SAMED
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CMS Report - Resource for Reimbursement

Importance for Medical Technology / Medical Device companies

September 2022

Contents

Note: This report not only summarises key elements from the CMS Industry report, 2021, it also draws information from the collated industry excel spreadsheets, and adds information from other sources to contextualise and explain the information presented.

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1. Introduction: medical schemes as social security mechanisms

Medical schemes are entities tasked by legislation to fund healthcare. They are subject to the Medical Schemes Act and the Regulations thereto. The legislation in 1998 constituted a break from the insurance-type cover, where insurers are more or less free to determine what they would cover, and at what premium. It was also in the past permissible to build in health-risk, and health behaviour into premiums and what was covered. This all changed in 1998, when the Medical Schemes Act become more akin social security mechanisms.

Social security law is different to insurance law. Social security provides a safety net, funded by the collective ("society", hence "social"), in order to prevent instances of social exclusion. Social exclusion is where persons may be driven to poverty, or severe financial distress, due to the risk of ill health materialising. In this regard, then, the collective agrees to fund the costs of such events, so that the individual would not face the negative implications. It is therefore possible to, as an individual or a family, to "get out more" than one has "put in". The Medical Schemes Act therefore gives effect to the social security principle of contributing according to means, but receiving benefits according to health needs.

A further important element is that medical schemes are not for profit entities, whereas insurance companies are for profit. Medical schemes administrators are, however, for profit, and managed care entities, where they are separate businesses in separate legal entities. Managed care functions can also be undertaken by a medical scheme, or by an administrator. All such programmes are, however, also subject to medical schemes legislation.

2. Council for Medical Schemes

2.1. The Council

The Council for Medical Schemes (CMS) is a statutory body created by the Medical Schemes Act. Its function is, first and foremost, to "*protect the interests of the beneficiaries at all times*".[i] It then has the power to:[ii]

- control and coordinate the functioning of medical schemes
- in a manner that is complementary with the national health policy
- make recommendations to the Minister on criteria for the measurement of quality and outcomes

- investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act. This it does in accordance with sections 47 – 50, which deals with complaints and appeals. Any person or entity, including medical device suppliers and providers, can use these processes to ensure fairness in reimbursement, DSPs, etc. and compliance with, for example, the managed care provisions in the Medical Schemes regulations.

The CMS also has powers to exempt entities from complying with any provision in the medical schemes' legislative framework. For example, it can exempt a scheme, or an option on a Scheme, from having to comply with the PMBs, or it can **exempt insurance products** from having to abide by most parts of the Act (e.g. from section 20, that regulates the "business of a medical scheme").

The CMS's most prominent power is to "*approve the registration, suspension, and cancellation of registration, of medical schemes or a benefit option*".

The Council comprises persons appointed by the Minister, who also appoints the chairperson. They are appointed for a period of three years and can be reappointed once. The current Council comprises the following persons:

- Dr Memela Makiwane (clinical pharmacologist)
- Dr Aquina Thulare (Technical Advisor on NHI to the National Department of Health);
- Ms Diane R. Terblanche (a consumer law expert who also formed part of the manufacturer / wholesaler issue before the Competition Appeal Court in 2000);
- Dr Hlupheka H. Mukhari (a General Practitioner ("GP") from Limpopo, who also works for the Foundation for Professional Development (FPD));
- Mr Imran Vanker (the Director of Standards at the Independent Regulatory Board for Auditors);
- Dr. Leavit T. Mkansi (who was a Magistrate in the Free State and has an LL.D degree)
- Mr Lusani Mulaudzi (an actually and independent Director at Bidvest Life);
- Mr Mabalane G. Mfundisi (CEO of an HIV Awareness Organisation);
- Mr Moerane M. Maimane (owner of Mogotlhong Human Capital);
- Mr Naheem Raheman (lawyer);
- Dr Nombeko P. Mbava (chairperson of the Financial and Fiscal Commission (a constitutional organisation making recommendations to Parliament on the allocation of budgets in the public sector))
- Adv Rodger T. Mareume (a lawyer who works for the National Prosecuting Authority – NPA);
- Dr Sugendra L. Naidoo (a GP from Cape Town);
- Dr Thandi S. Mabeba (a GP from Bronkhorstspruit);
- Dr Xolani Khayelihle Ngobese (an accountant and CEO of XQL Management Consulting).

The Council organises itself into the Committees, the most well-known being the Council's Executive Committee and the Appeals Committee. The **Appeals Committee** hears appeals from persons, organisations or schemes not satisfied with the CMS Complaints process's outcomes, or people who are unhappy with decisions by the registrar (e.g. the accreditation of a managed care organisation, the approval (or non-approval of scheme rules, etc.). Its current 7 members are: Ms Diane Terblanche*, Dr Thandi Mabeba, Dr Sugendra Naidoo, Dr Leavit Mkansi*, Adv. Roger Mareume* and Dr Honours Mukhari. The Appeals Committee must be chaired by a lawyer (denoted with an *).

The Council also has an Executive Committee (EXCO) of 5 members, responsible for the day-to-day tasks of the Council. Other Committees are: the Human Resource, Social and Ethics Committee (HRSE), the Audit and Risk Committee, the Information Communications & Technology Strategic Committee and the Nominations Committee (NomCom).

