CLASS OF BUSINESS TRAINING

Class: Health Services Benefits

Study Guide

2021

Contents

Class of business training legislative requirement

The Financial Sector Conduct Authority (FSCA) **Board Notice 194 of 15 December 2017: Determination of Fit and Proper Requirements** stipulates that an FSP and a representative must complete the Class of Business (CoB) training relevant to those financial products for which they are authorised **before** rendering any financial service in respect of such products.

A key individual must, likewise, complete the CoB training in respect of the classes of business for which he/she is approved to act as a key individual **before** managing the rendering of any such financial services.

The Determination of Fit and Proper requirements define “Class of Business training” as training in respect of a specific class of business and which training is provided and assessed by an accredited provider or an educational institution.

The Class of Business training applies to the following:

- All FSPs, Key Individuals, and Representatives appointed after 1 April 2018.
- FSPs, Key Individuals, and Representatives who seek authorisation, approval or appointment for new financial product categories after 1 April 2018.
- Representatives working under supervision as of 1 April 2018 or appointed under supervision after 1 April 2018.
- Certain exemptions apply, depending on the type of business one does, and how it is conducted. Please contact your compliance officer if in doubt.

FSPs, KIs, and Reps authorised before 1 April 2018 are considered to have completed the CoB training given their experience and are therefore exempt from CoB training unless they add new products to their licence.

Glossary of terms

Term	Definition
FSP	Financial service provider
Fit and proper	This is a set of requirements that must be fulfilled by FSPs, representatives, compliance officers, etc in the industry
Key individual	A key individual who is responsible for overseeing the activities of the FSP
General Practitioner (GPs)	A doctor who treat and diagnose a variety of medical conditions.

Introduction

The healthcare environment in South Africa is such a complicated sector currently. This has led to different stakeholders becoming anxious at the announcement pertaining the introduction of national health insurance.

Private healthcare is currently being offered under two arms; medical schemes and insurance companies that offer medical insurance products. Medical schemes offer benefits that range from non-comprehensive to comprehensive. However, sometimes these benefits are limited, and members are left stranded with co-payments, this is where medical insurance becomes necessary. Members can use money paid out from their medical insurance products to cover extra expenses that are not covered by the scheme.

The reasons why medical schemes are unique is that they cover all healthcare expenses and these are basically the same across all schemes. With this in mind, it is worth noting that there are no subclasses in the Health Services Benefits class.

Chapter 1: Products, characteristics, features in Health Services Benefits

Learning outcome:

By the end of this chapter, you should be able to:

- Describe the range of financial products within the Class of Business.

NB: - it is important to note that healthcare services in South Africa do not necessarily have different classes per se, but rather, medical schemes cover almost all healthcare costs incurred by the member. These will then be offered under different benefit options. The benefits that the member will have access to will then depend on the option they would have selected based on their affordability and needs.

1.1 Medical savings account

A medical savings account is a benefit offered to members of a medical scheme, specifically for expenses incurred on a day-to-day basis. If a member seeks medical attention, as long as they are not hospitalised, the bill will be paid from the medical savings account.

This is a new generation benefit that was introduced in order to instil accountability and responsibility in the use of benefits by members.

How does this work

This benefit is usually not available to all members of a scheme, only members belonging to new generation options will have access to this benefit. In the options where it is available, the Medical Schemes Act stipulates that a maximum of 25% of premiums may be allocated to the medical savings account. Therefore, depending on your option, you could have 10%, 15%, 20%, etc. allocated to the medical savings account.

As mentioned before, any cost that the member incurs when they are not hospitalised must be paid from the medical savings account. In essence, this money belongs to the member, they must manage the account and ensure that all their out of hospital expenses for the year are covered by the account. In case the member does not use all their allocated medical savings within a specific year, they will be carried over to the next year.

The account is pre-funded meaning that at the beginning of every year, the member is allocated their portion beforehand, and they can use it from the first day of the year. Should a member decide to leave the scheme during the year for whatever reason, three scenarios might take place:

i) The scheme will calculate the amount that has been utilised from the savings account. If it is less than what the member has contributed, it means that the member owes the scheme and will have to pay them.

ii) If the calculations indicate that the member's contribution is more than what they have utilised, the scheme will then decide on the following; if the member is moving to a new scheme that does not offer a medical savings account, or if they are not joining any scheme, the money will be paid to the member as cash, should they still have money in their account.

NB:- The payment will only be made after four months to cater to any claims that might come late after the cancellation of membership.

iii) The scheme could also transfer the balance in the medical savings account to the new medical scheme if the member is moving to another scheme that has a medical savings account.

Some members use up their savings accounts before the end of the year. In most schemes, the member will be allowed a certain number of GP visits where they will not pay for the consultation but might have a co-payment for the medication. However, if the member finds themselves using up their savings account every year, it might be necessary to reconsider moving to an option that has a higher allocation for a savings account.

Examples of procedures paid from the medical savings account

- Surgery and other procedures to correct refractive errors.
- In-Vitro Fertilisation and Infertility treatment.
- Treatment relating to sexual dysfunction.
- Treatment relating to or forming part of Organ Transplants including maintenance medication in the private sector.
- Treatment for cosmetic purposes.
- Treatment relating to or arising from participation in professional sporting activities.
- Examinations for insurance, school, association, emigration, visa, employment, or similar purposes.
- Obesity
- Educational Therapy
- Protective gear
- All costs relating to or forming part of the treatment of HIV/AIDS
- Costs associated with, or arising out of wilful self-injury, suicide or attempted suicide.
- Hearing devices including cochlear implant devices, whether introduced internally or not, as well as the maintenance of these devices.

- Household remedies, contraceptives, patent medicines, non-ethical and all proprietary preparations including but not limited to vitamins, minerals, face creams, body lotions, soaps, shampoos, laxatives.
- All costs arising from injury or illness for which any other party is liable unless the scheme is satisfied that there is no reasonable prospect of the member recovering adequate damages from the other party.
- All treatment and costs incurred for which benefits are not specifically provided.

Medical scheme members need to take note of the following:

- A member cannot use their savings account to pay for a co-payment.
- Out of hospital expenses are paid subject to available funds in the member's savings account
- The scheme cannot pay for any PMB condition from the member's savings account
- There are day-to-day expenses that are not paid from the savings account including;

a) MRI and CT scans
b) mammograms, cholesterol tests, and other screening tests
c) treatment for drug and alcohol dependency
d) psychiatric consultations and evaluations.

- If a family is covered, it is permissible and possible that one family member can use up the entire MSA on their own depending on their medical needs.
- In cases where a member is not utilising their MSA year in year out, it might be best to consider downgrading to a hospital plan to save on the premium contribution.
- It is not allowed for a member to pay for their monthly contribution from the savings account.

Class discussion

Discuss the article below as a class. How is this different from the normal medical savings account?

Health Funders Association - How Medical Savings Accounts are Changing – for the Better (hfassociation.co.za)

1.2 Hospital plan

This type of benefit can also be referred to as a risk pool. When the member contributes their premiums, part of the money is allocated towards their day to day expenses through the medical savings account, up to 25%. The rest will be allocated to the risk pool. This is a fund or benefit for all members of the medical scheme which covers all major healthcare expenses that are usually uncontrollable, like surgery. These events are typically low frequency but high costs which cannot be paid out of the pocket.

The downside of this type of benefit is that some procedures might not be covered at all e.g. cosmetic surgeries. Whereas some might carry huge co-payments. The following are examples of the procedures covered under this plan:

- Ward fees
- Operating theatres, unattached operating theatres & day hospitals
- Prescribed medicines & materials dispensed and used in hospital
- ICUs, Specialised ICUs & High Care Wards
- In Hospital Procedures & operations performed by GPs, Specialists, etc.
- Ante-natal consultations & foetal scans
- Confinements
- Radiology in hospital
- MRI scans, CT scans, Interventional Radiology, Angiograms, Duplex Doppler scans & Nuclear medical investigations
- Procedures & operations by Maxillo Facial and Oral Surgeons
- Ambulance Services
- Blood transfusion services
- Hospices & registered nurses
- Prosthesis & implants introduced internally as an integral part of an operation
- Renal Dialysis
- Oncology (Cancer) treatment
- Organ transplants
- Bio kineticists & physiotherapists

1.3 Comprehensive Plans

As the name suggests, these plans cover almost all healthcare expenses, but obviously at a higher cost as well. They combine day to day benefits, in-hospital cover, and chronic medication, subject to the rules of the scheme.

