is important to understand the different categories and the benefits typically covered.

These categories are used to design an option within the medical scheme. The benefit categories are considered in the subsections following.

The key to sound financial advice to a client is to match the option to the financial and health needs of the client.

2.1.1 Risk Benefits for Major Medical Expenses

Risk benefits are covered by the scheme from the common insured risk pool where cross-subsidisation occurs (younger and healthier members subsidise older and sicker members). Risk pool benefits include Prescribed Minimum Benefits and in and out-of-hospital benefits.

Unused funds not used by a member are not carried over to the next year.

2.1.2 Personal Medical Savings Account

The Medical Schemes Act provides that medical schemes can in their rules make provision for the allocation to a member of a personal medical savings account.

Personal medical savings account (MSA) benefit represents self-funding by members. However, the full year allowance is available to the member at the onset of the membership or on renewal.

MSA funds are used to cover discretionary benefits. Members with a benefit option that has a savings account may use the available funds to pay for discretionary benefits for themselves and/or their dependants. At the end of each financial year, the member's unused funds are carried over to the next financial year.

The following is prescribed in the Medical Scheme Act Regulations with regard to Medical Savings Account Benefits (MSA):

- ☐ A medical scheme may not allocate an amount that is more than 25% of the total gross contribution per financial year in respect of each individual member of the medical scheme to a member's MSA.
- ☐ Funds deposited in a member's personal medical savings account shall be available for the exclusive benefit of the member and his or her dependants.
- ☐ The fund in the MSA may not be used-
  - To offset contributions.
  - To offset debt owed by the member to the medical scheme following that member's termination of membership of the medical scheme.
- ☐ The funds in a member's medical savings account shall only be used to purchase or reimburse those relevant health services that do not form part of the Prescribed Minimum Benefits or be used to pay for the costs of a Prescribed Minimum Benefit.

If a member transfer to another medical scheme, the credit balance in a member's Medical Savings Account (MSA) shall be transferred to another medical scheme or benefit option with an MSA, when such member changes medical schemes or benefit options.

The credit balance in a member's Medical Savings Account must be taken as a cash benefit, subject to applicable taxation laws, when the member terminates his or her membership of a medical scheme or benefit option and enrols in another benefit option or medical scheme without an MSA or does not enrol in another medical scheme.

The Medical Scheme Council requires from every medical scheme to provide to the Registrar with regard to members' MSA, details of deposits into the MSA, debit and credit balances, amounts paid out to members and a detailed breakdown of benefits paid from the MSA.

2.1.3 Chronic Cover

Chronic cover provides cover for the provision of ongoing medication to treat chronic conditions other than the 27 chronic conditions on the Chronic Disease List.

2.1.4 Insured Day-to-Day Benefits

Insured day-to-day benefits refers to insured benefits that provide cover for smaller, out-of-hospital-related expenses, i.e. GP or dentist visits from an insured risk pool. These benefits are usually limited with either a financial or quantitative limit and are clearly described in the rules and member communication.

2.1.5 Above Threshold Benefits

Above threshold benefits covers expenses once benefits or funds in the MSA had been exhausted. For members to qualify for this insured benefit, the rules may include a self-payment gap before the above threshold benefit is activated.

2.2 MOST COMMON OPTIONS

Most medical schemes offer standard combinations of benefits in their options, but limits, exclusions, co-payments and reimbursement rates vary.

The most common options are considered in the subsections following.

2.2.1 Comprehensive Plans

Comprehensive plans usually provide unlimited hospital cover and comprehensive day-to-day benefits. The plans can also include a personal medical savings account.

2.2.2 Essential Plans

Essential plans usually provide unlimited or a high level of hospital cover and a medical savings account.

Comprehensive plans and essential plans are usually suitable for families and elderly persons.

2.2.3 Hospital Plans

Hospital plans only provide risk benefits for major medical expenses. It covers a range of treatment and procedures when you are admitted into hospital.

All hospital plans, however, have to pay for chronic medication prescribed for the 27 PMB chronic conditions.

Some hospital plans can include limited insured day-to-day benefits such as dentistry and optometry.

Hospital plans are usually a sound option for young, fit adults.

2.2.4 Salary-Based Medical Scheme Options

Some medical schemes offer entry-level cover for low-income earners, based on salary bands.

Most plans charge based on the salary earned so, although the benefits remain the same for all members, the higher-income earners are cross-subsidising low-income earners.

2.3 CONTRIBUTION DETERMINATION

Benefit categories are used to design a product option. Most important is that each option, however limited in benefits, will include the Prescribed Minimum Benefits (PMB).

Member contribution of an option will be determined by the following factors:

- ☐ How rich the benefits within the option are, in other words, to what extent the financial limits determined for a service are high or limited (low). More benefits, the higher the member contribution.
- ☐ The freedom or restriction of choice in choosing which doctors and hospitals the member can choose from. Options limited to network of doctors is usually associated with lower contributions.

- ☐ The financial benefit of rate at which the medical scheme will reimburse the service provider accounts. If the benefit related to the rate of payment, or medical scheme rate (MSR), is equivalent to the NHRPL, the doctor's fees may not be fully covered by the medical scheme and the member will be responsible to the service provider for the amount not covered. The contributions for options with an MSR at a multiple of NHRPL is usually higher.
- ☐ Whether the rules make provision for contribution based on the member's income.

Medical Scheme options allows for other persons to be covered beside the principle member. The principle member is usually charged the highest contribution with any adult beneficiaries charged slightly less. Children can be added as beneficiaries usually at a reduced rate.

The table following demonstrates the contribution based on the richness of benefits.

