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Briefing Summary



The Medical Schemes Act

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Impact of Changes To The Medical Schemes Act

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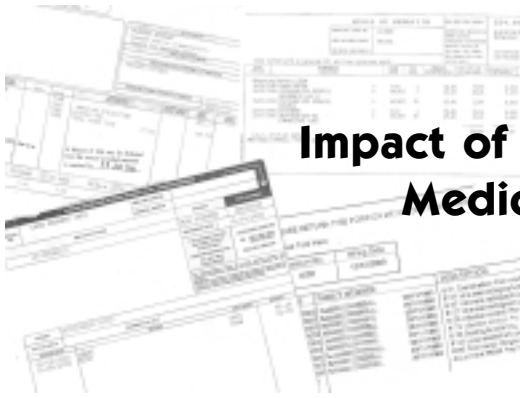
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Impact of Changes To The Medical Schemes Act

There have been extensive changes to the law governing medical schemes in the last two years. The legislative changes represent underlying changes in government policy in favour of increased regulatory control of not only medical schemes but also contractors to medical schemes such as medical scheme administrators, managed care organisations and brokers. The chapter explores these legislative changes and examines the changes in the functions of the Council for Medical Schemes and the impact of the prescribed Minimum Benefits Package.

Background

Private financing of health care in South Africa dates back to 1889. The Medical Schemes Act was introduced in 1967. 1993 saw major changes to the Act; many of a deregulatory nature:

- ❖ The abolition of compulsory direct payment to providers of services
- ❖ The abolition of the statutory status of RAMS and the scale of benefits
- ❖ Schemes could vary benefit levels and structures as they saw fit
- ❖ Medical schemes were allowed to operate pharmacies, hospitals and similar health establishments.

Effects of the 1993 deregulation were:

- ❖ Benefits for the elderly were diminished with the 1993 deregulation
- ❖ Benefit structures attracted the young and healthy
- ❖ High-risk individuals and groups were discouraged by loading their premiums on the basis of risk profile.

The 1998 New Medical Schemes legislation responded to these challenges by:

- ❖ Introducing a **Compulsory Minimum Benefits** package for all schemes
- ❖ Prohibiting discrimination on the basis of age, medical history and health status
- ❖ Requiring that contributions be determined only on the basis of income and/or number of dependants
- ❖ Enabling schemes and public hospitals to have an agreement for the provision of minimum benefits to its members with payment for hospitals
- ❖ Forbidding schemes from excluding applicants for membership or their dependants except on certain prescribed conditions
- ❖ Regulating administrators and other contractors to medical schemes, for example brokers and managed care organisations.

A major concern of the new legislation is equity of access to medical scheme membership and cross-subsidisation between the elderly and young and between low and high earners.

The 1993 changes to the Act allowed detailed and individual-specific risk rating and many variations in both the level and structuring of benefits, while the 1998 changes brought about community risk rating and more controlled levels and structuring of benefits.

Functions of The Council For Medical Schemes

The Council's functions pre-1998 were to:

- ❖ Control, promote, encourage and co-ordinate the establishment, development and functioning of medical schemes
- ❖ Advise the Minister on matters concerning medical schemes
- ❖ Investigate complaints and settle disputes in relation to the affairs of registered medical schemes as provided in the Act
- ❖ Perform such other functions as may be prescribed.

The new Act gives the Council far more purposeful and consumer-oriented functions, including to:

- ❖ Protect the interests of members at all times
- ❖ Control and co-ordinate the functioning of medical schemes in a manner that is complementary to the national health policy
- ❖ Make necessary recommendations to the Minister
- ❖ Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act
- ❖ Collect and disseminate information about private health care
- ❖ Make rules that are consistent with the provisions of the Act
- ❖ Perform any other functions conferred on the Council by the Minister or by the Act.

The powers of the Council for Medical Schemes have been extended with a defined focus on the protection of the interests of medical scheme members.