Some comprehensive options have got Threshold levels to build into the benefits, which means the following: Once a member's savings are depleted and the member receives any day-to-day treatment (GP, specialist, dentistry, x-rays) which he pays from his own pocket, then those invoices must still be submitted to the scheme. The reason for that is, that once the member has spent a specific amount from his pocket for day-to-day expenses, as stated in the scheme rules (depending on the option he is on), he would have reached the Threshold level and the scheme will start to pay for day-to-day expenses for the member at normal medical scheme rates and with sub-limits.

With some options, the member will be allocated a certain number of visits to the GP for the remainder of the year.

1.4 Medical insurance

This is an insurance policy that is offered by insurance companies and not medical schemes. It offers cover for a specific risk (health event), just like any other insurance policy.

Medical schemes are non-profit organisations where members make contributions in return for cover for all their healthcare expenses.

Medical insurance works differently from medical schemes in the sense that medical schemes are non-profit organisations whereas medical insurance is offered by an insurance company and legally they are permitted to make a profit. Medical schemes are also more comprehensive, and they can cover all your medical expenses depending on the option selected, of which medical insurance could only cover for example hospitalisation. If a member is not hospitalised, they will not be covered, no payment will be made, no matter how sick they are.

The difference between medical schemes and medical insurance is illustrated in the table below:

Medical Insurance	Medical Schemes
• Covers a specific health event like hospitalisation, disability, dread disease, etc. • Pays directly to the member • The pay-out can be used for whatever purpose the member feels like, even income replacement • Pays a predetermined fee per day or a lump sum • Pay-out is not related to costs, whether the costs are more or less, the predetermined amount does not change • Regulated by the Long-Term Insurance Act • Can also be used as a financial protection plan	• Covers a wide range of services; day to day, in-hospital costs, chronic medication • Pays directly to the service provider • The money is specifically for healthcare costs • Pays according to the NHRPL • Pays out what the service provider charges taking into consideration the scheme limit • Regulated by the Medical Schemes Act through the Council of Medical Schemes • Enrolment is open for anyone who wants to join and can afford the contributions • Medical schemes are obliged to

• Can be used to cover shortfalls from your medical scheme • Regulated by the Financial Sector Conduct Authority • No open enrolment, member is subjected to underwriting in terms of age, health status, etc	cover prescribed minimum benefits

1.5 Gap cover

Provides additional cover specifically for members of medical schemes. Sometimes healthcare practitioners charge more than the scheme's limit for the procedure and the member will be liable for a co-payment; that difference is what will be covered by the gap cover benefit. This is a separate short-term insurance policy that the member will have to purchase over and above their medical scheme cover.

Most schemes today will fund a limited amount towards Chemotherapy, Radiation, and Cancer Biological drugs. Gap provides an additional amount to assist with shortfalls on these treatments.

Some medical schemes can reimburse even up to 300% of the scheme rate, but ironically the healthcare providers could charge up to 500%. Therefore, there is a need for members to have gap cover on the side to cater to such instances.

Only members of registered medical schemes in South Africa are eligible for gap cover, up to the age of 60 years. As with medical schemes, waiting periods and exclusions are also applicable.

Waiting periods

- 3 months general waiting period applies to all new members
- 12 months waiting period will apply to anyone with a pre-existing condition

Exclusions

These refer to the procedures that will not be paid for under the gap cover benefit like the ones listed below:

- Obesity treatment
- Cosmetic surgery
- Specialised dentistry

- Costs of co-payments defined as percentages rather than rand amounts
- Claims that are older than six months
- Any limit, co-payment, or penalty imposed on you by your medical aid scheme for non-compliance with scheme rules or authorisation procedures.
- Ward costs in a hospital or step-down facility;
- Upgrades to a private room;
- Pre-admission consultation costs;
- Medication (both in-hospital and take-home);
- External prostheses (an artificial breast or a prosthetic leg);
- External appliances, such as wheelchairs or crutches;
- Routine medical examinations, such as ultrasounds;
- Home or private nursing;
- Mental health disorders, transportation costs (such as in an ambulance);
- Costs incurred for treatment by a non-designated service provider (determined by your medical scheme)

The table below illustrates the need for gap cover

Procedure	**Actual cost**	**Medical aid payment**	**For your account**
Hysterectomy	R 12 978	R 4 751	R 8 227
Coronary bypass surgery	R 40 752	R 13 588	R 1 959
Surgical wisdom teeth extraction	R 8 227	R 27 164	R 4 302

https://www.medicalaid-quotes.co.za/articles/gap-cover

Chapter 2: Terms used in the healthcare industry

Learning outcome:

By the end of this chapter, you should be able to:

Define the different terms that are used in the healthcare services benefits industry.

2.1 Open enrolment

A concept that refers to the fact that anyone who can afford to pay the stated premium can be a member of a medical scheme. The scheme is not allowed to rate members based on their risks, even if the member is very sick, or old, they must still be accepted by the scheme as long as they can afford the contributions.

2.2 Prescribed minimum benefits

A set of benefits that must be provided to all members of the medical scheme, regardless of the benefit option they have selected. These benefits include;

- Cover for any emergency condition
- Chronic medication
- Cover for diagnosis, treatment, and care for 27 chronic conditions

2.3 Reserve requirements

Legislation requires that medical schemes keep a minimum of 25% of their annual contributions in a reserve account. This account must not be utilised on a day-to-day 0basis, it is only reserved in case of catastrophic events where claims are more than average. The Medical Schemes Council monitors the reserve accounts for the schemes and any medical scheme who falls below a particular level will face the consequences.

2.4 Late joiner penalty

A fee that is charged on any person who joins the medical scheme after the age of 35 years. This is because the concept of open enrolment will make other individuals wait until they are old and sick to join a medical scheme. Hence if they are charged, it will protect the risk pool from those individuals who join the scheme when they are already sick, it will only be fair that they pay more. But this does not mean that only the sick members who join after 35 years will be charged, even if the individual is healthy, as long as they are above the age of 35, they will be charged the late joining fee.

2.5 Community rating

All members in a specific option for a medical scheme will pay the same premium regardless of their health status. There will be a standard fee for the different categories in each option, i.e.

- Principal member

- Adult dependant
- Child dependant.

No matter how old or sick the person might be, they will pay the same fee as anyone in the option.

2.6 Cross subsidisation

The young and healthy must subsidize the old and sick to curb an increase in premiums. In as much as the scheme cannot discriminate against the old and sick, but for their pool to be balanced and protected, they need to find ways to attract more younger members because generally, they claim less.

2.7 Pre-authorisation

This is the permission that a member will have to seek from the medical scheme before undergoing a certain procedure, like surgery or an in-hospital stay.

2.8 Chronic disease management

This is a program designed to manage the health of all scheme members with chronic diseases through education and constant monitoring of their conditions.

2.9 Formularies

A list of medications for members with chronic conditions for which the scheme will cover. Suppose a member has diabetes, their healthcare provider will have access to the list of drugs they can prescribe to that specific member depending on their tolerance to the medication. If the provider prescribes anything outside the formulary, the scheme might not cover. The only instance when the scheme will cover drugs that are not in the formulary is if the doctor motivates that the medication in the list is not appropriate for the member.

2.10 Designated service providers

This is a list of service providers selected by the medical scheme that is made available to the members. Upon acceptance as a member, they will be given a list of service providers within their area who are supposed to be the member's first choice for service provision. An exception is only for emergency conditions where a member can seek medical attention at any provider and the scheme will cover the costs. However, as soon as the member has been stabilised, they are supposed to be transferred to an institution within their network.

2.11 Exgratia payments

This is a discretionary payment to the member out of the goodness of the heart, favour, goodwill, where the scheme has no legal obligation to make a pay-out for the member. The payment can only be approved by the Board of Trustees.

2.12 Board of trustees

These are the custodians of the fund since the medical scheme belongs to the members. They are responsible for making the day to day decisions for the members and also setting the scheme rules. 50% of the board must be members of the scheme and the remainder can then appoint anyone based on the expertise required.

2.13 Proration of benefits

This refers to the proportional allocation of resources to ensure that they are distributed equally among the individuals involved.

CIRCULAR

Reference	:	Pro-ration of benefits upon resignation / termination of membership
Contact	:	Daisy Ditshoene
Telephone	:	012 431 0580
Facsimile	:	012 431 0680
E-mail	:	d.ditshoene@medicalschemes.com
Date	:	30 May 2011

Circular 20 of 2011: Pro-ration of benefits upon resignation / termination of membership

It has come to our attention that some medical schemes and administrators are applying Regulation 9 of the Medical Schemes Act, 131 of 1998 in a manner that is inconsistent with the Act.