	Comprehensive	**Essential**	**Save**	**Standard**	**Primary**
Limits*	Unlimited	Unlimited	Unlimited	R600 000	R500 000
MSR**	300%	200%	150%	100%	100%
Provider	Any hospital	Any hospital	Any hospital	Any hospital	Network
Chronic Benefits	Unlimited 64 conditions Comprehensive Formulary	PMB's only at Designated Service Provider 26 Conditions Restrictive Formulary	PMB's only at Designated Service Provider 26 Conditions	R6 500 per beneficiary R13 000 per family 45 conditions Comprehensive Formulary	PMB's only at Designated Service Provider 26 Conditions
Contribution					
Principle	R2 750	R1 080	R1 154	R1 665	R1 075
Adult	R2 560	R825	R895	R1 441	R840
Child	R560	R315	R350	R490	R342

Table 2.3.1: Example of Medical Scheme Options

**Limits: Financial limit per family per year*

**MSR: Medical scheme reimbursement rate to providers as % of NHRPL*

2.4 WELLNESS/LOYALTY PROGRAMMES

Although the so-called loyalty programmes do not form part of a medical scheme, certain clients may want to choose an option that provides access to these programmes at an additional fee. Wellness programmes are not administered by medical schemes.

Although loyalty programmes can encourage healthy living, being a member do not reduce monthly medical aid contributions.

It is important to establish whether the client specifically requests access to a wellness-based loyalty programme.

2.5 EXCLUSIONS

Medical schemes make provision in the rules for a list of exclusions. There will be no benefits available for the services listed under the Exclusion List.

The exclusion list of scheme options (Annexure C of scheme rules) deals with limitation of entitlements.

Exclusions usually include the following:

- ☐ Injuries sustained in professional and speed contests, unless they are PMBs.
- ☐ Wilfully self-inflicted injuries, unless they are PMBs.
- ☐ Treatment for obesity – both medical and surgical.
- ☐ While many schemes will pay for diagnostic tests to determine causes of infertility, they won't pay for IVF (in-vitro fertilisation) or similar procedures.
- ☐ Operations, treatments or surgery purely for cosmetic reasons.
- ☐ Cost of services rendered by persons not registered as a professional in accordance with the Medical Schemes Act.
- ☐ After-hours consultations, unless it is an emergency and/or the condition is a PMB. If it is purely the patient's choice and not an emergency, the after-hours consultation fee will be paid by the member.
- ☐ Experimental treatment or procedures where insufficient proof exists of their effectiveness.
- ☐ Unregistered medication.
- ☐ Telephonic consultation with GP, unless your scheme has a specific benefit for this.
- ☐ Costs of appointment cancelled by members.
- ☐ Examinations needed for visa, employment or insurance purposes.
- ☐ Hypnotherapy done by anyone other than a psychiatrist.
- ☐ Holiday for recuperative purposes.
- ☐ Transport of patients in anything other than ambulance services.
- ☐ Contraceptive devices.
- ☐ Treatment or operation for impotence, except for PMBs.
- ☐ Patent foods, including baby foods.
- ☐ Slimming preparations, toiletries and cosmetics.

2.6 TAX TREATMENT OF MEDICAL SCHEME CONTRIBUTIONS AND MEDICAL EXPENSES

In 2012, the South African Reserve Bank (SARS) changed the way it treats medical expenses and introduced a medical scheme fee tax credit.

The medical tax credit consists of the following two amounts:

- ☐ The medical scheme fees tax credit.

- ☐ The additional medical expenses tax credit.

These tax credits are considered in the subsections following:

2.6.1 Medical Scheme Fees Tax Credit

The medical scheme fees tax credit applies to fees paid by a member on behalf of the member and their dependants. The rebate for the 2019/2020 year of assessment is as follows:

- ☐ Main member: R310 per month
- ☐ First dependant: R310 per month
- ☐ Additional dependants: R209 per month for each additional dependant.

If medical aid contributions are deducted from the member's salary, PAYE will be adjusted accordingly. If contributions are done independently from the employer, the tax credit will become applicable when the tax return is calculated at the end of the tax year.

2.6.2 Additional Medical Expenses Tax Credit

The additional medical expense tax credit is a tax rebate for the overall amount of tax that need to be paid at the end of the year.

This amount accumulates throughout the tax year.

Qualifying out-of-pocket expenses include the following:

- ☐ Consultations, services or medications from a registered medical practitioner, orthopaedist, physiotherapist, dentist, chiropractor, herbalist, homeopath, optometrist, osteopath or naturopath.
- ☐ Admission to a registered hospital, including nursing homes.
- ☐ Care at patient's home by a registered nurse, nursing assistant, nursing agency or midwife.
- ☐ Medicines prescribed by a duly registered physician (as listed above) and acquired from a duly registered pharmacist.
- ☐ Medical expenses on services rendered or medicines supplied outside of South Africa and which are substantially similar to the services and medicines listed above.
- ☐ Money paid towards treatment of a physical impairment or disability (as long as it is a qualifying expense prescribed by the Commissioner).

It is important to note that over the counter medicines, such as cough syrups, headache tablets or vitamins, do not qualify as medical expenses, unless specifically prescribed by a registered medical practitioner and acquired from a pharmacist.

To calculate the additional medical expenses tax credit, special formulas are used. The specific formula to use depends the age of the member and whether the member or one of the dependants have a disability. The formulae used are detailed in the table following.

