Dear Valued Client and Colleague

Please find below a summary of the September 2011 industry news, happenings and regulatory matters for your attention. During the month of September 2011, the main industry discussion points were the publication of the CMS Annual Report for 2010-2011, where we have provided a summary of the key points for your attention, as well as the media attention around investigations into irregularities in the Medical Scheme Industry.

If you have any queries on the matters below, you are most welcome to contact your Business Operations Specialist, Relationship Manager or myself for further discussion or if you require copies of any of the publications, gazettes or CMS publications mentioned below.

1. The Council for Medical Schemes

   • CMS Circular 33 of 2011: Revision of SAICA Guide

   The CMS published Circular 33 of 2011 on the 13 September 2011, wherein the CMS wishes to inform all stakeholders that the SAICA Medical Schemes Accounting Guide (SAICA Guide) for 2011 financial year has been revised. The Guide is published on SAICA’s website.

   • CMS Circular 34 of 2011: Psychologist Scope of Practice

   In the CMS Circular 34 of 2011, which was published on 15 September 2011, the CMS stated that it has become aware that some medical schemes and administrators are rejecting claims from some categories of psychologists based on a scope of practice argument.

   The scope of practice for the psychology discipline is governed by the Health Professions Act and it is consequently only the HPCSA that is entitled to make any pronouncement on the scope of practice for psychologists and other health care professions.

CMS Circular 35 of 2011 was published on 16 September 2011. The CMS requests comments and input on the draft quality and health outcomes framework document.

The framework document serves as a process of consultation where the CMS seeks to obtain input from different stakeholders on the broad framework on quality and health outcomes. It also provides a list of proposed indicators to measure quality and outcomes in the medical schemes environment.

The deadline for the comments on the document is 28 October 2011.

• CMS Circular 36 of 2011: Guidelines on the preparation of Managed Care Agreements

The CMS published Circular 36 of 2011 on the 20 September 2011, which sets out the Guideline for the preparation of Managed Care Agreements in compliance with the Regulatory Requirements.

The Medical Schemes Act and the Regulations thereto provide for the requirements of providing managed care to medical schemes. One of the requirements in respect of managed care arrangements between medical schemes and MCO’s is that there must be a written agreement that regulates the relationship and which must be duly signed by authorised persons from both parties. This includes all amendments thereto.

A comprehensive and properly drafted managed care agreement ensures that both parties are fully aware of their rights and obligations in terms of the agreement. It also assists both parties in the identification and resolution of any disputes with regards to the execution of the agreement.

The guideline sets out the regulatory requirements i.e. Regulations 15A (Prerequisites for managed health care arrangements), 15E (Provision of health services), 15F (Capitation agreements) and 15J (General provision), the managed care accreditation requirements as well as general considerations.

• CMS Circular 37 of 2011: Guidelines on the preparation of Administration Agreements

In the CMS Circular 37 of 2011 dated 20 September 2011, the CMS sets out the Guideline for the preparation of Administration Agreements in compliance with the Regulatory Requirements.

The Medical Schemes Act and the Regulations thereto stipulate the requirements of providing administration services to medical schemes. One of the requirements in respect of administration arrangements between medical schemes and administrators is that there must be a written agreement that regulates the relationship and which must be duly signed by authorised persons from both parties. This includes all amendments thereto.

A comprehensive and properly drafted administration agreement ensures that both parties are fully aware of their rights and obligations in terms of the agreement. It also assists both parties in the identification and resolution of any disputes with regards to the execution of the agreement.

The guideline sets out the regulatory requirements i.e. Regulation 18 (Agreement in respect of administration), the administrator accreditation and other requirements as well as general considerations.

• CMS Press Release 7 of 2011: Medical Scheme investigations

In the CMS Press Release 7 of 2011 dated 23 September 2011, the CMS responded to media reports on investigations into the medical schemes industry.

The CMS and the Registrar have indicated that they welcome the investigation undertaken by the Hawks but wish to clarify certain points in the reports:
The COMMED matter

The former trustees of COMMED asked CMS to investigate COMMED in 2009 because of alleged irregularities in corporate governance. After an inspection was carried out by the CMS no corporate governance irregularities were found except for a contract worth R14.5 million which was awarded to a company called Brandnu. Brandnu was paid the contract sum in full before the contract commenced. COMMED at that stage reported a criminal case to the SAPS. The investigator furnished his inspection report to the CMS in October 2010 which report was handed to the police. The NPA officials have confirmed that they are pursuing the matter.

The Hosmed and Allcare matter

On 5 August 2010 the CMS appointed Ligwa Advisory Services to conduct an investigation into the actions and transactions concluded by the Board of Trustees of Hosmed. A report was handed to the CMS who reported all matters in the Ligwa report to the SAPS which was subsequently referred to the NPA.