Regulation 9 provides for:

9. Limits on benefits. – A medical scheme may, in respect of the financial year in which a member joins the scheme, reduce the annual benefits with the exception of the prescribed minimum benefits, pro-rata to the period of membership in the financial year concerned calculated from the date of admission to the end of the financial year concerned.

Medical schemes apply this provision to pro-rate benefits in instances where a member is admitted during the course of a financial year and the benefits are adjusted in proportion to the period of membership, calculated from the date of admission to the end of the particular financial year. This application of Regulation 9 is correct.

However, this Office has noted certain practices where Regulation 9 is interpreted to imply that benefits may be applied retrospectively if the member resigns or terminates membership during the same year of joining the scheme.

Instances have occurred where, upon termination of the member's membership, benefits already paid were recalculated and pro-rated based on the period of membership, with the result that members had to accept personal liability for such expenses. Medical schemes and administrators are requested to refrain from such an interpretation as there is no basis for it.

The only pro-ration of benefits permissible in terms of the Medical Schemes Act is from the date of admission to the end of the financial year concerned.

Medical schemes and administrators are advised to desist from this practice with immediate effect and apply Regulation 9 in the manner explained. Any incorrect or unlawful application of Regulation 9 in the past must be reversed and restitution must be made to any members or providers who have been adversely affected by such an incorrect or unlawful application of Regulation 9.

Dr Monwabisi Gantsho
Chief Executive & Registrar

2.14 Inception date

These all refer to the date on which an individual is registered as a member or dependant of the scheme. The policy or cover becomes effective on this date and premiums are also payable from this date. In most cases, this falls on the 1st of the month.

2.15 Date of termination

This is a reversal of what happens on the inception date basically, the cover of the member ceases on this date and they no longer have access to benefits as a member. In this case, the entire membership is inactive and cannot be restored like in the case of suspension.

Once membership had been terminated, it cannot be reinstated. This means that the member will have to reapply to the same scheme or any other scheme, of which waiting periods will be applicable again.

2.16 Suspension of membership

This is a temporary period during which membership is inactive usually due to unpaid premiums. Once premiums have been paid in full, membership can be reinstated. During the period of membership suspension, no one will have access to benefits, i.e. the main member and all their dependents. Should they seek any medical attention, they will have to pay out of their own pockets the full amount that the provider will have charged.

2.17 Pre-existing condition

This refers to any health condition that the member suffered from before joining the medical scheme.

Chapter 3: Fee structures

Learning Outcome:

By the end of this chapter the learner must be able to:

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

3.1 Medical scheme contributions are determined mainly by two factors

i. The option into which the member has been accepted. The more comprehensive the option is, the higher their contribution. However, because of community rating, everyone within that particular option will pay the same contribution regardless of their health status or age. There is a standard rate for principal members, adult and child dependants.

ii. The number of dependants. The more the dependants a principal member has, the higher their contribution.

Group activity: Learners are required to research the current fees for different medical schemes, compare them, and present their findings to the class.

3.2 Medical insurance premiums are determined by several factors

Age – the general assumption is that the older you get, the closer you are to your death bed, and the younger one is, they still have a longer life span. Therefore because of this, life insurance companies will charge higher premiums on older clients and fewer premiums on the younger clients. It is therefore advisable for younger clients to take out their health insurance policies early enough to avoid paying higher premiums.

Pre-existing conditions – the insurer will also consider if one has a medical condition, they are already suffering from by the time they apply. If so, that condition may be excluded from the cover, or they will be subjected to a 12-month waiting period. Ultimately, this client will generally pay a higher premium.

Weight – the appropriate weight of a person is determined by their BMI (body mass index), which also takes into consideration their height. The levels are as follows;

- 18 – 24 is normal
- 25 – 29 is overweight
- 30 and above is obesity

If the client is overweight or obese, they will be charged a higher premium.

Smoking – Smoking predisposes one to certain diseases like lung cancer and they will, therefore, be charged a higher premium as compared to a non-smoking client.

Gender – Women are generally considered to be lower risk clients as compared to men. Women, therefore, pay fewer premiums.

3.3 Comparison between medical scheme and medical insurance premiums

As noted previously, medical schemes do not admit members based on their levels of risk, admission is based on the affordability and the needs of the members. All members that fall under a particular option will pay the same premium.

On the other hand, under medical insurance, admission is sorely based on the level of risk the member brings. After considering the factors above, the risk will be classified as low, medium or high risk, a low-risk individual will be charged a lower premium, whereas the higher your risk is, the higher the premium will be.

Chapter 4. Risks associated with medical products

Learning outcome:

By the end of this chapter the learner must be able to:

- Explain the general risks associated with investing, purchasing, or transacting in products in the class of business.

Section A: For the business

4.1 Inflation

This is the general increase in prices and fall in the purchasing value of money. Inflation also tends to affect medical schemes as well, that is why the contribution charges increase almost every year. The money that is collected through contributions will be used to purchase certain medical equipment, drugs, etc, some of these are purchased outside South Africa and hence they will need to convert the rand to other currencies as well.

Therefore, this means that as long there is inflation in the South African economy, the schemes will need to increase the members' contribution since the purchasing value of the rand will have been eroded.

Besides the general inflation, there is also medical inflation and one of the contributing factors is when providers charge way more than the approved medical scheme rates, with some even reaching 500% of the scheme rate. For more information, refer to the articles below:

Article 1

Medical aid increases will be 'well above inflation'

October 3rd, 2018, South Africa

Medical aid increases well above inflation and is expected to hit members in 2019. Business Tech reports that according to data from medical aid companies, the industry generally follows the guideline of CPI+3% when determining price increases every year, but this has not always been the case. Data published by financial advisory group GTC shows that the average increase across medical aid schemes over the last decade has hit as high as 6.4 percentage points above inflation, with the average since 2006 sitting at CPI+3.4%.

Between 2006 and 2010, medical aid users would have seen annual increases well beyond 10%, with the largest increase seen in 2008, when prices went up by almost 13%. However, inflation that year was also incredibly high (in the wake of the global economic crisis) at 11.3%, meaning much of the rising costs were absorbed by the medical aid industry.

The report says that was the year that registered the lowest difference between inflation and medical aid increases, at CPI+1.4%. Looking beyond the data (post 2016/17), the medical aid industry in hiked prices by 9% in 2018, coming in a range of CPI+3%, while the average across the industry is expected to be in the range of 8% in 2019.

According to GTC, the data should serve as a warning and guideline for medical aid members who are plotting their financial security into retirement, as it is one of the most overlooked aspects of financial planning. GTC consultant André Lindeque is quoted in the report as saying that that retirement plans, in particular, should incorporate planned increases in medical costs – not only for medical aid schemes but also for the ad-hoc expenses that come with growing older.

"The cost of medical aid is one of the more significant expenditures for many households, and naturally people are tempted to decrease this line item in their budgets, as they attempt to scale down their lifestyles," Lindeque said. "However, great care should be taken before considering downgrading your provision for healthcare funding." This is mainly due to the likelihood of greater healthcare needs during retirement years.

The report says while planning for healthcare during retirement should be a priority for all – uncertainty still lingers across the medical aid industry as well the private healthcare sector in the face of government's plans to roll out a National Health Insurance. Medical aid schemes, in particular, will already be feeling the impact, following the publishing of the

Medical Schemes Amendment Bill in June, which outlined how they will have to change once brought into law.

Among the changes is the abolishment of co-payments – the out-of-pocket payments that need to be made by members when they are billed above the agreed rates of the medical aid schemes. The government's plan is also to do away with Prescribed Minimum Benefits (PMBs) and replace them with comprehensive service benefits.

The report says these, among many other changes, will have a profound effect on medical aids in the future, and, according to industry experts, may have the effect of increasing the cost of private healthcare, or severely limiting what they can cover.

According to GTC, PMBs already cost around R700 per month per beneficiary on medical schemes – but this escalates to well beyond R3,000 once beneficiaries get older (85+). Ad-hoc or out-of-pocket costs, meanwhile, totalled R30bn in 2016.

"The government's proposed National Health Insurance may promise cheaper universal healthcare over the long term, but there is still considerable uncertainty over the exact mechanics of the scheme – including what it will cover, to what extent, as well as the ultimate cost of the insurance to individuals," GTC said.

"Given the current state of the South African public healthcare system, combined with an anticipated increase in healthcare needs in the retirement years, it is a reality that every retirement plan should cater for regular and unforeseen medical expenses, which need factoring in at a higher rate to other inflationary assumptions, especially if someone is used to, and would prefer to maintain, private healthcare benefits," it said.

CIRCULAR 50 OF 2019: Guidance on benefit changes and contribution increases for 2020

This Circular serves to prescribe the requirements that must be adhered to by medical schemes for the assessment of annual medical scheme contribution increases, and benefit changes for the 2020 benefit year.