2.2. Day to day operations of the Council

The day-to-day operations of the CMS takes place by the Registrar (with specific powers in Act) & CEO. The various units are:

- Office of the Chief Executive & Registrar: Dr Sipho Kabane, which includes the Council Secretariat under Mr Mvulo
- Chief Financial Officer
- Chief Information Officer
- Corporate Services, which also includes human resources, communication and legal services (Mr John Letsoalo)
- **Regulation** (Mr Mfana Maswanganyi) which includes:
    - Accreditation (Ms Hannelie Cornelius);
    - Benefits, which approves changes to contributions and benefits, as well as compliance with the Act (under Mr Leboho (acting));
    - Compliance and investigations, which reviews and investigates possible transgressions of the Act, including **enforcement of CMS rulings**;
    - Financial Supervision (Ms Scheepers).
- Member protection, which includes:
    - The Clinical Unit, responsible for the **Review of the PMBs, clarification of PMB entitlements**, etc. under Dr Toko Potelwa;
    - **Complaints Adjudication**, under Ms Mumsy Mashilo (acting);
    - Education and Training;
    - Customer Care.

- Policy, research and monitoring (Mr Michael Willie) areas of **utilisation of health care services** in the private sector and development of a process for measuring **quality and outcomes** in the private health care sector, amongst others. They also publish research reports on various medical scheme issues, such as co-payments, for example.

Benefit and reimbursements effectively fall under Ms Mumsy Mashilo & Mr Khayalethu Mvulo (who is also the secretary of the Council, and therefore of the CMS Appeals Committee). The Council relies on a Clinical Review Committee ("CRC") under Dr Potelwa, which advises various business units on the clinical aspects that may crop up in complaints, accreditations, benefit approvals, etc.

There is a whole chapter in the Medical Schemes Act on the powers of the Registrar (chapter 9). **Section 43** is relevant in that it can be used to **trigger investigations into "any matter"** relating to a medical scheme. It has been used to ensure investigations into for example issues with exclusive DSP agreements, global fees or managed care agreements or accreditations. Section 16 also provides the Council with the power to refer the conduct of any person under a statutory council, e.g. a doctor or a nurse, the respectively the HPCSA and the SA Nursing Council.

3. Annual Report / Industry Report

In the past the CMS released a single report, called the Annual Report. It did not only contain, as all statutory bodies have to, its own report on performance, but also the performance of the medical schemes industry. From 2021, this report was split in two, now named the "Annual Report" and the "Industry Report". It contains information of the previous benefit year (i.e. the 2021 Report relates to the 2020 benefit year), and the graphs would include mostly data for that year (i.e. 2020), compared to the previous year (i.e. 2019) where industry data is concerned. The CMS also releases a comprehensive spreadsheet from which it draws the data in the Report, which contains the information that schemes must, by law, submit to the CMS on a quarterly basis.

The Reports are usually released from September onwards.

4. Industry Report: overall picture of schemes

The **number of medical schemes have about halved from 2000 to 2020**, from 144 to 76. The importance of large numbers to remain viable is evident from the data on the size of schemes that have declined, with smaller schemes making up the bulk of "disappearing" schemes up until 2018.

In contrast, **scheme options have increased**. During the Health Market Inquiry (2014 – 2019) ("HMI"), medical schemes argued that the increased number of options are in response to patient demand, and that it increased competition. Patients, however made presentations to the HMI that they found the options and their rules confusing. The HMI found that schemes were designing options to attract younger and healthier members,[iii] especially as risk-rating is prohibited by the Medical Schemes Act. The HMI also found that the options are incomparable,[iv] and suggested a standardised core benefit package.[v] Open scheme options have increased from an average 4.98 options per scheme in 2002, to 6.5 in 2020. Closed schemes had, in 2020 2.39 options, up from 1.76 in 2002.

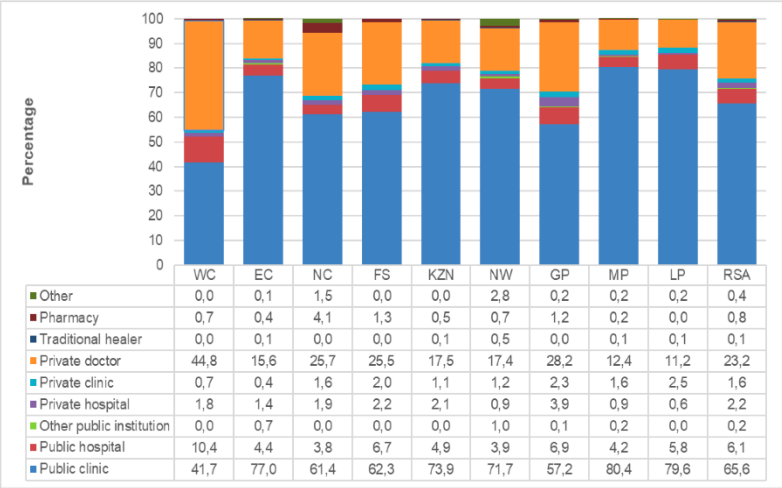
Medical scheme **membership declined from 2019 to 2020**. Only 4.02 million persons were principal members of schemes in 2020, with another 4.87 million dependents. This means that, of the South African labour force of around 23 million persons of which about 15.5m persons are employed (as at June 2022),[vi] **about a third of employed persons belong to medical schemes**. It must be born in mind that there are also collective bargaining health insurance mechanisms, which fall under the Labour Relations Act, 1995. These health cover instruments are generally not recorded in any analyses of the health sector. The Collective bargaining schemes generally offer primary care to employees, and are funded by employers (and in some cases some employee contributions). There are 10 schemes with fewer than the minimum total membership (6000) for viability. A further 13 schemes have less than 10 000 beneficiaries.

