Introduction to the Council For Medical Schemes and the Medical Schemes Act

Namaf Annual Trustee Training
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ABOUT THE CMS

- The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

- There are about 97 medical schemes in South Africa with around 8,679,473 beneficiaries.

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Minister of Health

Council	Registrar
Non-executive chair Deputy Chair 13 Council members	Executive Head and staff

The Council determines overall policy, but day to day decisions and management of staff are the responsibility of the Registrar and the Executive Managers.

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Vision

Promote vibrant and affordable healthcare cover for all.

Mission

The **CMS regulates** the **medical schemes industry** in a fair and transparent manner and achieves this by:

protecting the **public** and informing them about their rights, obligations and other matters, in respect of medical schemes;

- ensuring that **complaints raised by members** of the public are handled appropriately and speedily;
- ensuring that all entities conducting the business of medical schemes, and other regulated entities, **comply with the Medical Schemes Act**;
- ensuring the improved management and **governance** of medical schemes;
- **advising the Minister of Health** of appropriate regulatory and policy interventions that will assist in attaining national health policy objectives; and
- **ensuring collaboration with other entities in executing our regulatory mandate**

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Legislated mandates

The CMS has been established in terms of the Medical Schemes Act, Section 7 of which sets out the following functions for Council, which is the accounting authority or board of the CMS:

- Protect the interests of beneficiaries (of medical schemes) at all times.
- Control and co-ordinate the functioning of medical schemes in a manner that is complementary to national health policy.
- Make recommendations to the Minister of Health on criteria for the measurement of the quality and outcomes of relevant health services provided for by medical schemes and such other services as the Council may from time to time determine.
- Investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act.
- Collect and disseminate information about private healthcare.
- Make rules, not inconsistent with the provisions of this Act, for the purpose of the performance of its functions and the exercise of its powers.
- Advise the Minister of Health on any matter concerning medical schemes.
- Perform any other functions conferred on Council by the Minister of Health or by this Act.

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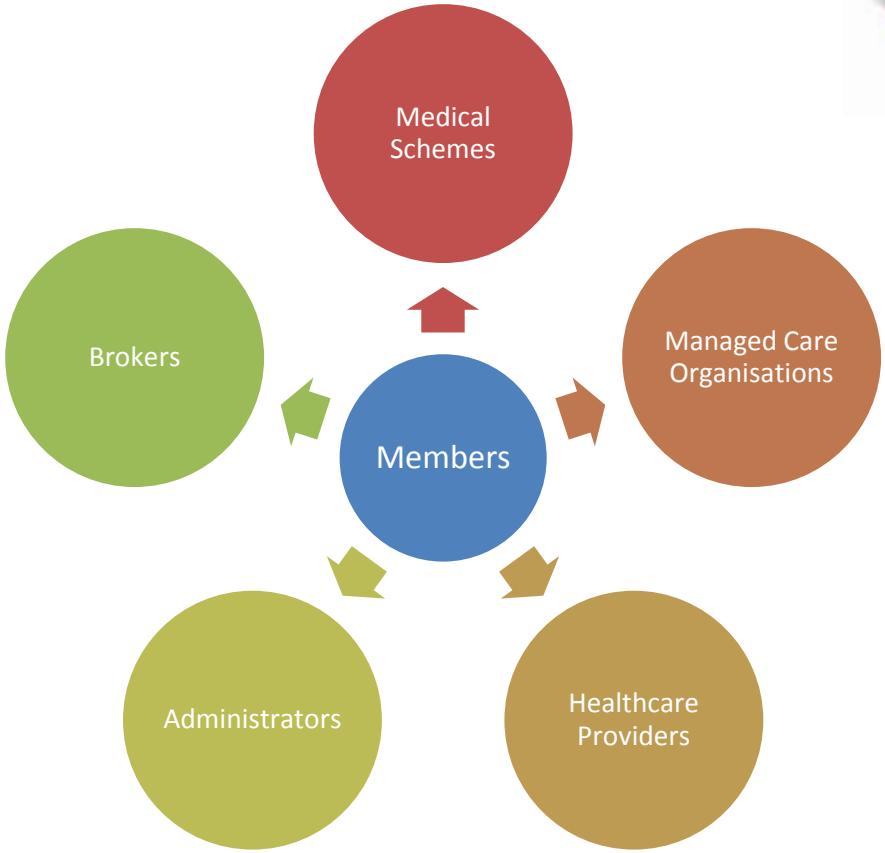
ROLE PLAYERS