One of the primary statutory mandates of the Council for Medical Schemes (CMS) as enshrined in Section 7 of the Medical Schemes Act, is to protect the interests of beneficiaries at all times and to coordinate the functioning of medical schemes. To this end, CMS' key objective is to endeavour that annual medical scheme contribution rate increases remain affordable to encourage equitable access to quality healthcare, and overall long-term sustainability of the industry.

1. Macro-economic outlook for 2020

This section provides a brief overview of key economic indicators, employment statistics, household consumption expenditure and utilisation indicators, which have a bearing on the contribution increase in the medical schemes industry. Overall, these factors have a direct and indirect impact on affordability of medical scheme contribution rates, financial performance of a scheme, risk pooling, cross subsidisation, membership growth and the long-term sustainability of the industry.

Article 2

South African Employer Medical Benefit Costs to Increase 10 Percent in 2020, Aon Survey Forecasts

27 September 2019

Gavin Griffin, Aon's Executive Head for Employee Benefits

Global health benefit costs set to rise 8 percent

Employer-provided medical benefit costs in South Africa are forecasted to rise 10 percent in 2020, outpacing the annual general inflation rate by 4.6 percent, according to the 2020 Global Medical Trend Rates Report released by Aon plc (NYSE: AON).

"The Medical Trend rate in South Africa for 2020 is expected to be slightly lower than the previous year, however, the medical trend rate levels in both nominal and real terms continue to be extremely high, and we do not expect to see a different path anytime soon. The increase in VAT taxes has already been fully assimilated by the SA market and we will continue to see carriers working to contain costs by extending network arrangements to direct utilisation to more managed care interventions. The supply and demand-side elements of utilisation have increased due to the ageing population of medical schemes as well as the increased incidence of chronic disease. Therefore, increased utilisation remains the major cost driver. A medical scheme with an ageing member base is expected to have a 2-3 percent increase in claims for every year that the average age increases. The need to grow or maintain solvency levels and the lingering ageing of the population will continue to pressure the market to keep medical trend rates at a high level," explains Gavin Griffin, Aon's Executive Head for Employee Benefits.

Globally, costs for employer-sponsored medical plans in 2020 are forecasted to increase 8.0 percent, up from 7.8 percent growth this year. This is mainly due to expanded benefits and a slight increase anticipated in general inflation.

Projected medical trend rates vary significantly by region. Costs are expected to increase the most in Latin America and Middle East/Africa regions, with average medical premium rates forecasted at 13.1 percent and 12.2 percent, respectively. In contrast, Europe is projected to see an average medical premium rate increase of 5.7 percent.

Health Care Benefit Cost Growth from 2019 to 2020 (Expected)

	2019	***2020***

South Africa	*11.0%*	*10.0%*
Global	*7.8%*	*8.0%*
North America	*6.4%*	*6.4%*
Latin America and the Caribbean	*13.2%*	*13.1%*
Asia Pacific	*8.6%*	*8.7%*
Europe	*5.1%*	*5.7%*
Middle East/Africa	*13.7%*	*12.2%*

Aon's report confirms the increasing impact of non-communicable diseases on health care costs globally. In South Africa, high blood pressure, diabetes, gynaecological / maternity, cancer, and ENT/lung/respiratory disorders were the most prevalent health conditions driving health care claims.

Leading Medical Conditions in South Africa and the World

	South Africa	*Global*
1)	*High blood pressure*	*Cardiovascular*
2)	*Diabetes*	*Cancer*
3)	*Gynaecological/Maternity*	*Diabetes*
4)	*Cancer*	*High blood pressure*
5)	*ENT/Lung Respiratory*	*Musculoskeletal*

Aon's report also confirms the growing prevalence of risks from unhealthy personal habits in South Africa, such as high blood pressure, high cholesterol, high blood glucose, lack of health screening, and physical inactivity. Mental health prevalence is on the increase and is

becoming a key focus for many employers.

Leading Health Risk Factors in South Africa and the World

	South Africa	***Global***
1)	*High blood pressure*	*High blood pressure*
2)	*High cholesterol*	*Physical inactivity*
3)	*High blood glucose*	*High cholesterol*
4)	*Lack of health screening*	*Bad nutrition*
5)	*Physical inactivity*	*Poor stress management*

"Many of the risk factors lead to chronic conditions with long term medical costs that make them difficult to treat and result in long-term medical cost increases," said Tim Nimmer, Aon's Global Chief Actuary for Health Solutions. "As a large portion of our waking hours is spent on the job, the workplace is a logical place to create a healthier culture and change behaviours. Our goal is to guide employers as they become more critical in helping individuals and their families to take a more active role in managing their health, including participating in health and well-being activities and better managing chronic conditions."

To view the report, visit https://healthresources.aon.com/reports-2/2020-global-medical-trend-rates-report.

4.2 Technology

We live in a digital world where technological changes happen overnight, and it becomes cumbersome for companies to keep up with the changes. Technology though has the good and bad side.

Positives of technology

- Technology presents a personalised experience in healthcare because it allows connectivity and easy access to information.
- Patients will become knowledgeable_and better able to compare quality and outcomes across clinicians and medical service providers.
- Convenience is also enabled as patients will avoid the long physical ques at the healthcare provider offices and rather wait in a virtual queue in the comfort of their homes.
- Robotic-assisted surgery, for example, allows minimally invasive procedures that reduce the need for blood transfusion and benefits patient outcomes in terms of less post-operative pain, reduced risk of wound infection, as well as a shorter hospital stay and faster recovery.
- Ultimately, according to the World Health Organisation, there is a prediction that rapid advancements in technology will drive better quality of healthcare and enable greater access to services by providing more diverse treatment models whilst lowering costs.

Challenges of technology

- Accessibility is an issue because not everyone has technology easily in their reach as some might not afford.
- The technology skills gap. South Africa is not a fully developed country which means that there is a huge number in the population who do not have technological skills. This will lead to the fact that in as much as medical schemes might put more effort to reach out to the greater population through technology, it will not go a long way as long as most people do not know how to use it.

4.3 Fraud

Fraud is a criminal act of intentionally deceiving, concealing, omitting valuable information for the sake of financial gain, or other benefits like obtaining fake identity documents. Fraud causes a headache to different states around the world because it is a white-collar crime, meaning that it is usually performed by a person of higher intellectual capacity, higher authority, or rather people with influence in an organisation. Hence, it is very difficult to detect as these will be highly esteemed and respected individuals. Billions of dollars are lost every year to fraud around the world.

Fraud in healthcare is still a white-collar crime that involves filling of dishonest claims for the sake of financial gain. Fraud is a crime committed by a syndicate. It is almost impossible for one to defraud a medical scheme by themselves and hence they would need to collaborate with employees in different departments to pull it off. Unfortunately, some employees may be

part of the syndicate unknowingly, only to realise during an investigation that they are being implicated in the crime as well. It involves misrepresentation in the form of withholding certain material information, altering the information, or proving falsified information altogether. Sadly, in some instances, the perpetrators are the clients themselves who are supposed to be assisting to fight against it.

Sometimes members are knowingly or unknowingly given “free offers” in exchange from their membership details for the medical schemes. The members are given free medical treatment and consultations that sound appealing and legitimate, but the fraudsters will then, working hand in hand with some service providers, bill the medical scheme for fictitious services that were never rendered. What then makes it worse is the fact that members do not analyse their claim statements or even read communications from their schemes. Claims history and updates are sent to their emails, but they sit in the inboxes with no one bothering to open. If members could track this, they will serve the schemes and themselves billions of Rands.

Article 3

Efforts to curb fraud, waste, and abuse of medical aids necessary to keep costs low

Anthony Pedersen

17 May 2019

When medical aids are abused through fraud or waste, the costs come back to the client through increased fees. Medscheme is ensuring that as little of this as possible occurs

Do medical schemes and administrators employ racial profiling, bullying, and rogue tactics against Black and Indian doctors? No.

What is the impact of fraud, waste, and abuse on the medical aid sector? At least 10 to 15% of all medical aid claims are fraudulent, abusive, or wasteful, about R22-billion last year alone.

So why has the past week been characterised by accusations that medical schemes and administrators were bullying the medical providers and patients? Medical schemes and administrators are obliged by law to safeguard the funds of the members against abuse and any funds recovered in this regard help to keep annual increases of medical aid under control.

Funds recovered help keep members' fees low and deviant providers are in the minority

Medscheme recovered R147-million from the approximately R45-billion paid in claims. This is roughly 0.3% of the total claims paid. The true savings are therefore from the change of claiming behaviour on the part of medical providers posts forensic intervention which is over R11-billion. These are claims that would have been paid and would have required a higher contribution increase from members and reduced benefits.