Age and disability status	Formula
Under 65 (without disability)	Total contributions paid to the medical scheme Less 4 X medical scheme fees credit Plus (Qualifying medical expenses paid less 7.5% of taxable income) = Answer X 25% = Rebate
Under 65 (with disability)	Total contributions paid to the medical scheme Less 3 X medical scheme fees credit Plus Qualifying medical expenses paid = Answer X 33.3% = Rebate
65 or over (with or without disability)	Total contributions paid to the medical scheme Less 3 X medical scheme fees credit Plus Qualifying medical expenses paid = Answer X 33.3% = Rebate

Table 2.6.1: Formula for Calculating Tax Rebate

2.6.3 Definitions

I) Medical Dependants

Medical dependants include the following people:

- ☐ Husband or wife.
- ☐ Child or stepchild that is -
  - Younger than 18 years of age.
  - Younger than 21 years of age and is/was partly or entirely dependent on tax payer and is/was not yet liable to pay normal tax for the year.
  - Younger than 26 years of age and is/was partly or entirely dependent on tax payer, is/was not yet liable to pay normal tax and is a full-time student.
  - Is any age and is/was unable to care for themselves because of a disability, is not liable for normal tax for that year and is partly or entirely dependent on tax payer.
- ☐ Any family member financially responsible for.
- ☐ A person who is recognised by the registered medical scheme or fund as a dependant.

II) Disability

Moderate to severe mental, physical, hearing, intellectual, communication or vision disabilities count as disabilities for tax purposes. The client and a registered medical professional must complete and submit the ITR-DD form in order to qualify as having a disability.

2.7 TAX TREATMENT OF MEDICAL SAVINGS ACCOUNT

Withdrawals from the MSA for purposes other than relevant health service are taxable.

Transfer of funds to the member from the MSA after cancellation of membership of the medical scheme is taxable.

Transfer of the MSA to an MSA of another medical scheme when changing medical schemes option, is not taxable.

Interest received on the MSA is not taxable and has no tax implications.

Topic 3 Comparative Medical Scheme Analysis

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Perform a comparative medical scheme analysis.

3.1 INTRODUCTION

In order for a broker to advise a client, a continuous process of evaluation of medical schemes needs to be undertaken. Medical schemes usually may adapt the rules and contributions for a new benefit year. This may impact on the suitability to the needs or affordability of the client.

All these changes to the rules and contributions need to be approved by the Registrar of Medical Schemes.

3.2 MEDICAL SCHEME ANALYSIS

The aim of the analysis of a medical scheme is to select a portfolio of medical schemes and options that the broker feels are sustainable, as well as provide good benefits and value.

The analysis furthermore will provide an understanding of the benefits and restrictions within every option of the various medical schemes. Every option represents a unique product.

Such an ongoing analysis of medical schemes should include the following:

- ☐ Membership size and demographics of the scheme.
- ☐ Benefit options.
- ☐ Financial status and stability.
- ☐ Annual and interim contribution increases.
- ☐ Credit rating.

The information can be collected from the following sources:

- ☐ The Annual Report of the Council for Medical Schemes
- ☐ The latest financial statements and annual report of the schemes
- ☐ The Council for Medical Schemes website
- ☐ Trade publications
- ☐ Medical Scheme websites
- ☐ Rating agencies

The concepts to be considered during the analysis are considered in the subsections following.

3.2.1 Membership

I) Membership Size and Trends

Although size per se does not represent a good medical scheme, the number of beneficiaries is however important in terms of the ability of the medical scheme to manage the risk within its insured population.

It is also important to consider the requirement in the Act that the minimum size of any scheme and option should be 6 000.

But it is not only the number of beneficiaries that is important but also to monitor trends and changes in membership size over time, as it will provide the following information:

- ☐ Growth is good for clinical risk in the membership but may negatively impact on solvency levels.
- ☐ Decline of membership may be an indication of poor service or benefits that are not attractive.
- ☐ A decline in membership may indicate a client perception of poor value.

A medical scheme with a larger membership base may have greater bargaining power with health care service providers like hospitals or doctor groups and should be able to provide more competitive benefits.

A bigger medical scheme should also be able to negotiate competitive administration and managed care contracts.

A medical scheme with a small membership may be new and growing, or member numbers are falling to the extent that it may need to consider merging with another scheme or it could face liquidation.

II) Average Age of Beneficiaries

The average age of ±32 of all beneficiaries in the open medical scheme market serves as a useful benchmark.

Each increase of the average age by 1 year above that benchmark increases the reality that the burden of disease within the scheme population may escalate. The burden of disease is represented by the increase in chronic conditions like HIV, high blood pressure and diabetes as well as a higher incidence of cancer.

This burden of disease is associated with higher claims and the probability of higher contribution increases.

The pensioner ratio refers to the number of members in a medical scheme above the age of 65 years. The reported average is ±6% of membership. Every percentage point above the average may also represent an aging population.

3.2.2 Benefits and Options

A good understanding of the options and benefits offered within those options are essential. Similar options and benefits need to be compared between different schemes in terms of the contribution rate.

Some of the important factors that need consideration:

- ☐ The overall and sub-limits relevant to an option.
- ☐ Any exclusions of benefits.
- ☐ Inclusion of a medical savings account.
- ☐ Are above threshold limits included?
- ☐ The rate of reimbursement to providers.
- ☐ The use of networks of providers that may limit choice of doctor, dentists or pharmacy.

- ☐ Any restrictions on medicines via a formulary.
- ☐ Co-payments or deductibles for services required.
- ☐ How the benefits deal with severe diseases like cancer or kidney failure requiring dialysis.
- ☐ The requirements with regards to PMB, i.e. DSP-arrangements.

It is important for a broker to track changes to annual benefits and options with regard to benefit changes, limits and sub-limits and new exclusions, at the time of benefit reviews for a new benefit year. It is essential to assist and guide clients at the time that benefit changes are made.