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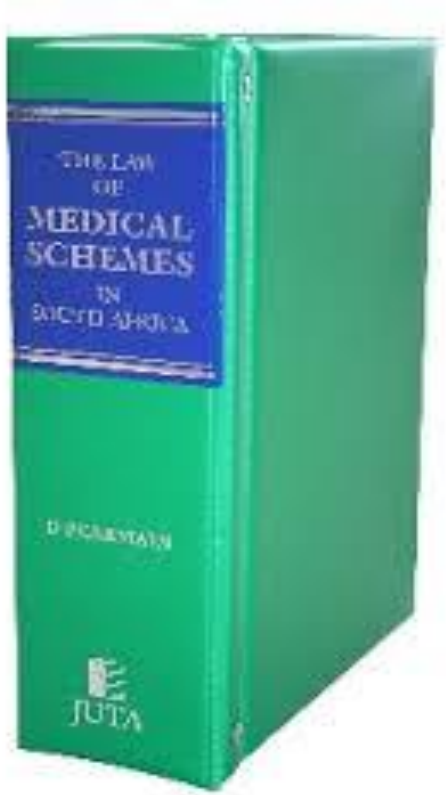
DEVELOPMENT OF THE MEDICAL SCHEMES ACT



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Health insurance evolved in SA over the past number of years:

1st Medical Scheme

Created by De Beers in 1889

1st Medical Schemes Act promulgated in 1967

Legislative reform led to a number of amendments to the MSA and Regulations

MSA 131 of 1998

Implemented to modernize and update the system with a view to ensure fair access to medical schemes.

Schemes were allowed to “cherry pick” low risk profile members.

Contributions were based on age, health status, claims history etc.

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Medical Schemes Act, No. 72 of 1967

- This Act ensured that medical schemes were run on the basis of solidarity principles: it contained defined minimum benefits and required community-rating.

- By 1980 : Too many medical schemes with a consequent inadequate spread of risk - pressure began to build to allow even more flexibility and less regulation

- In 1986 the Browne Commission argued for risk-rating and experience-rating within schemes:
  - Greater flexibility in contribution rate determination should be allowed
  - Charge different contribution rates for different classes of risk
  - Different levels of benefit to be chosen by groups or individuals to satisfy their needs

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Medical Schemes Act, No. 72 of 1967 - Continued

- The stage was set for an application of mutuality principles for the next 11 years

- Member's contributions were based on:
  - number of dependants;
  - income level;
  - age;
  - geographic area;
  - actual claims experience;
  - extent of cover provided;
  - period of membership;
  - size of group to which member belongs

Amendment Act, No. 23 of 1993

- Introduced statutory guaranteed minimum benefits and guaranteed payment for claims were removed from Act
- Schemes would be able to exclude or limit cover for procedures, and risk-rate to a greater extent, but balanced by increasing ability for schemes to directly supply healthcare by owning clinics / hospitals and employing healthcare professionals.
- Benefits declined and the older and sicker membership were excluded from cover to a greater extent
- By the mid-90s no open scheme was permitting anyone older than 55 to join as an individual member
- Virtually all open schemes applied life-time exclusions for pre-existing conditions.
- By 1999 the majority of medical scheme membership was in an environment which excluded vulnerable groups from cover.

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Medical Schemes Act 131 of 1998 PILLARS

Open enrolment

- Any applicant may join an open medical scheme of his/her choice
- No discrimination on arbitrary grounds

Community rating

- Members on the same option pay the same contributions
- Differentiation: number of dependants & income of the main member

Prescribed Minimum Benefits

- Members are protected against unforeseen health events which can have catastrophic financial implications
- Includes DTP's , 25 chronic conditions and emergencies

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Medical Schemes Act 131 of 1998

PILLARS

Waiting periods & Late joiner penalties	• Prevents “scheme hopping” by members • Removes the opportunity for anti-selection against schemes
Improved governance	• Removes historical conflicts of interest embedded in the oversight of medical schemes
Regulation of Intermediaries	• Accreditation of brokers, administrators and managed care organizations
Financial Sustainability	• Minimum solvency level of 25%