In 2018, Medscheme investigated 1 101 cases, of which 830 had forensic findings. This represents only 3% of the approximately 24 500 healthcare service providers (19 000 medical professionals, 4 950 pharmacies, and 550 facilities) we pay monthly. All other providers were paid without an audit;

Out of the 830 forensic matters, we lodged 94 complaints with the Health Professions Council of South Africa (HPCSA) for fraudulent or unethical conduct, which we encourage the HPCSA to investigate as a matter of urgency.

In 2018, payment of less than 0.3% practices was held back subject to resolution of suspected fraud, waste, and abuse and of these 830 forensic interventions, only 21 complaints (2.5% of all the cases) have been formally lodged with the Council of Medical Schemes (CMS).

These stats are an indication that a very tiny minority is impacted by our audits, and that

the claims of bullying are without basis. However, the company encourages any organisation or individual to lodge complaints with the industry regulator or pursue legal processes.

Context of fraud waste and abuse

Every minute somewhere someone is involved in the abuse and waste of health care services or is committing fraud against the medical aid sector.

When someone goes to the doctor for a headache, stomach cramps, a skeptic wound, and a doctor performs blood tests, could this be considered medical aid abuse, waste, or fraud?

To make matters worse, what if the doctor bills for services not rendered, use incorrect codes for services, usually at a higher tariff, waive deductibles and or co-payments, a bill for a non-covered service as a covered one and unnecessarily or falsely prescribe drugs.

How about "phantom billing", misrepresenting services such as performing a tummy tuck and billing it as a hernia operation or an appendectomy.

There is also "upcoding" — that is billing for a more expensive service than the actual one provided.

Other examples of fraud, abuse, and waste include health providers admitting patients to hospitals, when it is not clinically necessary, to access in-hospital medical aid benefits; health providers admitting healthy patients to hospitals to enable patients to claim for the Hospital Cash Back Plan insurance policies; claims are submitted on items such as hearing aids and frames for glasses when the patient does not need the item or even when the patient is not aware of the claim; healthcare providers using multiple practice numbers and then submitting duplicate claims for the same service.

Fraud, abuse, and waste of health services and funds are unethical and illegal. It is a waste of the financial resources of the health care sector, costing it more than R22-billion a year according to the Board of Healthcare Funders (BHF) and the Council for Medical Schemes.

The BHF has previously indicated that some medical aid members are making money by selling their cards to patients outside doctors' offices, one of the more common types of fraud.

The organisation has said medical aid contributions amounted to over R100-billion a year, and between 8% and 12% was lost to fraudulent activities.

There is also collusion between medical aid members, patients, pharmacies, and doctors

who committed the crime in exchange for money or other "gifts". In some cases, pharmacists allowed cardholders to embark on unrestricted shopping.

It is unethical and illegal when a doctor knowingly bills for a procedure that was not provided. The major distinctions between fraud, abuse, and waste is being able to prove intent. Whilst one fraud is criminal, waste and abuse are either negligence or opportunistic.

Why are medical schemes easy targets for fraudsters? Because unlike other forms of insurance, medical aids pay upfront and in good faith when a claim is submitted. This is to ensure members can have immediate access to healthcare treatment when they need it most.

We then check retrospectively that claims and payments made were correct, in line with the treatment provided and the scheme rules.

Amongst others, we have technology software to do trends on various elements of the claims, including Treatment regimes, the average duration of treatments, and average numbers as well as average claims (per area of specialty). Our predictive analysis tool assesses all our claims nationally and we then look where there are significant outliers. Those would be the claims that are investigated to ensure that they are valid.

It is a pity that some doctors have accused us of being insensitive when we investigate mainly wastage and abuse, as fraud requires that intent be proven. However, at Medscheme we are only focused on what was the doctor entitled to be paid, irrespective of whether he intended to over-charge the medical scheme or not.

Delays occur when a service provider refuses to allow us to validate the claims and we withhold payment. Instances where we have determined abuse, then we request the doctor to pay back the funds not due to them and where there is clear fraud — we report them to authorities.

Ultimately, the wastage and abuse of medical aid funds come back to the patient through increased medical aid contributions.

For example, through our predictive tool, we have over the past 18 months saved R200-million which historically would have been incorrectly paid out or not recovered. These savings assist the schemes to improve member benefits and the quality of care that the member can access.

When funds are wasted or abused, there will either be fewer benefits or higher annual contributions.

Corruption is a silent killer for the health sector. According to Transparency International, a global civil society organization leading the fight against corruption, common corrupt practices in health care sector include worker absenteeism; theft of medical supplies; bribery in medical service delivery; fraud and embezzlement of medicines, medical devices, and health care funds; improper marketing relations; weak regulatory procedures; opaque and improperly designed procurement procedures; and diversion of supplies in the distribution system for private gains.

It is a pity that despite the staggering costs of fraud the discussion of insurance fraud has always centred on defining the problem rather than on finding solutions. We need viable approaches for uncovering and recovering fraudulent claims.

Indeed, the perpetrators of health care fraud continue to find new ways to siphon money from the health care sector which ultimately impacts the premiums we all pay for cover.

Here are some ways to protect yourself from health care fraud and help keep health care costs down for everyone:

Read and understand medical aid agreement so that you know what and who is covered and what is not covered by your benefits.

When visiting a doctor, ask questions about the services you receive. Are they necessary? Are they a luxury?

Protect your medical aid card. Keep it away from thieves. It represents your benefits.

Scrutinise your doctor's receipts and medical bills. Understand each item listed on your bill to confirm that services were performed.

If you have co-payments, always ask for a receipt and check it before you leave the provider's office for accuracy. Save it as your proof of payment should a question arise at a later time. Question any charges that exceed your co-payment.

And finally, always notify your healthcare provider if you suspect abuse, waste, and fraud or any suspicious activity.

Everyone must co-operate both medically and financially at all levels of medical treatment to ensure an honest, reliable, and successful medical care.

Anthony Pedersen is chief executive of Medscheme, a subsidiary of AfroCentric Group of companies, which provide health administration and health risk management solutions to the healthcare funding industry.

Article 4

Medical aid schemes caught in a vice between fraud and claims of racial profiling

By Tim Cohen

4 July 2019

SA's largest medical aid scheme, Discovery, investigates about 3,500 potential fraud cases a year — and 82% turn out to be valid, according to documents provided by the scheme. (Photo: EPA / Jon Hrusa)

Fraud against medical aid schemes is a massive problem everywhere. But this is South Africa, so there is an additional aspect to the issue. And that is, you guessed it, race. An organisation for medical professionals has made the explosive allegation that SA's top medical aids are guilty of racial profiling in their efforts to combat medical aid fraud. But is it racial profiling or just one more sad example of SA's skewed society?

All insurance companies face a high level of fraud, but it is a little-known fact that it is an extreme problem for medical aid schemes. Recently at the Council for Medical Schemes' inaugural Fraud, Waste, and Abuse Summit, it was estimated that fraudulent practices cost members somewhere between R22-billion and R28-billion a year.

That would constitute about 25% of all premiums paid by SA's 8.8 million medical aid members. Or to put it another way, if there were no fraud, your medical aid bill would come down by a quarter, and given the way they have been escalating that would be a very welcome discount.

SA's largest medical aid scheme, Discovery, for example, investigates about 3,500 potential fraud cases a year, and 82% of them turn out to be valid, according to documents provided by the scheme.

Why is this so high? For one thing, medical aid fraud is kind of easy. With an insurance claim on a car that has been in an accident, for example, the value of the damage is comparatively simple to quantify, and the evidence of the accident is most often very obvious.

With medical aid fraud, it is costly for the medical aids to investigate and the nature of the fraud is often complex. How do you know whether a doctor has examined a patient and for how long?

Weirdly, one of the examples of fraud Discovery has had to deal with is the supply of

fraudulent sick notes. The doctor was supplying fraudulent claims for consultations. Discovery had to use undercover investigators to test the allegations.

Some of the claims are simply stupid. One doctor claimed he was treating 50 patients a day. But mostly, the way medical aid schemes find out about it is through tip-offs by patients. About 53% of fraudulent claims are discovered in this way and the remainder is found out by applying statistical algorithms.

When a fraud is suspected, a medical aid scheme requests an interview with the medical professional, and, of course, this ends up being a pretty tough interview. Often, to assess whether the doctor had seen the patients or clients he or she claimed to have treated, the medical aid demands to see the patients' files. It is a touchy point for privacy reasons, but often there is no other way.