- CMS Press Release 8 of 2011: GetMed Medical Scheme Deregistered

The CMS have taken the decision to cancel the registration of GetMed Medical Scheme in terms of the Medical Schemes Act.

GetMed Health Protection Plan started off as a range of benefit options for the sick fund of the Bargaining Council for the Building Industry in Kimberley i.e. GetMed (Pty) Ltd is a company that administers these benefit options on behalf of the Bargaining Council. They then proceeded to market their product all over the country at an attractive price. The Registrar determined that this product clearly fell within the definition of “doing the business of a medical scheme” as defined by the Medical Schemes Act and agreed to conditionally register GetMed Medical Scheme on 17 December 2010 as a medical scheme in order to afford protection to the large quantity of members already managed by GetMed Health Protection Plan.

The following conditions were imposed:
(i) To provide a financial guarantee as required by the Medical Schemes Act for all medical schemes;
(ii) To pay the application fees for the accreditation of the administration and managed care organisations;
(iii) To provide further documentation to the Accreditation Unit of the Office of the Registrar for Medical Schemes based on the initial evaluations done on their administration and managed care organisations; and
(iv) To provide a reinsurance contract for evaluation by the Office of the Registrar.

GetMed Medical Scheme failed to comply with the conditions set out above and the Registrar concluded that GetMed Medical Scheme would not be able to fulfil the conditions of its registration. In the interest of the members of GetMed Medical Scheme specifically and the medical scheme industry in general, the Registrar cancelled Getmed’s registration as a medical scheme.

- CMS publishes 2011 Quarter 1 Report

On the 14 September 2011, the CMS published the CMS Quarterly Report for the period ended 31 March 2011.

Kindly note that this report reflects consolidated industry data only, as data on an individual scheme level has not been audited and could therefore not be made available to the public.

In respect of the monitoring of financial performance and soundness of medical schemes, the report highlights the following important trends:
Accumulated funds and solvency levels
Membership, age distribution and pension ratio
Contributions and relevant healthcare expenditure
Non-health expenses
Operating results
Investments

• **The CMS Annual Report 2010-2011**

The CMS published its Annual Report for the year 2010-2011 on 6 September 2011. The report assesses the work done by the CMS under its broad strategic aims. Below is a summary of the salient points contained within the report.

1. **Monitoring of the Medical Schemes Act and recommendations of improvements**

   i. **Regulatory and policy developments**

      o **Reviewing legislation**
      The Council for Medical Schemes (CMS) continued to interact with the Department of Health and the Ministry on the Medical Schemes Amendment Bill. A comprehensive legislative review process aimed at addressing shortcomings in the Medical Schemes Act.

      o **Regulation 8 and the Board of Healthcare Funders of Southern Africa**
      The Legal Services Unit continued to support the Office of the Registrar and the Council in ensuring that medical schemes properly comply with Regulation 8 of the Medical Schemes Act and pay in full for PMB conditions. The BHF sought to challenge the CMS' position on Regulation 8 in the High Court. The court postponed the matter and it is anticipated that it will be heard during the forthcoming financial year.

      o **Demarcation and top-up or gap cover**
      The Legal Services Unit continued to work with the Compliance Unit in its interventions to prevent insurance products doing the business of a medical scheme from continuing to operate. The Supreme Court of Appeal (SCA) ruling in the Guardrisk case in 2009 saw a prohibition of top-up and gap cover products, and legal steps to curb these products have been taken during the period under review. A number of products have been identified and will be subjected to judicial scrutiny during the forthcoming financial year. The importance of acting against insurance products doing the business of a medical scheme lies in the fact that these products, while eroding the principle of risk cross-subsidisation, are not obliged to provide the protection to policy holders which medical schemes are required to furnish in terms of the Medical Schemes Act.

      o **Consumer Protection Act**
      The advent of the Consumer Protection Act 68 of 2008 (CPA) which became law on 1 April 2011 has far-reaching implications for both consumers and regulatory bodies. As the Medical Schemes Act is consumer orientated and seeks to protect members of medical schemes, a process was embarked upon to analyse the CPA with a view to establishing the extent to which the Medical Schemes Act was aligned with the CPA and to identify those areas where the regulatory framework requires adjusting.
Competition Act

The Competition Act 89 of 1998 makes it incumbent on the Competition Commission to enter into agreements with other regulatory bodies where their jurisdiction and roles overlap.

The respective custodians of the Competition Act and Medical Schemes Act share regulatory oversight where entities which fall within the ambit of the Medical Schemes Act – including schemes, administrators and healthcare brokerages – wish to merge or buy each other out. The CMS are engaged with the Commission to clarify their roles as regulatory bodies.