3.2.3 Financial Status/Stability

I) Solvency Levels

The solvency of the scheme represents the reserve levels as required in the Medical Schemes Act. The prescribed minimum reserves requirement seeks to ensure that schemes have enough reserves to withstand unexpected high claims experiences, for example, at the time of an influenza-epidemic. A good example was the swine flu epidemic of 2009 resulting in a high volume of claims for doctor visits, pathology tests and hospitalisation. The reserves absorb the shocks until corrective action can be taken. This in turn ensures that scheme members continue to have sufficient confidence that their claims will be met.

All schemes must maintain a level of 25% of their gross contribution income.

When assessing a scheme's performance, it is necessary to take into account the growth in membership of the scheme. If it is growing, it may dilute the reserves, if membership declines, the reserves may increase. If a scheme loses members and the solvency drops, it spells disaster.

If a scheme had not reached its required solvency ratio, the contribution may be increased more than the actual anticipated claims to bring the solvency to the required level.

II) Contribution Per Beneficiary Per Month

Contribution per beneficiary per month is a valuable indicator to compare contributions for a similar set of benefits with competing medical schemes.

III) Net Health Care Result

The scheme's expenses are classified either as an underwriting profit or an underwriting deficit or loss.

The net health care result refers to the risk contribution income minus health care expenditure and non-health care expenditure. Therefore, it excludes medical savings account contributions and refers to the risk position of the scheme.

When the scheme makes a loss (the net health care result is negative) it means that claims plus other non-health care expenses exceed the contributions income.

IV) Claims Experience

The claims experience refers to the health care expenditure as a percentage of the Risk Contribution Income.

The average claims experience for 2018 across all medical schemes was reported at ±72.7%.

V) Non-Health Care Costs

Non-health care costs are represented by the following:

- ☐ Administration fees
- ☐ Managed care fees
- ☐ Broker commissions
- ☐ Bad debt

The Council for Medical schemes sets a target of 10% for non-health care costs for medical schemes.

The combination of health care and non-health care expenditures represents the total cost and determines either a profit or loss if subtracted from gross contribution income.

3.2.4 Annual and Interim Increases

The Council for Medical Schemes reports on the average increase in the monthly contribution to be paid by members. Anything above the average should be carefully evaluated.

Any interim increase that is motivated for and of which members may be informed during the benefit year may indicate that the medical scheme is in trouble.

3.2.5 Credit Ratings

Global Credit Rating (GCR) is an independent company that rates the claims paying ability of medical schemes over a 12 to 18-month period. In other words, it rates the medical scheme's capacity to service their claims.

The following factors are taken into account in the rating-process:

- ☐ How quickly the scheme's investments can be realised to pay claims
- ☐ The number of months' claims that a scheme can pay from its cash reserves.
- ☐ The scheme's balance sheet.
- ☐ The number of months' claims a scheme can pay from its overall reserves.
- ☐ The size and profile of a scheme's membership base.
- ☐ The scheme's solvency ratio.

A rating of AA+ is regarded as the highest rating and BBB- the lowest.

The table following provides a description of each rating.

Rating	Description
AA +	Very high claims paying ability.
AA	Protection factors are strong.
AA -	Risk is modest but may vary slightly over time due to economic and/or underwriting conditions.
A +	High claims paying ability.
A	Protection factors are above average although there is an expectation of variability in risk over time due to economic and/or underwriting conditions
A -	
BBB +	Adequate claims paying ability.
BBB	Protection factors are considered adequate for the present, but there is considerable variability in risk over time due to economic and/or underwriting conditions.
BBB -	

Table 3.2.1: Medical Aid Schemes Rating Descriptions

In view of the industry risk characteristics associated with the South African Medical Schemes operating environment, an industry risk ceiling of AA (Double A) for medical schemes has been applied.

3.2.6 Service Levels

Service levels refers to the scheme's administration, specifically, how quickly claims are paid. Service levels can be difficult to determine, but the average claims pay-out period for the last 18 months can be obtained from the medical scheme.

The broker can also survey members and health care providers for their experience with the scheme.

If a scheme has poor service levels, health care service providers may ask members to pay in cash and to claim back from the scheme. This could leave members out of pocket for some time and result in their being dissatisfied with the scheme.

Service levels of the managed care function of a medical scheme need also to be considered. The following factors are important:

- ☐ How long does it take for authorisation for chronic diseases and for new medicines to be registered on the system before a prescription can be filled?
- ☐ How easy or difficult is it to get authorisation for hospitalisation?
- ☐ How difficult is it to get authorisation for diagnostic tests like MRI's?

Topic 4 Broker Interaction With Client

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Stipulate the requirements surrounding interaction of the broker with the client.

4.1 ADVISORY FEES

Other than renumeration received from the Medical Scheme, a broker may in addition also receive compensation from one of the following:

- ☐ A member or a prospective member.
- ☐ The employer of such member.
- ☐ A broker employing such a broker.

To be able to claim such compensation form a member or an employer, the broker must have a direct signed contract with a member or such an employer (broker agreement) in which the terms of the services and the contemplated compensation for these are specified.

Such an agreement also makes provision for the process in the event that the client wants to cancel the agreement. It can also stipulate that outstanding invoices will attract interest.

The arrangement can make provision for the payment of the contracted service fees at stipulated times like monthly or quarterly.

In the event that a client does not pay the agreed amount of the service fee on or before a determined date, the overdue amount can be seen as Incidental Credit. The maximum interest that can be charged as per the National Credit Act on incidental credit is 2%.