Restricted schemes have a higher average dependency ration, at 1.4, whilst open schemes have 1.07, bringing persons covered by medical schemes in total to **8.89 million**.

Mandatory membership for the employed, and scheme amalgamations have been on the regulatory cards for many years, but have never been implemented.

The age distribution of membership is also noteworthy. The Industry Report notes that there is a decreasing slope between ages 5 – 9 years and 20 – 24 years, and the trend is consistent throughout the years.[vii] Part of the unimplemented policy reforms noted by the HMI, is the lack of mandating membership. This means that younger, employed persons do not belong to medical schemes, thereby depriving schemes of vitally important internal risk-cross subsidisation. The average age of 35.3 years in open schemes was higher than the industry average of 33.4 years in 2020, while restricted schemes had a lower average age of 31.2 years.

Medical scheme membership remains low for the overall population, at around 16% (or, as set out above, 30% of the employed population). This differs from province to province, with 39% of the Gauteng population covered by medical schemes, 16% of the Western Cape - and 15% of Kwa-Zulu Natal. The Northern Cape only has a 2% coverage, with other provinces between 4% and 7% of their populations.



	WC	EC	NC	FS	KZN	NW	GP	MP	LP	RSA
Other	0,0	0,1	1,5	0,0	0,0	2,8	0,2	0,2	0,2	0,4
Pharmacy	0,7	0,4	4,1	1,3	0,5	0,7	1,2	0,2	0,0	0,8
Traditional healer	0,0	0,1	0,0	0,0	0,1	0,5	0,0	0,1	0,1	0,1
Private doctor	44,8	15,6	25,7	25,5	17,5	17,4	28,2	12,4	11,2	23,2
Private clinic	0,7	0,4	1,6	2,0	1,1	1,2	2,3	1,6	2,5	1,6
Private hospital	1,8	1,4	1,9	2,2	2,1	0,9	3,9	0,9	0,6	2,2
Other public institution	0,0	0,7	0,0	0,0	0,0	1,0	0,1	0,2	0,0	0,2
Public hospital	10,4	4,4	3,8	6,7	4,9	3,9	6,9	4,2	5,8	6,1
Public clinic	41,7	77,0	61,4	62,3	73,9	71,7	57,2	80,4	79,6	65,6

According to the 2022 SA Household Survey,[viii] a person in **23.2% of households visited a private doctor**, 2.2% a private hospital and 1.6% a private clinic. The state that the public sector services 84% of the population by simply deducting medical scheme membership from the total population, is therefore not accurate. There is therefore, a large, uninsured population that currently do use the private sector, but without the benefit of risk pooling (social insurance). It is for this reason that the BHF is reported to take the CMS to court for its failure to allow the implementation of **low-cost benefit options**, whilst permitting insurance companies to offer insurance products to lower-income households.

5. Health profile of beneficiaries

Hypertension, hyperlipidaemia and diabetes mellitus type 2 remain the most prevalent conditions on the CDL of medical schemes. Annexure F of the CMS Industry Report annexures list each of the 26 chronic conditions' prevalence per age group per 1 000 beneficiaries. This is depicted as per

entry and verification (E & V) criteria, as well as prevalence according to claims (at least one claim for that condition in the benefit year) and prevalence on disease management programmes:

PREVALENCE PER 1 000 BENEFICIARIES	E&V[ix]	AT LEAST 1 CLAIM / ANNUM	DISEASE MANAGEMENT
Addison's disease	0.08	0.22	0.17
Asthma	17.81	57.25	41.57
Bipolar mood disorder	5.11	14.15	11.47
Bronchiectasis	0.20	0.87	0.45
Cardiac heart failure	-	10.81	6.29
Cardiomyopathy	7.21	7.05	5.12
Chronic obstructive pulmonary disease	1.97	5.79	2.98
Chronic renal disease	1.15	5.63	2.52
Coronary artery disease	9.25	26.76	18.59
Crohn's disease	0.26	0.91	0.65
Diabetes insipidus	0.03	0.18	0.10
Diabetes mellitus Type 1	2.05	11.58	4.76
Diabetes mellitus Type 2	38.42	77.81	57.64
Dysrhythmias	4.75	10.82	8.13
Epilepsy	5.14	15.14	10.39
Glaucoma	4.26	11.71	8.73
Haemophilia	0.02	0.07	0.06
HIV/AIDS	36.56	63.57	47.67
Hyperlipidaemia	45.66	110.93	89.08
Hypertension	104.84	303.00	156.84
Hypothyroidism	19.06	34.81	27.56
Multiple sclerosis	0.27	0.63	0.47
Parkinson's disease	1.02	2.11	1.72
Rheumatoid arthritis	3.90	10.97	7.48
Schizophrenia	0.57	1.46	1.07
Systemic Lupus Erythematosus	0.67	1.92	1.38
Ulcerative colitis	0.51	2.16	1.23

The CMS also collects some prevalence data on other conditions, based on the extent of claims received. This does give an idea as to the extent of conditions in the total medical scheme population. Due to Covid-19, both the 2019 and 2020 data[x] is depicted below:

	2019	2020
Cancer		
Number of beneficiaries with cervical cancer (per 1 000 female beneficiaries)	4.29	3.38
Number of beneficiaries with colon cancer (per 1 000 beneficiaries)	1.81	1.60
Number of beneficiaries with liver cancer (per 1 000 beneficiaries)	0.21	0.25
Number of beneficiaries with lung cancer (per 1 000 beneficiaries)	0.93	0.86
Number of beneficiaries with prostate cancer (per 1 000 male beneficiaries aged 40 years and older)	27.81	26.83
Number of beneficiaries with breast cancer (per 1 000 female beneficiaries)	16.04	14.29
Number of women aged 30 -49 years screened for cervical cancer (per 1 000 female beneficiaries aged 30 to 49	82.31	64.70
Ophthalmology		
Number of beneficiaries who received cataract surgery (per 1 000 beneficiaries)	10.42	9.00
HIV, TB		

Number of HIV negative beneficiaries issued with Post Exposure Prophylaxis (PEP) following Occupational Exposure (per 1 000 beneficiaries)	24.19	24.60
Number of HIV negative beneficiaries issued with Post Exposure Prophylaxis (PEP) following Sexual Assault (per 1 000 beneficiaries)	17.67	18.14
Number of TB patients with test results for isoniazid and rifampicin drug susceptibility (per 1 000 beneficiaries with a confirmed TB diagnosis)	422.99	491.65
Number of unique beneficiaries with confirmed TB diagnosis (per 1 000 beneficiaries)	0.85	0.64
Number of unique beneficiaries on first line TB treatment (per 1 000 beneficiaries with a confirmed TB diagnosis)	675.88	765.98
Number of unique beneficiaries tested for HIV (per 1 000 beneficiaries)	37.51	32.00
Immunisation		
Number of beneficiaries with influenza vaccine (per 1 000 beneficiaries)	51.53	46.08
Number of children (0 years and older) who received OPV (Oral Polio Vaccine) vaccine (per 1 000 beneficiaries aged under 15 years)	3.50	3.46
Number of children (0-1 year) who received BCG (Bacillus Calmette-Gurein) vaccine (per 1 000 beneficiaries aged under 1 years)	2.12	1.58
Number of children (1-15 years) who received Hepatitis A vaccine (per 1 000 beneficiaries aged under 15 years)	0.58	0.64
Number of children (14-24 weeks) who received Rotavirus vaccine (per 1 000 beneficiaries aged under 1 years)	41.85	48.38
Number of children (1year and older) who received MMR (Measles,Mumps and Rubella) vaccine (per 1 000 beneficiaries aged under 15)	21.11	22.83
Number of children (6 - 18 weeks) who received Quadrivalent vaccine (per 1 000 beneficiaries aged under 1 years)	23.11	26.41
Number of children (6 weeks - 9 weeks) who received first Dtap (Diptheria, Tetanus, pertussis) vaccine (per 1 000 beneficiaries aged under 1 years)	0.64	0.53
Number of children (6 weeks- 5 years) who received PCV (Pneumoccocal Conjugate Vaccine) vaccine (per 1 000 beneficiaries aged under 5 years)	48.34	52.18
Number of children (6 weeks) who received Rotavirus vaccine (per 1 000 beneficiaries aged under 1 years)	50.83	56.61
Number of children (9 months and older) who received chickenbox vaccine (per 1 000 beneficiaries aged under 15 years)	13.54	13.28
Number of children (9 months and older) who received Measles vaccine (per 1 000 beneficiaries aged under 15 years)	1.95	1.33
Women's health & contraception		
Number of pap smears paid for (per 1 000 female beneficiaries aged 15-69 years)	124.31	99.62
Number of women using contraceptives (per 1 000 female beneficiaries aged 15-49 years)	209.54	203.73
Intra Uterine Contraceptive Device (IUCD) inserted into a woman aged 15-49 years (per 1 000 female beneficiaries aged 15-49 years)	10.54	9.43
Subdermal contraceptive implant inserted just under the skin of a woman aged 15-49 years upper arm (per 1 000 female beneficiaries aged 15-49 years)	0.18	0.22
Mental health		
Number of beneficiaries with depression (per 1 000 beneficiaries)	90.39	87.84
Number of beneficiaries with psychosis (per 1 000 beneficiaries)	6.58	6.33

It must be noted that the above data also reflects benefits provided by schemes. Preventative and screening care are often not funded, as it is not part of the PMBs, and/or not part of other scheme benefits.

The CMS also collects general data on surgeries (day admissions, overnight etc.), but no diagnostic data is provided, which makes deductions on the types of procedures, and therefore possible prevalence, difficult. The Industry Report also contains the top 20 PMB DTPs – Diagnosis and Treatment Pairs in terms of expenditure, i.e. the most expensive conditions to fund per average beneficiary per year, and it includes:

1. Default emergency
2. Pregnancy
3. Major affective disorders
4. Covid-19
5. Acute and subacute ischemic heart disease; including myocardial infarction and unstable angina
6. Metastatic infections; septiceamia
7. Closed fractures/ dislocations of limb bones/epiphyses
8. Respiratory conditions of the newborn
9. Bacterial; viral; fungal pneumonia
10. Cataract; aphakia
11. Cancer of breast – treatable
12. Cancer of the gastro-intestinal tract; including oesophagus; stomach; bowel; rectum; anus – treatable
13. End-stage renal disease regardless of cause
14. Adult respiratory distress syndrome; inhalation and aspiration pneumonias
15. Stroke (due to hemorrhage; or ischaemia)
16. Life-threatening cardiac arrhythmias
17. Respiratory failure; regardless of cause
18. Spinal cord compression; ischaemia or degenerative disease NOS
19. Non-inflammatory disorders and benign neoplasms of ovary; fallopian tubes and uterus
20. Obstruction of the urogenital tract; regardless of cause

The nr 1 DTP, namely default emergencies, has a price tag of R5.8 billion, with cataracts at R1.8 billion, and the cancers between R1.62- and R1.75 billion. Given the number of, for example, breast cancer patients listed above, the cost per breast cancer patient could be calculated. The same with depression.