Evaluating the risk profiles of schemes

The Medical Schemes Act provides for open enrolment, community rating and prescribed minimum benefits (PMBs). These three pillars of the Act control risk-rating to a large extent and protect older and sicker members against discrimination in favour of younger and healthier members of medical schemes.

A system of risk adjustment is an important element required to strengthen these solidarity principles in healthcare, however given the focus on the development of National Health Insurance (NHI) but due to uncertainty surrounding the final details of NHI, a risk adjustment system was never implemented.

Defining PMBs

Following the review of PMB Regulations, which had started in 2008, the CMS submitted draft amendments to PMB Regulations to the Minister of Health. These draft amendments will be published for public comment soon.

Developing a Code of Conduct on PMBs

Subsequent to the release of various Circulars, a workshop was held with the affected parties on 11 May 2010 in Johannesburg’s East Rand.

Parties to this process agreed that it is in the best interest of medical scheme members to proceed with a collaborative approach to find solutions to PMB-related problems; this led to the establishment of a representative task team.

The PMB Task Team prepared a PMB Code of Conduct during June and July 2010 - which is available on their website (www.medicalschemes.com) – addresses appropriate behaviour expected of stakeholders to ensure compliance with existing PMB Regulations made in terms of the Medical Schemes Act 131 of 1998.

National Health Insurance

The Council for Medical Schemes (CMS) believes that access to quality care is the right of every South African.

The strategic reform of the South African health system is being initiated and driven by the Department of Health and the Ministry.

Monitoring ICD-10

The Office of the Registrar continued to monitor the implementation of the International Classification of Diseases – 10th Revision (ICD-10) codes.

Practice Code Numbering System (PCNS)

The CMS monitors on a quarterly basis the key statistical information about all providers registered in the PCNS.
2. Protecting beneficiaries of medical schemes and the public by authorizing the conduct of medical schemes and monitoring their financial performance

i. Status of schemes

- The number of registered medical schemes dropped from 105 in January 2010 to 99 in January 2011 (5.7% decrease);
- The number of open schemes decreased from 30 in the year 2010 to 28 in 2011 (6.7% decrease);
- The 75 restricted schemes falling to 71 in the same period (5.3% decrease).

ii. Amalgamations

The Office of the Registrar dealt with eight proposed amalgamations. Of the eight proposals, seven were ultimately confirmed by the Registrar, namely:

- Discovery Health Medical Scheme (Discovery) and Afrisam SA Medical Scheme amalgamated into Discovery with effect from 1 June 2010.
- Discovery and Umed amalgamated into Discovery with effect from 1 July 2010.
- Momentum Health and Ingwe Health Plan amalgamated into Momentum Health with effect from 1 October 2010.
- Medshield Medical Scheme and Oxygen Medical Scheme amalgamated into Medshield with effect from 1 October 2010.
- Thebemed and Suremed Health amalgamated into Thebemed with effect from 1 October 2010.
- Moremed Medical Scheme and Clicks Group Medical Scheme amalgamated into Moremed with effect from 1 January 2011; the new scheme has been named Horizon Medical Scheme.
- Topmed Medical Scheme and the Built Environment Professional Associations Medical Scheme (B.E.P.Meds) amalgamated into Topmed with effect from 1 January 2011.

The CMS did not confirm the proposed amalgamation between Sizwe Medical Fund and Gen-Health Medical Scheme because of material concerns that the amalgamation would not serve the best interests of the members of the two schemes. Gen-Health was eventually liquidated due to the persistent deterioration of its financial situation; this regulatory intervention ensured that members of the scheme were not faced with financially catastrophic consequences.

iii. Liquidations

Gen-Health Medical Scheme was liquidated on 12 October 2010 after the curator appointed by the High Court failed to bring about the anticipated turnaround of the scheme.

iv. Curatorships

Protea Medical Aid Society was placed under curatorship on 29 October 2010 following an investigation revealing irregularities relating to the running of the scheme.

v. Status of options

The ongoing trend in the consolidation of medical schemes mentioned in the previous Annual Report continued to result in a decrease in the number of benefit options.

- The number of registered benefit options decreased from 332 in January 2010 to 316 in January 2011.
- This represents a drop in the number of benefit options in open schemes from 174 to 171 between 2010 and 2011, and a drop in the number of options in restricted schemes from 158 to 145 during the same period.
vi. Contributions

The average gross contribution increase for all medical schemes in 2011 was 9.2%.

vii. New Medical schemes

One medical scheme was registered in the period under review. Getmed Medical Scheme had submitted its application for registration in the 2009-2010 financial year but was not registered then as there were serious inconsistencies in its application that required it to resubmit certain sections of the application.