No initiation or service fee may be charged over and above the interest provided for.

In terms of the National Credit Act, the broker doesn't need to be registered with the National Credit Regulator when such an arrangement is in place.

A medical scheme may not deduct such contracted service fees, which result from a direct contract with a client or an employer, on behalf of the broker.

4.2 CONTACTING OF CLIENTS AND CONFIDENTIALITY

Like many other professional services, new clients are obtained in a broker's business principally by referrals or recommendations from an existing client or by personal initiation or networking.

The broker is generally concerned with ensuring that certain issues in terms of starting a business relationship with the potential new client are in place but also that requirements in the regulatory environment are addressed.

The essence in satisfying both criteria is to follow a process with the view to developing a process that will eventually lead to a relationship of trust between the broker and the client. In the medical scheme environment, it is important to develop a relationship that will span over time because of the nature of ongoing services rendered by the broker to the client.

Existing broker processes and procedures dealing with leads sharing, prospecting and referrals need to be in line with the Protection of Personal Information Act. Therefore, the broker must ensure before directly contacting the client that the broker is permitted to provide direct marketing to such a person.

The General code of Conduct deals with the stipulations regarding contacting of a client (outlined in Module 1) and must be followed by brokers.

In terms of confidentiality of information, the broker must comply with the provisions set out in the Protection of Personal Information Act and the Financial Advisory and Intermediary Services (Act).

The broker also needs to disclose all information regarding the Financial Services Provider on first contact as prescribed in terms of the General Code of Conduct.

4.3 BROKER AGREEMENT WITH CLIENT

Once contact has been established and the client wishes to pursue a relationship with the broker, the broker needs to enter into a broker agreement with the client.

Such a broker agreement must include the following:

- ☐ Full administrative details from the client.
- ☐ Full details of the brokerage including the following:
  - License and accreditation numbers.
  - To which medical schemes he is contracted.
  - Details of commission agreed to with medical schemes.
  - Details of professional indemnity insurance.
- ☐ The rights to the services the client can expect, including the following:
  - Entitlement to a needs analysis and risk assessment.
  - To be supplied by a copy of the advice record.
  - Entitlement to full disclosure of the details of the intermediary, the product supplier, fees and commissions payable.
  - Entitlement to details of the medical scheme or product recommended.
- ☐ The services provided by the broker, including the following:
  - Assessment of the client's risk profile.
  - Analysis of the client's financial situation and ability to sustain contributions.
  - Provision of advice on appropriate methods and products to satisfy the health care needs of the client.

- Providing the client with sufficient cover through an appropriate medical scheme option or product to address the client's health situation.

☐ Once the member has joined a scheme, the member may wish to retain the services of the broker to provide ongoing service and advice in respect of that member's continuing relationship with the medical scheme. These services should be listed.

☐ Declaration of confidentiality: This states that personal information will be kept confidential by the intermediary, the medical scheme and the administrator.

☐ Consent by the client to the use of personal information for direct marketing purposes.

The client must acknowledge that he has read and understands the document and has been fully apprised of his rights by signing the document.

4.4 NEEDS ANALYSIS

4.4.1 Introduction

Before a medical scheme can be recommended to a potential client, the broker needs to explore aspects in order to understand the client's needs as well as what that client can afford.

To be able to understand these needs, a broker needs to develop a structured process of information-gathering and evaluation. This information will enable the broker to appropriately advise the client on a suitable medical scheme and option.

The prescription under the General Code of Conduct with regard to the steps of advice should be included in this process.

4.4.2 Information Generation and Evaluation

The process of obtaining the required information from the client so as to advise in terms of the appropriate medical scheme and option, should include an in-depth interview covering all the aspects listed in the subsections following.

This information is not only needed for the evaluation and recommendation but also to assist the prospective member in the application process.

I) The Natural Life-Cycle of the Client

A client's health needs at every stage of the lifecycle varies and may determine the need for a specific medical scheme product.

The information needs to guide the broker to advise on which medical scheme option will be the most suitable for that specific client's health needs and circumstances.

The following are examples of the lifecycle that need to be considered:

☐ A single person perhaps needing only a hospital plan.

☐ A young married person contemplating starting a family with good benefits covering childbirth and neonatal care.

☐ A middle-aged person with teenage children needing good day-to-day cover.

☐ An older client and spouse with chronic diseases needing a comprehensive plan.

II) The Client's History of Medical Scheme Membership and His Reason for Change

The information regarding previous membership and breaks in membership is very important in order to determine the waiting period applicable and the late-joiner penalties.

III) Client Financial Information

The income and employment status of the member is important to establish what the client can afford and how sustainable the contribution to the medical scheme will be over time.

This information needs to be matched with the most appropriate medical scheme option that makes provision for the health needs of the member.

If the client is permanently employed, the employment contract may make provision in a structured salary package for an employer contribution to a medical scheme or for a subsidy. If the medical aid contribution is subsidised, the broke need to determine the amount.

If the client is self-employed, the broker needs to work through a budget and look at the client's disposable income.

It is important that the broker demonstrate to the client the impact on his financial situation when considering the affordability of contributions of different medical scheme option contributions.

In this regard, the tax relief should also be calculated**.**

IV) The Health Status of the Principle Member and Every Dependant

The health status of the principle member and every dependant is important to evaluate the richness of the benefits that is required to serve the needs of the member and his family.

The broker needs to evaluate the following:

- ☐ **Historic health care expenditure:** Understand how much the member/family spent on acute and chronic medicine, emergency care, dentistry and eye-care over the previous year or two.
- ☐ **PMB conditions:** Do any of the member or dependants suffer from any of the listed PMB conditions and the medication used?
- ☐ **Chronic non-PMB conditions:** Any other chronic conditions that need ongoing use of medication.
- ☐ **Previous medical advice sought:** Any condition for which the member and/or the dependants sought medical advice for the 12 months prior to the application for membership.