If the CMS were to collect more details on both prevalence and cost, it would also be possible to make more informed proposals on risk-sharing- and alternative reimbursement models for specific conditions and the treatment thereof.

From some of the utilization data, medical scheme prevalence can also be estimated. The Industry Report categorises this information underutilization of medical technology, denoting conditions for which medical devices (as defined in the Medicines and Related Substances Act, 1965) are frequently used:

Certain technologies: per 1 000 beneficiaries[xi]		% of medical scheme beneficiaries
Dialysis patients	12.60	1.26%
Patients utilisingangiograms	1.37	0.14%
Patients utilising bone density scans	4.22	0.42%
Patients utilisingcomputerized tomography scan (CT scan)	40.70	4.07%
Patients utilising magnetic resonance imaging(MRI) scans	23.60	2.36%
Patients utilising positron emission tomography(PET) scan	0.59	0.06%

6. Utilisation data

The Industry Report 2021 records the following utilisation data: the average cost per visit and the average portion paid by schemes:[xii]

2020	Total number of visits	Average number of visits per patient	Amount claimed per patient	Amount paid by scheme (risk and savings)
GP visits	6 579 624	3.05	R498.71	R459.11
Dentist visits	1 726 443	1.74	R1 439.82	R1 209.89
Medical specialists	2 784 838	3.43	R1 518.82	R1 270.91
Surgical specialists	1 681 372	1.93	R3 551.39	R3 021.03
"Support specialists"[xiii]	6 970 702	2.19	R1 635.01	R1 513.48
"Supplementary and allied" visits[xiv]	4 145 854	3.07	R1 234.25	R1 112.05

In terms of hospitalization use, per 1 000 beneficiaries, the following data is recorded per level of acuity (LOA):[xv]

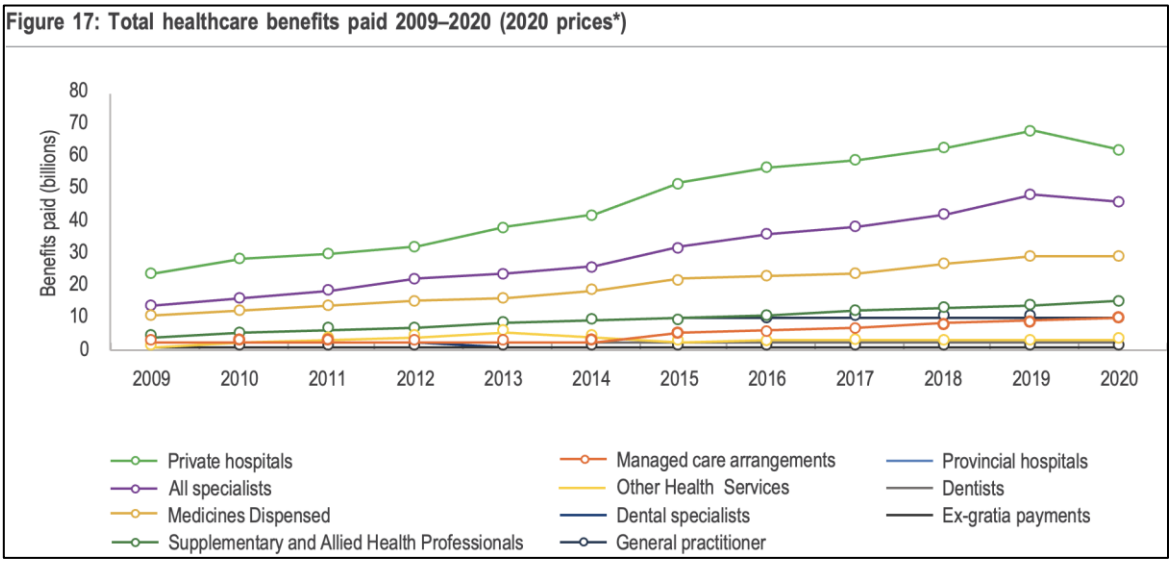
2020 (per 1 000)	General ward	High Care	ICU	PMB
Number of admissions	131.83	22.21	11.06	57.96
Average Length of Stay (LOS)	3.66	3.51	5.34	

This information is important for suppliers and providers in showing cost savings if treatment options avoid stays in ICU and High Care.

7. Benefits paid (claims data)

Perhaps the most well-known figure of the CMS Reports is the one depicting overall benefits paid by schemes in total per year, adjusted for inflation. Not surprisingly, and due to the impact of Covid-19 and lockdowns in 2020, expenditure on private hospitals decreased by 8.83% in 2020. Private hospital benefits made up, on average, 36.7% of benefits for the period 2009 to 2020:

Figure 17: Total healthcare benefits paid 2009–2020 (2020 prices*)