If there is a fraud, the medical aids demand the money back, and if it is paid and the fraud is not serious, they stay on the payment system. But if it is serious, they get booted, and that is a big, big problem for medical professionals.

This week, a hearing was held at the Human Rights Commission, where Dr. Donald Gumede, chairperson of the National Health Care Professionals Association (NHCPA) made allegations of "racial profiling". (See our report here.) Three medical aids testified at the hearings, denying the claims of course. The medical aids claim they have no data at their disposal that specify the race of doctors. They use the Board of Health Funders' PCNS online portal system which does not carry any demographic identifiers.

Gumede told Business Maverick that the vast majority of people who have been cut off are black. There have been "one or two" white people, but 99% of those who have brought their complaints to the NHCPA are black, he said.

The medical aid schemes, he says, are so powerful and rich, they can bully people into submission. And he makes the tricky point that handing over patient case files is an invasion of privacy. The medical aid schemes "hold all the cards," he says.

But the problem for Gumede and the NHCPA is that correlation is not causation; just because the majority of victims of medical aid banning orders are black does not necessarily mean they are being targeted on a racial basis.

But it does, obviously and sadly, say something about the skewed nature of South African society – and perhaps also the tendency to see problems that are essentially social through a racial lens. BM

4.4 Other challenges in the industry

- Human resource shortage: - to provide quality healthcare, the institutions must have adequate staff members or medical personnel at any point. However, in some institutions, there is a shortage of staff. This might not necessarily be healthcare personnel; shortage of cleaning staff might also affect the quality of healthcare because a dirty healthcare environment will be a breeding ground for diseases.
- Emerging diseases: - these will always present a challenge to the healthcare industry because whenever there is a new disease, especially if it is infectious, attention and resource will be diverted to combat the new disease. Some medical personnel might need to undergo training on how to manage the new disease, thereby creating a shortage of caregivers for some patients who will be already suffering from other conditions.
- Shortage of medicine: - this goes without saying, in as much as the healthcare personnel might be well skilled and giving the best care to the patients, as long as there is no medication to give to the client, then the client might not be healed completely or their condition might worsen.

Section B: For the client

4.5 Co-payments

Because medicals scheme contributions are very high, it would provide peace of mind to a member to know that whenever they seek medical attention their bill will be covered in full. However, in some instances, they run the risk of incurring co-payments e.g. if they use a provider that is out of network, or in case the provider charges way above the scheme rate.

4.6 Cancellation of membership

Should a member not disclose information during the application, miss out on their contribution or not follow any of the regulations of the Medical Schemes Act

4.7 Stale claims

When a member seeks medical attention, the claim is supposed to be submitted to the medicals scheme as soon as possible. Any claims submitted after 4 months will not be paid by the medical scheme as it is considered a stale claim.

Chapter 5. The appropriateness of different product to different clients

Learning outcome:

By the end of this chapter, the learner must be able to:

- Analyse the appropriateness of different products or product features in the class of business for the types of clients or groups of clients.

Medical schemes, unlike other insurance companies, operate on the principle of open enrolment, meaning that no one can be denied membership. The main determinant for the suitability of a product to a client is the question of whether the person affords the contributions or not. Monthly contributions differ from one option to another, lesser options have lower contributions, and the more comprehensive options have higher contributions.

The second factor is whether the options offer benefits that cater to the health needs of the family e.g. if there is one with a chronic condition, they would need to go for the option which has a chronic medication benefit.

5.1 Young person, single, newly married

Generally, if a client has just started working and they are single, they do not require comprehensive cover since they will still be healthy and the chances of suffering from a chronic condition are also low. They will then be suited for an option that offers hospitalisation cover only but not a comprehensive option. These options are also cheaper and will be suitable since they will most probably still be earning a lower salary.

You will also have direct control over your medical expenses, plus you have core medical cover in case of emergencies. It is a good idea though to have separate medical savings account for dentistry, doctors' visits, and an acute medication for minor illnesses, such as colds and flu.

An older client who has a family will do better with a more comprehensive option that will offer day to day benefits since their children might require this most of the time, chronic medication for themselves as the risk of getting a chronic condition is higher as you get older. Lastly, the option must also offer hospitalisation cover in case of any family member being hospitalised.

5.2 Younger families

These families require more of day to day benefits that will provide the following:

- Optometry.
- Certain clinical procedures (gastroscopy, colonoscopy, tonsillectomy).

- MRI and CT scans in and out of the hospital.
- Private hospitals in South Africa paid at 100% of agreed tariff for elective hospitalisation.
- GP visits, specialist visits, and acute medication.
- Basic dentistry, pathology, radiology, and physiotherapy.

5.3 Older families

Older families are more mature, and they would require peace of mind knowing that almost all medical expenses are taken care of. They will just have to be prepared for small co-payments on certain procedures. A comprehensive cover will be more suitable for this type of family.

- Joint replacements.
- Oncology benefits
- Cover for biological drugs.
- Unlimited hospital cover for any PMBs at a private hospital in South Africa paid at 100% of the agreed tariff.
- Specialist visits usually covered at 80% of the cost in and out of the hospital.
- More comprehensive cover for chronic conditions.
- Optometry.

According to the website www.money101.co.za, between traditional and new generation medical schemes, suitability is as follows;

5.4 Traditional medical schemes

- Families with young children, who visit the GP or specialist regularly, and have to claim for medication, take the children for dental check-ups, claim for blood tests and x-rays – in short, families who use a wide range of benefits will be more suited to a traditional option.
- Families where dentistry and optometry benefits are important, and you want peace of mind that each member of the family can have two dental check-ups and one optometric check-up every 24 months.
- Higher-claiming families.

5.5 New-Generation schemes

- Healthy individuals, who do not need too much day-to-day cover, but want peace of mind that if they do visit the doctor or the dentist a few times a year, the cost will be covered.

- Families with older children, where it is not necessary to visit the doctor at the slightest sign of the sniffles and where the over-the-counter medication will suffice.
- Individuals who seldom visit the doctor or buy medication but who have extensive dental or optometry expenses – where the amount claimed will not be prescribed by sub-limits within your day-to-day benefits, but rather by the amount of savings available.

Group activity: the analysis of the appropriateness of a product based on income levels has not covered in the manual. Discuss in groups and present back to the class, what products you would recommend to the following groups and justify why:

a) Low-income households
b) Middle-income households
c) High-income households.

Chapter 6: Role players in healthcare services

Learning outcome:

By the end of this chapter the learner must be able to:

- Name the typical role players or market participants in respect of products in the Class of Business, including their legal structure.

6.1 Health funders

These are the institutions that are responsible for paying the medical bills or expenses incurred by the members and in return, the members contribute every month. This provides peace of mind to the members because they know that in the event of any sickness or need for medical attention, they will be covered. The institutions include medical schemes and some insurance companies that offer medical insurance products.

6.2 Health facilities

These are facilities within which members receive healthcare. It could be hospitals, clinics, pharmacies, etc.

6.3 Medical personnel

Medical personnel who are trained to render different healthcare services. Since the body is very complicated, it is almost impossible for an individual to know every disease that affects individuals. Therefore, medical personnel have different areas of specialties. A few examples are listed below;

Gynaecologist – a doctor who specialises in treating conditions related to women.

Paediatrician – specialises in children's health.

Nurses – provide holistic care to the patient usually under the instruction of a doctor.

Pharmacists – specialises in dispensing medication to the patients as per the prescription from the doctor.

6.4 Medical Schemes Council

This is a statutory body responsible for monitoring compliance with the Medical Schemes Act. They will then submit reports to the Minister of Health regularly.

6.5 FSCA

Financial Sector Conduct Authority is a statutory board responsible for monitoring compliance in the whole financial sector industry for which medical schemes are also part of. They also submit reports to the Minister of Finance.

6.6 Department of Health/ Minister of Health

The head of the healthcare sector in the country. They help to make policies and regulations for the industry together with the different sub-committees.

6.7 Clients

Clients are the most important stakeholders in the industry. Without clients there is no business because they are the recipients of healthcare services that are offered in the industry and in turn, they contribute a premium towards the cover. However, clients must take responsibility in ensuring that they disclose honest information during the application, otherwise, claims will be rejected, membership could be cancelled, etc. it is also the responsibility of the clients to ensure that claims are submitted on time.

Chapter 7: Applicable legislation

Learning Outcome:

By the end of this chapter the learner must be able to:

- Explain the impact of applicable legislation, including taxation laws, on products in the class of business.

7.1 Medical Schemes Act

This is the main Act that governs the industry. The regulatory body responsible for monitoring compliance to the Act is referred to as the Council of Medical Schemes. Most of the details of the Act have already been described in the previous chapters and also in the chapters to follow. A summary of the reasons why the Act was introduced is given below.