V) Propensity to Take Risk and Limit Choice

Some members want medical schemes that cover most of the health needs under a risk coverage. Other members elect to decide to fund discretionary costs themselves. It is important to distinguish the client's preference.

The broker need to ascertain if the client is willing to self-fund some costs for clinical care of out-of-hospital (ambulatory) services and if so, if the client can afford it financially should the need arise.

VI) Willingness to be Limited in Choice of Health Care Providers

The broker needs to assess if the client is willing to be limited in terms of choice of doctor and other providers, i.e. access to a list or network of doctors or pharmacies and if so, does the client have easy access to these network providers.

VII) Wellness/Loyalty Programmes

Although the so-called loyalty programmes do not form part of a medical scheme, certain clients may want to choose an option that provides access to these programmes.

Topic 5 Membership Application

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Understand the principles of membership.
- Complete and submit an application form on behalf of a client
- Understand the underwriting process.
    - Assist the client to accept the proposal.

5.1 PRINCIPLES OF MEMBERSHIP

The medical schemes act makes provision for principles applicable to membership. These principles are considered in the subsections following.

5.1.1 Open Enrolment

A medical scheme must admit all members who apply to be a member of an open medical scheme. This principle is qualified in terms of access to restricted membership schemes. It means that a medical scheme cannot deny membership based on a prospective member's age, health status or previous claims experience.

5.1.2 Community Rating

This means that all members within the same option of a medical scheme will pay the same contribution, irrespective of their age or their health status. The only differentiations allowed in contributions are in respect of income (higher income individuals can have higher contribution rates) or number of dependants or both.

5.1.3 Right to Admission

A medical scheme cannot cancel or suspend a member's membership or that of his dependants except on the grounds of one or more of the following:

- ☐ Failure to pay, within the time allowed in the rules of the medical scheme, the monthly membership contribution.
- ☐ Failure to pay any debt owed to the medical scheme.
- ☐ The submission of fraudulent claims.
- ☐ Committing a fraudulent act.
- ☐ The non-disclosure of material information.

Material information in this context refers to the withholding of any information in relation to previous health conditions that may have an impact on assessing the application of membership.

5.1.4 Continuation Membership

This principle ensures that a member or dependant will be able to choose to continue membership on a restricted medical scheme. These include the following:

- ☐ A member who retires from the service of his employer.
- ☐ A member whose employment is terminated due to age, health or disability.
- ☐ A member's dependants after the death of the member.
- ☐ Where an employer group decides to change medical schemes.

5.1.5 Cross-Subsidisation

The principle of community rating supports the principle of cross-subsidisation. According to this principle the monthly contribution fee of the more healthy and younger members within a scheme population who claim less, will be used to cross-subsidise the monthly contribution of sicker and older, higher-claiming members.

5.1.6 Minimum Benefits

The Prescribed Minimum Benefits (PMB) refers to the minimum benefits available to all members irrespective of the medical scheme option they chose.

5.2 MINOR MEMBERS

The Medical Schemes Act does allow for a minor to become a principle member provided that the relevant contribution is paid. Such a minor will be registered as a principal member and not as a child dependant.

5.3 COVER FOR NEWBORNS

Existing members will receive immediate healthcare cover for a new born baby. However, the birth must be reported to the medical scheme according to the rules of the scheme.

5.4 COMPLETION OF APPLICATION FORM

In completion of an application form to become a member of a medical scheme, it is essential to-

- ☐ Make sure that all the personal and banking information is accurate.
- ☐ Ensure that the health-related information is complete and does not omit any health conditions or medical advice sought.
- ☐ Record accurately prior membership of medical scheme and break-in cover.

5.4.1 Disclosure of Material Information

Material information is that information which is relevant to the decision by a medical scheme on whether or not to impose a general or condition-specific waiting period. Therefore, an applicant would have to disclose conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which he applied for membership.

The importance of applying due caution in providing accurate information is that a medical scheme may cancel or suspend the membership if, at the time of applying, the member failed to disclose material information.

This information is of importance to the scheme and protection for schemes and is used to predict their overall risk exposure for purposes of budgeting and planning.

It also enables schemes to manage the risk of members who wait until they know they're about to face a major health event before they decide to join a medical scheme.

5.4.2 Financial Adviser's Declaration

Most application forms have a broker declaration section that needs to be completed by the broker. The information required includes the following:

- ☐ The accredited status as broker in terms of the Medical Schemes Act and accreditation detail.
- ☐ The licensed status in terms of the FAIS Act at the date of signing the application form.
- ☐ A declaration that the broker has been appointed by the client to provide advice about the application.
- ☐ A declaration that the broker has a valid contract with the medical scheme.
- ☐ A declaration that the client was informed of the commission payable by the medical scheme to the broker.
- ☐ A declaration that the advice was impartial advice and in the best interest of the client.
- ☐ A declaration that the broker accepts accountability for any advice given to the member about completion of the application form and joining the scheme.

This declaration is signed by the broker.

5.4.3 Client Signature

It must be ensured that the applicant is in agreement with all the information disclosed, provided and recorded in the application form and that it is factually correct and that no information was omitted. This is especially important with regards to any medical condition for which the applicant or any of the dependants received medical attention during the previous 12-month period.

The applicant must personally sign the application form. A copy of the application must be retained for record-keeping purposes.]