Time frame of Medical Schemes Act No 131 of 1998

Became operative on	01 February 1999
Regulations first published on	20 October 1999
Regulations became operative on But Chapters 3, 4 and 8 and Annexures A and B only became operative on	01 November 1999 01 January 2000
Full implementation began on	01 January 2000

Review of Regulations

- ◆ The regulations require the Department of Health together with the Council for Medical Schemes to review the Prescribed Minimum Benefits at least every two years
- ◆ It is thus necessary to monitor the impact, effectiveness and appropriateness of Prescribed Minimum Benefits provisions on a continuous basis.

The reviews should look at:

- ◆ Inconsistencies or flaws in the current regulations
- ◆ The cost-effectiveness of health technologies or interventions
- ◆ Consistency with developments in health policy; and
- ◆ The impact on medical scheme viability and its affordability to members.

Concerns raised with respect to the Prescribed Minimum Benefits package include:

- ◆ The availability of services at public hospitals and public sector waiting lists
- ◆ Problems with billing and fee structures in public hospital facilities
- ◆ The ambit of the Prescribed Minimum Benefits
- ◆ Understanding of clinical treatment protocols and policy issues

- ❖ Additional financial risk to medical schemes as a result of the minimum benefits and how schemes are managing this risk
- ❖ Administrative problems experienced by schemes due to the Minimum Benefits Package.

Consumer Affairs

The new Act allows for complaints by providers of health care services and contractors to medical schemes and medical scheme members. Written complaints should be dealt with as follows:

1. First, register a complaint with the schemes. If not resolved
2. Register it with the Registrar of Medical Schemes, and if still no satisfaction
3. Lodge an appeal to the Council against a decision of the Registrar
4. If still unresolved, an appeal against the Council's decision may be lodged with the Appeal Board constituted in terms of the Act.

Recourse to the justice system through the courts, is also available.

The alternative, faster and cheaper system of dispute resolution created by the Act is most welcomed, especially when considering that Court proceedings are costly, out of the financial reach of the average person and takes time to resolve issues.

More information on the new Act and the Council for Medical Schemes is available on their website at the address www.medicalschemes.com

Occurrence of Undesirable Business Practices

In terms of section 61 of the Act certain business practices may be declared undesirable. The Registrar of Medical Schemes has so far identified the following business practices as undesirable:

- a) The splitting of an employer group by moving low risk members to a new scheme and leaving higher risk members behind
- b) Moving an entire employer group out of one scheme and splitting the group into two or more groups. The groups are then placed with different schemes with higher risk members directed to one scheme and lower risk to another
- c) Encouraging this behaviour by financial incentives, including differential commission structures which discriminate against older members, higher risk members or on any other basis as provided for in terms of section 29(1)(n) of the Act
- d) The Registrar took the view that the effect of these practices was to discriminate against certain schemes and consequently their members and to undermine the principle of community rating.

Reinsurance Issue

Reinsurance involves a second insurer with whom the first/direct insurer, contracts to share in the risks that the direct insurer has assumed on behalf of its members of beneficiaries. It is sound business practice to reinsure a scheme against sudden catastrophic or extraordinary liabilities which the scheme may be unable to meet.

Unfortunately some medical schemes and their administrators have abused reinsurance principles and used it as a way to strip medical schemes of funds.

The Medical Schemes Council's investigations into reinsurance revealed that:

- a) There was a massive increase in the number of new reinsurance contracts used by medical schemes – especially from 1998 to 1999
- b) The total amount paid in reinsurance premium grew from R6 million in 1996 to R700 million in 1999
- c) Sixty percent of open schemes used reinsurance in 1999 compared with a mere 25% of restricted membership schemes
- d) In 13 schemes, the reinsurance losses ranged from 7% of accumulated reserves to over 100%
- e) The five major traditional reinsurers in South Africa had 68% of the market in 1999 by number of contracts
- f) In 1999, 12 % of contracts – representing 94% of reinsurance premium, appeared to have been created expressly for the purpose of removing profit from schemes
- g) Larger schemes do not need reinsurance, but constitute by far the largest participation in reinsurance contracts
- h) Huge commissions were paid to brokers for reinsurance agreements (an estimated R7 million was paid in 1999)
- i) In the life insurance industry commissions are not usually paid at all for reinsurance.