Rand Mutual Association (RMA) remains unregistered; further information is needed to complete its motivation for registration.

viii. Assessing the financial performance of schemes

- As at December 2010, the number of registered medical schemes had decreased to 100 from 110 in 2009; there were 27 open schemes and 73 restricted schemes.
- There were 179 registered benefit options in open schemes in 2010 (including 13 that were deregistered during the year) compared to 190 options in 2009; this represents a decrease of 5.8%. In restricted schemes, there were 159 options (including 6 that were deregistered during the year) in 2010 compared to 161 in 2009.
- The total number of beneficiaries increased by 3.1% to 8 315 718.

ix. Age Distribution

- The average age of beneficiaries in restricted schemes was 32.0 years in 2006; this reduced to 29.3 years in 2010.
- The average age of beneficiaries in open schemes was 31.9 years in 2006; this increased to 32.9 years in 2010.

These changes in average age may appear insignificant, but they have huge financial implications for medical schemes. They are the result of GEMS attracting large numbers of young and healthy members at the expense of other schemes.

x. Non-healthcare expenditure

The average increase in total non-health expenditure for all medical schemes in 2011 was 6.0%. This includes administration costs associated with collecting contributions and paying out benefits, printing costs associated with schemes’ brochures and benefit guides, the cost of running call centres and legal costs.

Medical schemes spent R7.8 billion on administration in 2010 – a growth of 4.4% from R7.5 billion in 2009.

xi. Accrediting administrators and managed care organizations

- Administrators
  During the period under review the CMS conducted on-site evaluations of five self-administered medical schemes to assess their conduct and compliance with the accreditation standards for administration.
  There were 16 accredited third-party administrators and eight accredited self-administered medical schemes as at 31 March 2011.

- Managed care organisations
  There were 43 accredited managed care organisations as at 31 March 2011.
2. Medical Schemes

- **Apparent Medical Aid Irregularities**

David Tselapedi, an employee of Allcare Administrator, in September pleaded guilty to fraud in exchange for a 12-year suspended sentence. He is expected to provide evidence which will indict trustees of taking bribes to the detriment of the schemes.

Allcare currently administers four medical schemes - Hosmed, Community Medical (Commed), PG Bison and Malcor - covering 160 000 members.

Tselapedi has admitted providing false invoices between R50 000 - R150 000 to Commed as well as rigging elections, ensuring that Allcare was appointed as administrator.

The CMS are in possession of a forensic report from February 2010, that indicates:

- The Hosmed chairman and a mayor in Mpumalanga, Speed Mashilo, had R100 000 paid into his bank account by a Hosmed broker in order to keep his contract;

- The wife of Hosmed trustee, Joseph Sithole, received a R1-million contract to provide "wellness services" for municipalities. There was however "no evidence of service delivery";

- Allcare MD, Muzi Twala, ran a company called The Printing Hub, which was paid R3.8-million for printing 138 000 brochures for Hosmed members, a figure that was 105 000 more than the total medical aid membership. Investigators indicated furthermore that there was "no evidence of proof of delivery of printed materials";

- Hosmed brokers were paid inflated sums by Allcare, with no evidence of submitted invoices. This included 10 brokers not even registered with the CMS;

- VAT of R3.2-million was paid to brokers who were not even registered as VAT vendors; and,

- Fraudulent invoices under the name of Pamla Banzi were created, so that a sum of R685 680 was paid to a mysterious bank account that did not belong to the company.

Allcare CEO Howard Phillips has dismissed Tselapedi’s claims that Allcare was involved in the rigging of any elections to ensure it was reappointed as Commed's administrator.

- **Sizwe Medical Scheme Principle Officer suspended**

The board of trustees of Sizwe Medical Fund has suspended their principal officer Linda Gabela, who stands accused of alleged fraud and maladministration of the scheme’s funds.

Gabela is replaced by acting principal officer Mel Pohler, pending a disciplinary inquiry. The suspension has come shortly after the fact that the CMS had advised the board that they needed to act on allegations of voter proxy fraud against two board members, Lucille Teegler and Samuel Marcus after the scheme's December 2010 elections. Failure by the board to take action could result in the possible removal of the entire 10-member board.

Sechaba Medical Solutions, the Administrator of Sizwe, have in a completely unrelated matter, suspended its CEO, Thokozani Magwaza, over alleged corporate governance irregularities. Tumie Seani has been appointed acting CEO pending the outcome of an independent investigation.
3. **NHI**

- **NHI Green Paper comment period extended**

  Please find attached the government gazette dated 15 September 2011, whereby the Minister of Health has granted an extension in the period of time for comments to be submitted on the National Health Insurance Green Paper to **30 December 2011**.

Kind Regards

Matthew Dijkstra  
Head of Clinical and Client Management  
MediKredit Integrated Healthcare Solutions (Pty) Limited  
**Direct Number:** +27 11 770 6411  
**Cell Number:** +27 72 230 4490  
**Email:** matthewd@medikredit.co.za