5.4.4 Submission Date of Application

The submission date of the application to the medical scheme becomes important when there has been a break in membership. This is also referred to as the uncovered period.

The application date refers to the actual date on which the medical scheme receives an application for membership or registration of a dependant. Premiums are also payable from that date.

Applications submitted before a pre-determined date of the month may be processed and membership registered on the 1st of the following month. If submitted at a later date in the month, it will be activated in the following month, unless the scheme requires more information from the applicant.

5.4.5 Pro-Rata Benefits

Certain of the medical scheme benefits are given on a calendar year basis, which means that an annual limit for benefits are specified in the rules of the medical scheme.

If a member joins a scheme on a date other than 1 January, the benefits are calculated pro-rata, which means that the client will receive an adjusted limit in terms of the benefits determined by the time registered. So, an annual limit of R12 000 for a benefit may be pro-rated to R9 000 for the year if the membership is activated on April 1 of the benefit year.

5.5 THE UNDERWRITING PROCESS

When applying for membership to a medical scheme, the information is used to evaluate the following:

- ☐ The clinical risk of the applicant and his dependants for risk management and administrative services.
- ☐ To decide whether a late-joiner penalty applies.
- ☐ To decide whether to impose waiting periods.

Remember, according to the Medical Schemes Act and as provided in the model rules, the costs of contributions to a medical scheme can be determined only on the grounds of income or number of dependants of the member, or on both income and number of dependants.

This means that strictly speaking, the underwriting process is limited to the evaluation and provisions as considered above.

5.6 REQUEST FOR FURTHER INFORMATION

Before finalising an application for membership, the medical scheme may request further information from the client regarding the following:

- ☐ Previous membership history.
- ☐ Medical conditions or those of his dependants.
- ☐ Income.

The medical scheme may insist on a medical report so that it knows whether to apply certain waiting periods, but the scheme must pay the costs of any medical tests or examinations it requires.

If the client belongs to a scheme currently, the membership of that medical scheme must not be cancelled until the client signed the acceptance letter.

5.7 ACCEPTANCE LETTER

The letter the member gets back from the scheme in response to the application, known as the acceptance letter, will detail the terms and conditions of the person becoming a member. An acceptance letter is usually valid for 30 days.

Should the medical scheme approve the application for membership, without any conditions, it need to be ensured that-

- ☐ The member signs the acceptance letter and returns it to the medical scheme.
- ☐ There is absolute clarity about the inception date.
- ☐ The member resigns from current medical schemes when accepted because it is illegal to be a member of more than one medical scheme at the same time.

The acceptance letter notifies the client formally of any waiting periods and late-joiner penalties that will apply. The client must understand this impact.

The client must sign the acceptance form only after having read the terms and conditions carefully, as well as ensuring that he understands and agrees to them.

The client must confirm the total contribution to be paid monthly.

On acceptance of the acceptance letter, membership will be activated on the system and a welcome letter and a welcome pack with the membership card and the benefit/member guide will be sent to the member.

In the event that the applicant challenges or request a review of the imposed conditions, the scheme will review the decision. In the event that an applicant is still aggrieved, a complaint can be lodged with the Principal Officer, the medical scheme's dispute committee or the applicant can complain to the Council for Medical Schemes.

5.8 RECORD-KEEPING

The broker must ensure that copies of the application form and any correspondence relating to the application process in any format, including electronic and hard copy, is retained in terms of the FAIS Act.

5.9 ANNUAL OPPORTUNITY TO CHANGE OPTIONS

The Medical Schemes Act makes provision that a member can change from one option to another once a year, usually at the start of the new benefit year. Changes from options are not allowed during the benefit year. Notification of benefit changes and contributions are sent to members by the medical scheme 3 months prior to a new benefit year.

From a broker perspective, it is essential to guide the member through the implications of any benefit changes and contribution increases. The member needs to be informed to what extent the product (option) continues to or does not meet the health needs of the members and dependants.

Any changes need to reach the medical scheme before the allocated date to affect the required information of the member system.

Topic 6 Processing and payment of claims

LEARNING OUTCOMES

After studying the topic, the learner should be able to-

- Understand the processing and payment of claims.

6.1 MEDICAL SCHEME CLAIMS HANDLING PROCESS

The process a medical scheme needs to have in place to be able to manage claims, includes the following:

- ☐ Receive, validate and pay claims in accordance with the scheme rules and the Medical Schemes Act
- ☐ Pay contracted fees to providers where applicable.
- ☐ Appropriately communicate to providers and members as prescribed if a claim is queried or rejected.
- ☐ Provide and send claims-advice statements to members and providers.
- ☐ Pay claims from a medical savings account according to scheme rules and the Medical Schemes Act.
- ☐ Provide fraud detection services.

6.2 PRE-AUTHORISATION

Hospital admissions for non-essential or non-life-threatening procedures need to be authorised by the medical scheme prior to a member being admitted, unless there is a medical emergency.

If no pre-authorisation has been obtained, the medical scheme can refuse to pay.

Pre-authorisations are obtained by contacting the scheme administrator at least three days before admission.

6.3 SUBMITTING A CLAIM

Any account submitted according to the provisions of the Medical Schemes Act, must be paid by the medical scheme within thirty 30 days of receipt of the account. Benefits will only be paid for a relevant health service to a duly registered health professional with a registered practice number if the rules make provision for the benefit and funds are available.

Claims are usually submitted by the service provider directly to the medical scheme. A copy of such a claim is then sent to the patient for record purposes, clearly indicating that the claim has been submitted to the scheme.