The Council for Medical Schemes and the Registrar of Medical Schemes are currently following up on these matters.

Medical Schemes Contributions

Heavy increases in medical scheme contributions have been predicted since the inception of the new Act. Major changes to the Act affecting the cost structures of medical schemes have been cited as:

- ❖ The wider definition of a “dependant” in the new Act
- ❖ The fact that schemes must pay for a wider range of ailments including AIDS, organ transplants, tuberculosis etc. that were often excluded in the past
- ❖ Payments for the treatment in hospital of any infections or illnesses that are AIDS related
- ❖ Expectations of a 20% to 25% rise in the cost of medicines.

Medical aid contributions saw an average increase of 18% in January 2000 against 7% for the CPI.

The table below shows changes in net contributions between 1996 to 1998.

- ❖ The percentage difference in the net contribution income of medical schemes between 1996 and 1997 was 9%
- ❖ Net contribution income for 1998 was 11.66% more than that in 1997

	1998 (Million)	% Change	1997 (Million)	% Change	1996 (Million)
Net Contribution Income	R17 386.069	11.66%	R15 570.860	9%	R14 323.459
Healthcare Management Expenses	R312.463	116.51%	R144.321	100%	-
Administration costs	R1 459.374	33.48%	R1 093.289	-4%	R 1 138.405

- ◆ Administration expenses increased by almost 33.5% in comparison to a reported 4% *decrease* between the preceding two years which is also disquieting
- ◆ Medical contribution increases are averaging 18%.

These are alarming increases and if there is no reduction in increases to:

- a) health care management expenses, and
- b) administration costs

the system will be unable to fulfil its primary function of funding the costs of health care treatment.

Implementation of the Prescribed Minimum Benefits Package

One of the strategic objectives is to attract paying patients to public sector hospitals. The objective of the Prescribed Minimum Benefits (PMB) is to:

- a) Avoid incidents where individuals lose their medical scheme cover in the event of serious illness and the consequent risk of unfunded utilisation of public hospitals
- b) Encourage improved efficiency in the allocation of private and public health care resources.

Both of these objectives are in keeping with the broader strategy of improving resource mobilisation and the management of resources without neglecting the attainment of equity in resource allocation.

PMB previously not covered by medical schemes are:

- Inpatient psychiatric care for 3 weeks
- Substance abuse and drug rehabilitation
- Attempted suicide
- HIV associated disease: infections and tumours
- Sexually transmitted diseases
- Imminent death: comfort care and pain relief
- Infertility.

- ❖ The provision of minimum benefits by a scheme is obligatory regardless of where the service is received
- ❖ In the private hospital industry, discrimination by medical schemes against HIV/AIDS patients still exists
- ❖ Authorisations for hospitalisation or extensions of inpatient stays are being refused when the possibility of an underlying diagnosis of HIV/AIDS becomes obvious
- ❖ Labour legislation prohibits the testing of employees for HIV/AIDS yet an employer in a restricted membership scheme could have illegitimate access to that information by virtue of its participation on the Board of Trustees of the scheme.

Conclusions

There is a need for the education of all stakeholders including individual members of schemes and providers of health care services such as public and private hospitals, as to their rights and obligations in terms of the Act.

Over the next few years there needs to be:

- ❖ Close monitoring of the mechanisms of the Act
- ❖ Regular assessments of the efficacy and appropriateness of the Minimum Benefits Package in particular
- ❖ Closer communication and co-operation between public and private health sectors, not only at central and provincial government level but also between hospitals and other health facilities at the level of actual health service delivery.