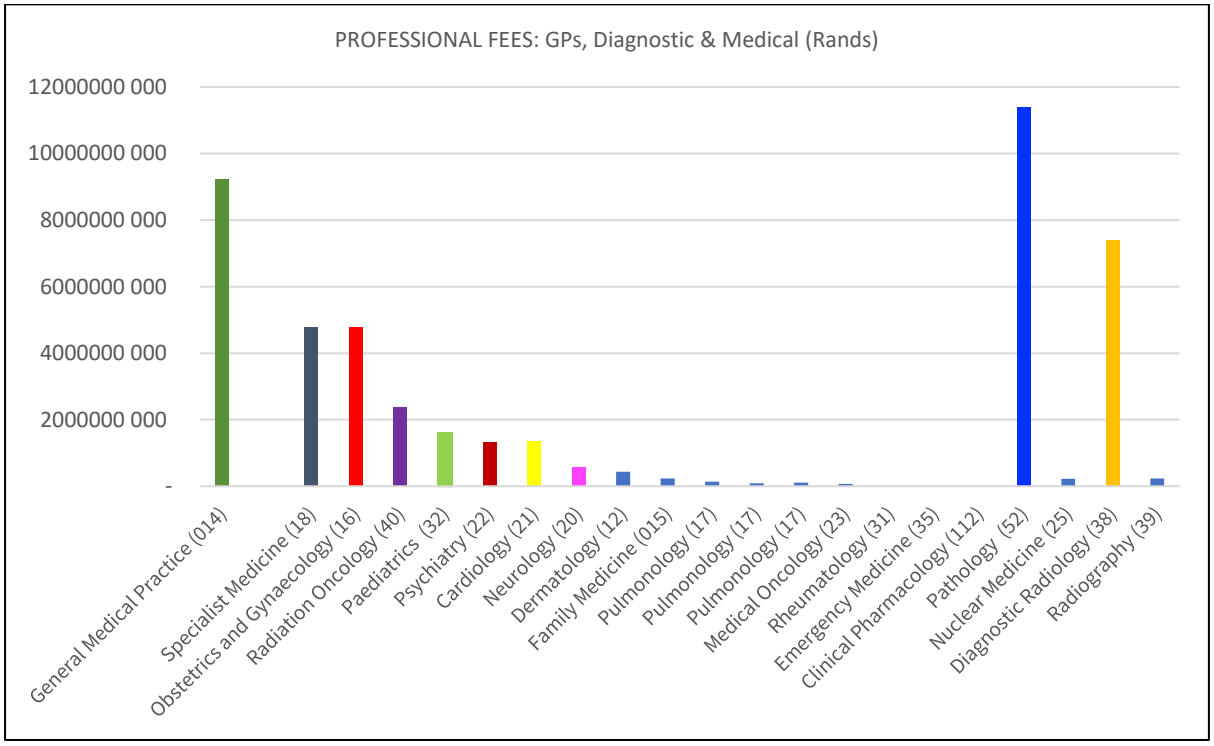


More revealing, and allowing for comparisons with the public sector, is the **spend per beneficiary** (i.e. per patient covered by a medical scheme). The total expenditure per average beneficiary per year in 2020 was at **R19 080.79** (i.e. R7 655 (Hospitals) + R5 157 (specialists) + … etc.). The **public sector** is reported to have spent some **R4 480** per capita per annum, on healthcare, in 2018/2019.[xvi] There are also portions of health care that are funded by the Compensation Fund (for occupational injuries and – disease) and the Road Accident Fund.

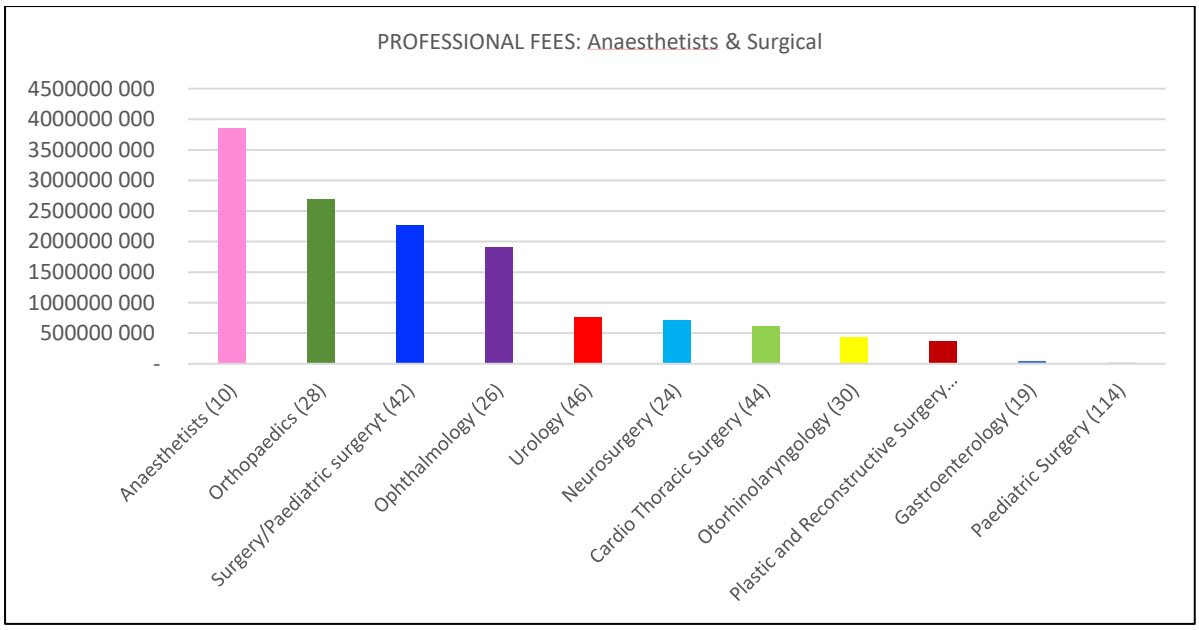
It must be noted in relation to hospitals and specialists, that such expenditure is a function of what is included in the Prescribed Minimum Benefits (PMBs) as mandatory to fund by all schemes on all options. The PMBs was intended to ensure coverage, in line with social security principles, of expenditure that an individual or household could not cover on their own, and for which the risk has to be shared with a larger risk pool.