Service providers may however request from a patient/member to settle (pay) the claim directly with the provider. The member will in that instance submit the claim to the medical scheme. The medical scheme will reimburse the member according to the benefit portion as per the medical scheme rules. The medical scheme will refund by making a direct payment into the member's bank account.

Ultimately the member/patient will always be responsible for settling the account of the unpaid portion of the account to the health professional.

It is the responsibility of the member to check whether the claims have been paid by the scheme, even if the service provider submits the claims. That can be done by checking the claims-advice received from the medical scheme against the original claim from the service provider.

It is possible that a medical scheme does not reimburse the full account but only a benefit according to the scheme rules or in cases of certain procedures, not at all. The member will then be responsible directly to the service provider for the unpaid portion of the claim.

6.4 REQUIRED INFORMATION ON CLAIM

The following information needs to be clearly visible on the claim form before submitting claims:

- ☐ The surname and initials of the member.
- ☐ The surname, first name and other initials, if any, of the patient.
- ☐ The name of the medical scheme and the membership number of the member.
- ☐ The practice code number (PR Number) issued by BHF through the PCNS system.
- ☐ Name and practice number of the referring doctor (if a specialist account).
- ☐ The relevant codes that relate to such relevant health service:
  - Diagnostic codes, i.e. the ICD10 codes.
  - Procedure codes, i.e. the NHRPL code.
  - Medicine codes, i.e. the Nappi-codes numbers.
- ☐ The date on which each relevant health service was rendered.
- ☐ The nature and cost of each relevant health service rendered.
- ☐ Where a pharmacist supplies medicine according to a prescription, a copy of the original prescription if the scheme requires it.
- ☐ Certain provisions for accounts rendered by hospitals with regards to operations and procedures performed.

6.5 SUBMISSION PERIOD

A claim must be submitted as soon as possible after receiving the service.

If a claim is submitted later than the last day of the fourth month after the date on which the medical treatment was provided, the claim will be regarded as stale and the account will not be paid.

6.6 REJECTION OF CLAIMS

A medical scheme can reject a claim if it is of the opinion that an account is erroneous or unacceptable for payment.

If accounts or statements from service providers are rejected, it may be for the following reasons

- ☐ The required information as listed was not provided.
- ☐ The benefit claimed is listed as an exclusion.
- ☐ The claim reached the medical scheme too late - after the stale date.

In the event of an account being rejected, the medical scheme must -

- ☐ Inform both the member and the relevant health care provider within 30 days after receipt of such account that it is erroneous or unacceptable for payment.
- ☐ The scheme must state the reasons for such an opinion.
- ☐ The scheme must give the service provider the opportunity to correct and re-submit such account within a period of 60 days following the date from which it was returned for correction.

6.7 CLAIMS FOR SERVICES PROVIDED OUTSIDE OF SOUTH AFRICA

It is important that members understand that benefits are available for services rendered in South Africa. However, the medical scheme rules may provide to cover services in Lesotho, Swaziland and Namibia.

The implication is that the medical scheme will not pay for any medical expenses incurred outside South Africa.

Glossary of Terms

Administration costs:	The costs incurred for administration services such as claim processing, billing and overhead costs. Administration costs are usually expressed as a percentage of premiums.
Ambulatory care:	Health services that do not require hospitalisation
Benefits:	Health services covered under a medical scheme contract
Beneficiaries:	All the individuals covered by a medical scheme including principal members and their dependants
BHF:	Board of Health care Funders
Capitation:	A pre-determined Rand amount per covered person. This usually refers to a negotiated monthly payment per covered person paid to a medical care provider. In return for the capitation payment, the provider assumes responsibility for the provision of health services for that person for the agreed time period.
Claims experience:	The experience the medical plan or group has for total health related claims for a specific period.
Community rating:	The process of developing premium rates based on the overall community (or plan) claims experience rather than on group-specific claims data.
Contribution:	The consideration paid to a scheme for providing coverage (premium)
Council:	The Council for Medical Schemes
Demographics:	Refers to the demographic mix, primarily referring to age and sex, of the members within a group/medical scheme.
Drug formulary:	Listing of prescribed medications covered in medical scheme benefits.
FAIS Act:	The Financial Advisory and Intermediary Services Act, 2002
Fee-for-service:	A form of payment to health care providers where the providers receive payment on a per service basis. This payment form is generally contrasted with capitation payment.
Fee schedule:	A listing of procedure codes for medical services with pre-set tariff amounts per code.
FSP:	Licensed financial service provider, intermediary, broker
Generic drug:	A chemical equivalent but cheaper version of a brand original name drug.
General Code: FAIS ACT:	General Code of Conduct for Authorised of Conduct Financial Services Providers and Representatives
Member:	The contract holder responsible for paying premiums to the medical scheme
NHI:	National Health Insurance
NHRPL:	National Health Reference Price List
Open enrolment:	A principle whereby no underwriting is applied to medical scheme applicants
Outcomes:	The results of medical services usually measured as an improvement in health status
Out-of-pocket costs:	Are amounts which members are required to pay for medical coverage. These could arise as a result of co-payments, deductibles, benefit limits or exclusions.
Registrar:	Registrar of the Council for Medical Schemes

Regulations	Regulations in terms of the Medical Schemes Act, 1998 and Amendments
Risk analysis:	The process of evaluating the expected medical care costs for a group and determining what product, benefit level and price to offer in order to best meet the needs of the group.
Service providers:	Doctor, pharmacist, dentist, physiotherapist, hospital, etc.
Underwriting:	Prospective risk assessment for the purposes of determining contribution premium level and/or benefit eligibility.
Waiting period:	A time period which must elapse following a member's enrolment before which they are eligible to submit a claim. This may apply to non-emergency services only.