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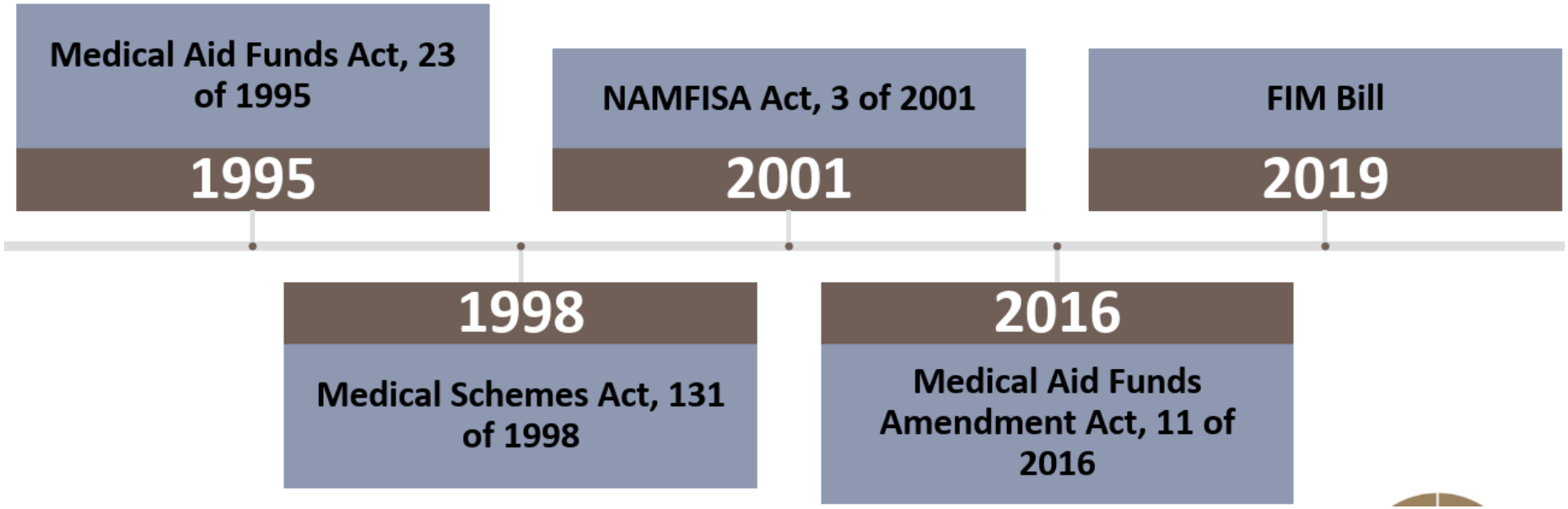
Statutory Development: Namibia



Source: Namibian Association of Medical Aid Funds Presentation at 2019 BHF Conference

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COMPLAINTS & DISPUTES

Dispute Resolution

- Adjudication at scheme level
  - Decisions of schemes/PO's
  - Decisions of scheme's Dispute Committee
- Adjudication at CMS level

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Significant developments over the last decade

2003

- Promulgation of the National Health Act
- Regulations amended to require a minimum solvency level of 25%
- Prescribed Minimum Benefits expanded to include 25 chronic conditions

2004

- Ruling by the Competition Commission prohibits any form of tariff setting between schemes and groups of health care providers
- Single Exit Price (SEP) introduced in an attempt to curb medicine costs

2005

- The Government Employees Medical Scheme (GEMS) comes into existence and becomes the second largest medical scheme. GEMS is a restricted medical scheme.

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2006

- CMS publishes the National Health Reference Price List (NHRPL) as a guideline for healthcare service tariffs
- Deductibles and self-payment gaps were introduced by the industry
- REF pilot project and shadow return process initiated

2010

- High Court ruling renders NHRPL invalid and sets it aside
- High Court dismisses an application brought by the Board of Healthcare Funders (BHF) to pay PMB's at scheme rate instead of in full as per legislation
- A code of conduct is published to address issues surrounding PMB's.

2011

- The Consumer Protection Act (CPA) is promulgated
- The Green Paper on National Health Insurance (NHI) is published and the pilot period of 14 years starts.

2012

- Private healthcare pricing is investigated by the Competition Commission
- Medical deductions are converted into medical tax credits
- Publication of draft regulations on the demarcation between Health Insurance Policies and Medical Schemes by National Treasury

2013 to Present

- Outdated Act: we are currently busy with the drafting and passing of significant amendments to the Medical Schemes Act
- Demarcation between medical schemes and health insurance products
- Governance of medical schemes:
- The affordability challenge and the absence of a Pricing Commission to regulate healthcare costs
- Health Market Inquiry by Competition Commission into the pricing of health care
- Fine tuning of procedure, diagnostic and tariff codes
- Value add evaluation of managed care organizations
- Incomplete system of Social Health Insurance in an environment of NHI initiation
- Requirement for technology driven clinical and actuarial models to protect members
- Inadequate Regulatory funding model- Levy System

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2019 – 2024: Universal Health Coverage

- New Vision (2019-2024): **“Promote affordable and accessible healthcare cover -Towards Universal Health Coverage.”**
- CMS will play an integral supportive role to the National Department of Health in establishing a National Health Insurance (NHI) system in South Africa.
- Some of the current activities where CMS is involved in include:
  - Establishing a National Beneficiary Registry of all funded patients which will link with the NHI Patient Registration System.
  - Establishing a National Coding Authority (ICD10/PCNS)
  - Developing a basic benefit package which will form the foundation of the initial comprehensive healthcare package of the NHI

Thank You

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