The Industry Report also shows that hospitalisation is still, largely, funded on a fee for service basis (R62.69 billion), with alternative reimbursement models (fixed fees, global fees and per diems) at R20.42 billion.

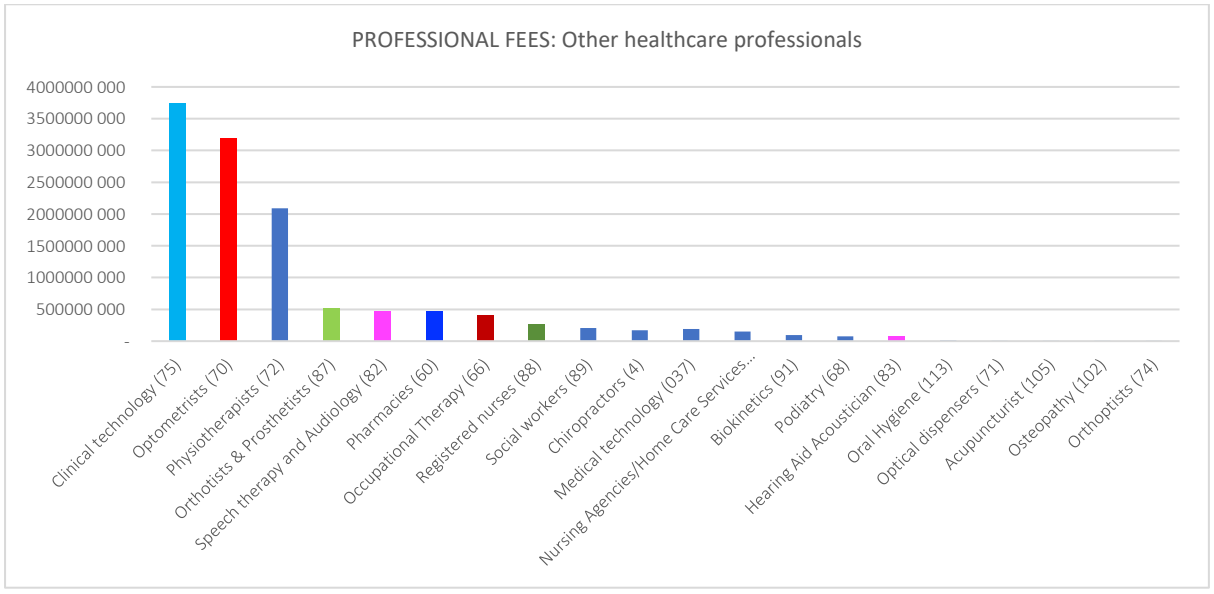
Unpacking the various bigger expenditure items require analysis of the Annexures[xvii] which accompany the Industry Report, the following details emerge:



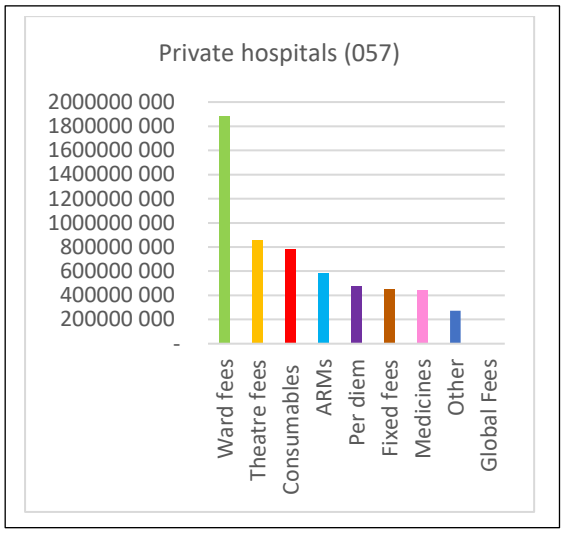
In some cases, medical devices and equipment used form part of the professional fees, in the form of hire fees, rentals, and use fees. The same applies to hospital equipment, which may be included in a hospital bill, or even "hidden" in a single line global fee bill.

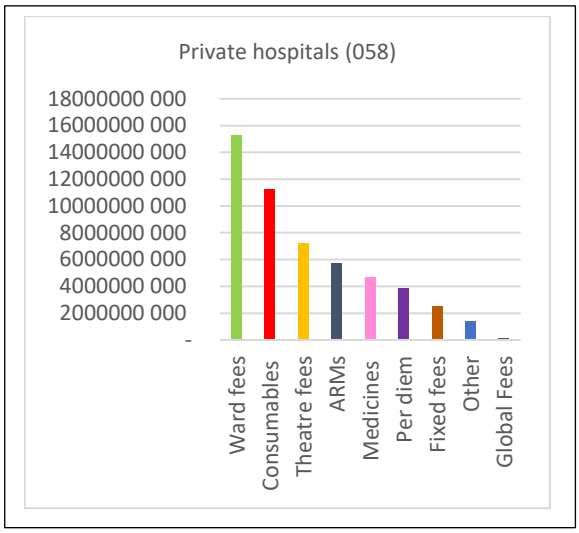


What the CMS calls "allied and supplementary healthcare professionals", include mostly healthcare professionals registered under the Health Professions Act (e.g. clinical technologists, speech therapists, etc.) and not the Allied Health Professions Act (e.g. acupuncturists). Some of these professionals' professional fees billed to funders include medical devices and equipment, such as audiologists, optometrists, orthotists & prosthetists, of which the professional fees are sometimes included only as a mark-up on the devices.