The rationale for the Medical Schemes Act

- Introducing a Compulsory Minimum Benefits package for all schemes, also known as prescribed minimum benefits.
- Prohibiting discrimination based on age, medical history, and health status by promoting open enrolment.
- Requiring that contributions be determined only based on income and/or the number of dependants through the concept of community rating.
- Enabling schemes and public hospitals to have an agreement for the provision of minimum benefits to its members with payment for hospitals.
- Regulating administrators and other contractors to medical schemes, for example, brokers and managed care organisations.

7.2 Income Tax Act

Qualifying for medical tax credits

Most members of medical schemes do not know that they qualify for tax credits. Medical schemes do send tax certificates every year but it is very few members who know the purpose or even utilise them.

Categories for tax credits

a) An individual is entitled to tax credits relating to their medical scheme contribution
b) Tax credits could also come from medical expenses that the member has been unable to recover from their medical scheme.

Below are some categories into which different individuals fall under and how much tax credit they qualify for.

Taxpayers who are 65years and over

- ✓ Basic monthly tax credit for contributions paid to a medical scheme: - R310 for yourself as a principal member (assuming you are paying the contributions), R310 for the first dependant (R620 in total), and R209 for each additional dependant.
- ✓ 33.3% of so much of the contributions you pay to a medical scheme that exceeds three times the amount of the medical scheme fees tax credit to which you are entitled
- ✓ 33.3% of the amount of any qualifying medical expenses you have paid and not recovered from your scheme or policy.

In summary

The member can claim a tax credit of 33.3% for all expenses they pay to a medical professional - for hospitalisation or prescription medication and for which their scheme or policy fails to reimburse.

Disabled taxpayer

These tax credits are applicable in cases where the principal member or spouse or child is disabled. Disability is defined as - a moderate to severe limitation of any person's ability to function or perform daily activities as a result of a physical, sensory, communication, intellectual or mental impairment, if the limitation -

(a) has lasted or has a prognosis of lasting more than a year; and

(b) is diagnosed by a duly registered medical practitioner following the criteria prescribed by the commissioner."

NB: - the disability tax credit is only applicable to the child or spouse dependent. It does not apply to any other dependant like your mother

According to SARS regulations, if you wish to claim an additional tax credit for a disabled family member you must complete a Confirmation of Diagnosis of Disability form. The form must be completed by a registered medical practitioner and if the disability is permanent, this must be reviewed every 5 years. Should the disability be temporary, the form expires after one year meaning it must be completed yearly.

The benefits are the same as those of a taxpayer who is 65years or older.

- ✓ Basic monthly tax credit for contributions paid to a medical scheme: - R310 for yourself as a principal member, R310 for the first dependant, and R209 for each additional dependant.

- ✓ 33.3% of so much of the contributions you pay to a medical scheme that exceeds three times the amount of the medical scheme fees tax credit to which you are entitled
- ✓ 33.3% of the amount of any qualifying medical expenses you have paid and not recovered from your scheme or policy.

Taxpayers younger than 65 with no disability or disabled family members

- ✓ Standard monthly medical scheme credits of R310 and R209
- ✓ 25% credit of the contributions that exceed four times the amount of the medical scheme contributions tax credit,
- ✓ All qualifying medical expenses that exceed 7.5% of the taxpayer's taxable income. In reality, you are most unlikely to cross this threshold unless your taxable income is low, and your non-reimbursed qualifying medical expenses are very high. The average taxpayer will therefore normally only qualify for the monthly tax credit.

Qualifying medical expenses

Qualifying medical expenses refer to the incurred medical expenses that were not paid for by the scheme.

- Services rendered and medicines supplied by any duly registered medical practitioner, dentist, optometrist, homeopath, naturopath, osteopath, herbalist, physiotherapist, chiropractor or orthopaedist;
- Hospitalisation in a registered hospital or nursing home;
- Home nursing by a registered nurse, midwife or nursing assistant, including services supplied by any nursing agency;
- Medicines prescribed by any duly registered physician (as listed above) and acquired from any duly registered pharmacist;
- Expenditure incurred outside South Africa in respect of services rendered or medicines supplied which are substantially similar to the services and medicines listed above;
- Any expenses prescribed by the Commissioner and necessarily incurred as a result of any physical impairment or disability.

7.3 National Health Insurance Bill

Currently, the government is in the process of implementing national health insurance. This is a financing system that is designed to pool funds for the whole nation to enable access to healthcare for all South African citizens, regardless of their social status. All individuals will

be able to access healthcare services without paying because the costs of their care will be funded from the national pool. The system is going to be implemented for 14years and is not yet fully functional. Some of the effects of the NHI on medical schemes are as follows:

- Medical schemes will only be allowed to offer complementary services that will not be offered under the NHI system
- It will be up to the members to choose to continue with their current medical schemes because most of the basic healthcare services will be offered under NHI.
- The government will also contract some of the private hospitals and medical facilities under the NHI.
- Medical tax credits might be scratched out and the money will be contributed towards the national pool
- It will be mandatory for all working South Africans to contribute to the NHI, and this might prove to be expensive for medical scheme members. Therefore, medical schemes run a risk of losing members

Chapter 8: The impact of economic and environmental factors

Learning Outcome

By the end of this chapter the learners must be able to:

- Describe the impact of applicable economic and environmental factors.

8.1 What Is the Economic Cycle?

These are the different stages that the economy goes through. These range from expansion down to contraction. Many factors are considered to determine at which stage the economy is in, like consumer spending and interest rates.

Stages of an economic cycle

Expansion stage

- Rapid growth
- Interest rates tend to decrease.
- Production increases
- Inflationary pressures start to build up though

Peak stage

- The stage is characterised by maximum growth in the economy
- The stage creates certain imbalances in the economy that need to be corrected.

Contraction stage

- At this stage, the imbalance created when the economy was at the peak will be corrected.
- Growth slows
- Employment falls
- Prices stagnate

The trough of the cycle

- This is when the economy hits the lowest point
- Growth begins to recover

In conclusion, when consumers spend more, there will be more demand in commodities and therefore companies will hire more workers. If more people are employed, they are bound to

afford medical scheme contributions. Therefore, there will be a higher demand for medical scheme products, and this will be a good time to expand business for schemes.

However, as the cycle moves from one stage to the other, there will be a shift in the consumer demand for goods and services and the reverse happens. Less demand for services will force businesses to retrench some workers. When a person is not employed anymore, they will start cancelling their policies, a medical aid included and therefore business will be low for the schemes. Usually, medical schemes with larger risk pools will be able to survive during these adverse periods.

8.2 Interest rate and monitory policy

Monetary policy is defined as measures that are put in place by the reserve bank to limit the supply and circulation of money to the public. They also control the interest rates and in turn, this controls inflation. In the process, the monetary policy also influences the economic cycle.

How does the monetary policy control the economic cycle?

When the economic cycle is on the trough stage, the Reserve Bank can lower their interest rates, that way, this will encourage consumers to borrow, increasing their levels of spending, increasing demand in the products and services and thereby boosting the economy by allowing it to enter into the expansion stage.

Because the expansion stage usually creates inflationary instability, the Reserve Bank can in turn increase their interest rates. This will reduce the consumers' appetite for borrowing, leading to a decrease in spending, demand, and economic performance.

From the above, it clear that the manipulation of interest rates by the Reserve Bank creates unsustainable distortions in the structure of relationships between industries and businesses.

8.3 Gross Domestic Product

Gross Domestic Product (GDP) refers to the monetary value of all goods that were produced and finished within the borders of a country during a specific period, usually a year, quarterly, etc. this enables economists to be able to estimate the economic growth rate, thereby giving a guideline to policymakers, investors and businesses in strategic decision making.

As part of the planning, medicals schemes also consider the gross domestic product values for the year as well. If the GDP is low, which might mean that the country is experiencing a recession, this will create a gloomy outlook for the medical scheme business. On the other hand, if the GDP is high, the country will be able to afford quality healthcare.

8.4 Employment Rate

Employment rates refer to the extent to which available labour resources are being utilised in the business circles. This only considers the working-age population which generally between the age of 15-65 years. They are determined or affected by economic cycles as noted earlier, but they are also significantly affected by government policies on education and income support, which usually create employment opportunities for women and other disadvantaged groups. If the employment rate is high, more people will afford quality healthcare, especially private healthcare and this will lead to the growth of the sector. However, a downside situation is created if the is a significant drop in the employment rate.

8.5 Government debt

Government debt is the sum of all amounts that are owed by the country to individuals, companies, and other governments. The downside of huge debt is that the debt holders could request for higher interest rates over a long period. This will in turn weaken the country's currency leading to a slowdown in economic growth. As the investors and debt holders notice the decline in the currency value, demand will be lower because investors will pull out.

Once investors pull out, employment rates will decrease and thereby reducing the demand for private healthcare especially.

8.6 Demand and supply

Demand and supply in economics refer to the relationship between the number of goods that producers plan to sell at certain prices, and the quantities that consumers are willing to buy. If more goods are produced, we say the supply is higher, on the other hand, if consumers purchase more of these goods, then we also say the demand is high.

However, the price of a commodity depends on the interaction between demand and supply in the economy. If the demand for goods is high and producers cannot meet the demand, the prices for the goods will be higher. On the other hand, if the demand is low, the price will also go down.

Once the producers and consumers agree, the resulting price is referred to as the equilibrium price. When equilibrium is reached, it means that the quantity of the goods supplied by producers equals the quantity of demand by the consumers.

Chapter 9: Industry standards and codes of conduct

Learning Outcome

By the end of the chapter the learners must:

- Understand industry standards and codes of conduct relevant to the class of business.

9.1 Rules of a Medical Scheme

- The rules of a medical scheme must include the following matters for a medical scheme to be registered:
- Appointments: - board of trustees, principal officer, auditor, the liquidator in case of a voluntary dissolution
- The quorum necessary for trustee meetings and annual general meetings and also the manner of voting
- Who is responsible for the safe custody of securities, books, documents?
- How contracts between the scheme and different suppliers are to be entered into and the conditions of terminations thereof.
- The power to invest funds
- Complaints resolution processes
- If a medical service has been rendered to a member, the provider is supposed to bill the medical scheme and the claim must be settled either to the member or the provider within 30 days
- In case of an amount that has been paid to a provider or member and they are not entitled to it, either fraudulent or otherwise, the money will be deducted from the benefits due to them respectively
- Conditions of member admissions and the manner of charging the premiums
- There should be no limitation to reimbursement for any member who seeks a health service from a public hospital as long as they are covered on the respective member's option
- All payments are to be done according to the scheme rules or recommended guideline

- Continuation of membership: - in cases where employment contracted has been terminated for whatever reason or where the main member dies and leaves behind his dependants.
- The scheme may only cancel membership in the following instances:
    a. failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules;
    b. failure to repay any debt due to the medical scheme;
    c. submission of fraudulent claims;
    d. committing any fraudulent activity; or
    e. the nondisclosure of material information.
- Donations to any health care service provider must be in the interests of all or some of the scheme's members
- The granting of exgratia payments must only be in line with the business of a medical scheme as defined in the Act
- Purchase of any insurance policies on the lives of the officers for the medical scheme
- The allocation of benefits to the personal medical savings account
- Membership of a minor who is assisted by his or her parent or guardian.

Amendment to the rules

- The scheme can only make amendments to the rules provided this has been approved by the Registrar upon receiving a written notice certified by the principal officer.
- The Registrar may approve or reject the amendment if it is going to be unfair on the members. If the amendment is rejected, the medical scheme will be given 30 days to amend the rules in the manner prescribed by the Registrar.

Approval and withdrawal of benefit options

As long as the scheme has more than one benefit option, they need to apply to the Registrar for approval

Conditions for approval

- Prescribed minimum benefits must be included in the option
- The option must be self-supporting in terms of membership and financial performance
- The option must be deemed to be financially sound
- The financial soundness of the other existing options must not be jeopardised by the new option

If the Registrar is not satisfied, they may request for financial guarantees for the financial soundness of the option. If at any point the Registrar is no longer satisfied with the financial soundness of the option, they may withdraw approval and the option must then be discontinued by the scheme within the prescribed period.

9.2 FAIS general code of conduct

The main aim of the code is to protect consumers of financial services and to professionalise the financial services industry. Medical schemes are in the financial services as well and hence there is a need for compliance with the FAIS act.

To achieve this, medical schemes must;

- regulate the selling and advice-giving activities of their brokers
- ensure that the clients are provided with adequate information and proper advice about the financial product they have selected
- ensure that their brokers are fit and proper.

FAIS general code of conduct record-keeping obligations

1. The FSP must have adequate systems and procedures in place to record verbal and written communications relating to the provisions of financial services to clients.

- Telephonic conversations regarding the provision of financial services must be recorded and the records kept for five years.

2. The FSP must be able to retrieve the records and other material documentation relating to clients or financial services.

- When the Registrar needs access to records of clients and/or financial services provided (such as the record of advice) this must be produced within the required period (seven days).

3. The records and documentation must be kept safe from destruction.

- This requirement is also part of the risk management systems and procedures which must be put in place in terms of Section 11 of the General Code. Banks and insurance companies have obligations to ensure that documentation must be kept safe from destruction and it is important that the FAIS Act requirements are included in these arrangements.

4. The records must be kept for five years after the termination of the product, to the knowledge of the FSP or in any other case after the rendering of the financial service.

5. Record-keeping may be outsourced as long as the records are available for inspection within seven days of such a request by the Registrar.

- The General Code makes provision that FSPs may outsource their record-keeping to third parties. The condition is that the FSP can meet all the requirements regarding record-keeping and retrieval of records if the function is outsourced. These requirements should, therefore, be included in the agreements between the FSP and third parties to enable the FSP to meet the legislative requirements.

6. It is permissible to keep records in an appropriate electronic or recorded format, as long as it is accessible and can be easily converted to a written or printable format.

- There must be a provision in the systems and procedures for an FSP to access and convert voice-logged records to a written format if required. In certain instances, clients must be given a copy of the voice recording if the request comes before the FSP could convert it into a written format.

7. If an FSP advertises a financial service by telephone, an electronic, voice-logged record of all communications must be maintained. If no financial service is provided within 45 days of the telephonic advertisement, the record may be discarded.

8. Clients must be able to get copies of the telephonic advertisement records within seven days of the request if the information has not yet been converted to a written format.

NB: - there are other regulatory measures addressed in the code which have not been mentioned here

Medical Scheme Codes of Conduct

Medical schemes also have their specific codes of conduct. The difference is the code of conduct of one medical scheme will not affect another medical scheme. This code will be a set of guidelines designs to guide and behaviour of employees and help management to make day to day decisions.

Bibliography

https://www.hst.org.za/publications/Kwik%20Skwiz/KWIKSKWIZ_SAHR_Ch13.pdf
https://www.medicalaid-quotes.co.za/articles/gap-cover
https://m.fin24.com/Money/Health/what-gap-cover-will-and-wont-pay-for-20170330
https://www.linksave.co.za/index.php/what-is-gap-cover
https://www.medicalbrief.co.za/archives/medical-aid-increases-will-well-inflation/
http://www.medicalschemes.com/files/Circulars/Circular50Of2019.pdf
https://www.fanews.co.za/article/surveys-reports-and-ratings/34/general/1195/south-african-employer-medical-benefit-costs-to-increase-10-percent-in-2020-aon-survey-forecasts/27595
https://ehealthnews.co.za/three-trends-shaping-future-healthcare-sa/
https://iafrica.com/is-technology-the-future-of-private-healthcare-in-south-africa-with-the-introduction-of-nhi/
https://mg.co.za/article/2019-05-17-00-efforts-to-curb-fraud-waste-and-abuse-of-medical-aids-necessary-to-keep-costs-low/
https://www.dailymaverick.co.za/article/2019-07-04-medical-aid-schemes-caught-in-a-vice-between-fraud-and-claims-of-racial-profiling/
http://www.scielo.org.za/pdf/cura/v42n1/12.pdf
https://www.businesslive.co.za/bt/money/2019-06-30-when-you-qualify-for-tax-credits-for-medical-expenses/
https://www.sars.gov.za/TaxTypes/PIT/Pages/Additional-Medical-Expenses-Tax-Credit.aspx
https://www.iol.co.za/personal-finance/understanding-medical-scheme-fees-tax-credits-19621780
https://www.businesslive.co.za/bt/money/2019-06-30-when-you-qualify-for-tax-credits-for-medical-expenses/
https://www.sars.gov.za/TaxTypes/PIT/Pages/Additional-Medical-Expenses-Tax-Credit.aspx

https://www.iol.co.za/personal-finance/understanding-medical-scheme-fees-tax-credits-19621780
https://ewn.co.za/2019/09/30/private-healthcare-report-various-role-players-colluded-to-rob-consumers
https://www.investopedia.com/terms/e/economic-cycle.asp
https://data.oecd.org/emp/employment-rate.htm
https://www.britannica.com/topic/supply-and-demand