There is also an interesting difference in expenditure ratios between acute hospitals code 57 (category A, under a 100 beds) and code 58 (over a 100 beds) in terms of theatre fees and consumables, and medicines, for example:

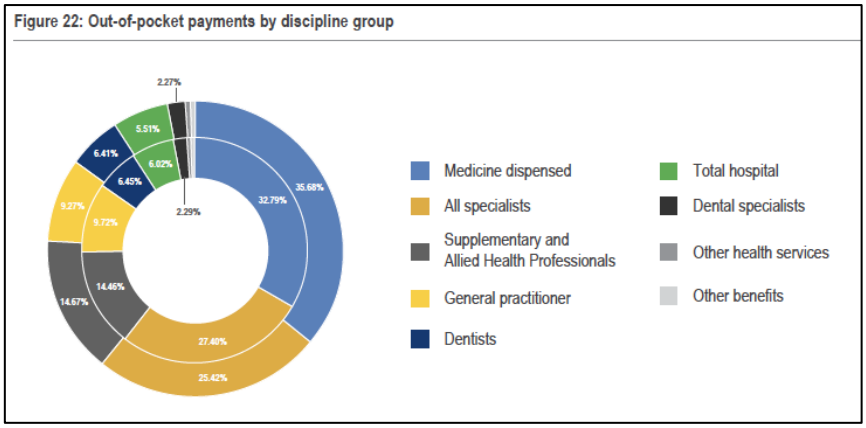




The CMS regrettably do not collect, or require information on DSPs – designated service providers. DSPs could apply to the supply of services for PMB conditions (health care professionals and/or hospitals) (regulation 8 of the Medical Schemes Regulations, 1999), but some schemes also appoint product suppliers (medical device / medical technology companies) as DSPs. For non-PMBs, preferred providers and suppliers could be appointed under the managed care regulations (Chapter 5 of the Medical Schemes Regulations), and could be recorded as part of the per diems, fixed fees, etc. A DSP agreement could also include such arrangements. This is however not reflected in the CMS report as such.

8. Out of Pocket- and savings account expenditure

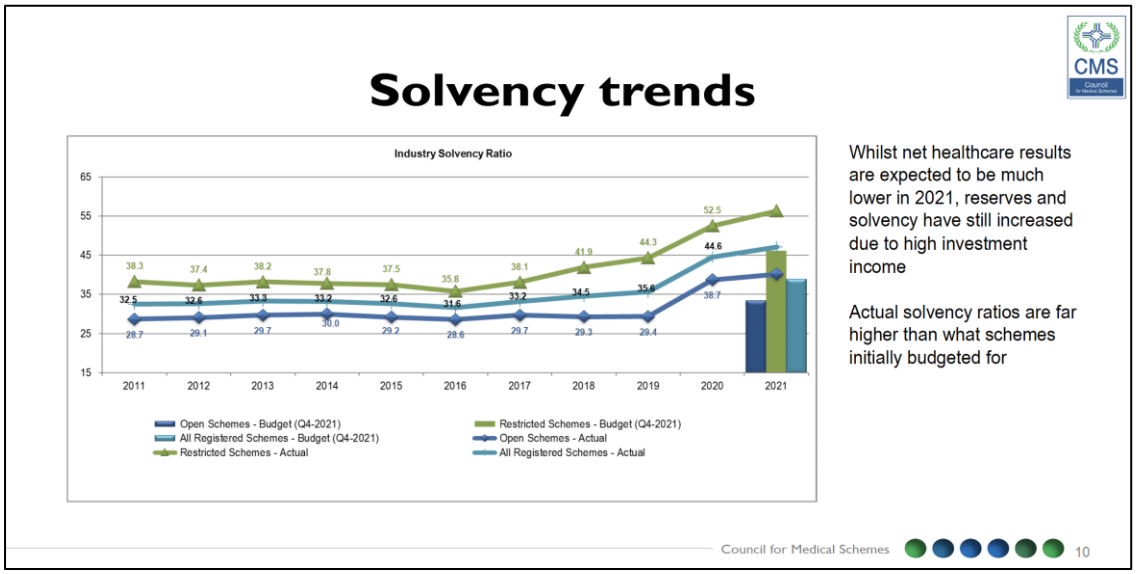
A further important calculation in the CMS Report is that relating to out-of-pocket expenditure. The inner circle depicts the proportions of 2019, versus 2020 (outer circle). Out of pocket expenditure is, proportionally, higher for medicines and specialists, than for hospitals. This may be a function of the claims processes, and possibly contracts between hospitals and medical schemes, rather than whether a patient's condition is a PMB or not.



In May 2022, the CMS released a report[xviii] on what was termed the erroneous payment of PMB claims from savings. The CMS noted "a consistent error where schemes continue to fund the treatment of PMB conditions from Personal Medical Savings Account (PMSA). It is engaging with the affected schemes to deal with possibly incorrectly funded PMBs from the PMSA, to the estimated value of R470 million."

9. Scheme solvency

Scheme solvency in 2020 were at 44.55% - the statutory requirement being 25%. The CMS noted in the Industry Report that all medical schemes incurred a surplus of R24.85 billion compared with R7.08 billion in 2019, representing an increase of 251.15%. The net assets increased by 33.60% from R73.29 billion in 2019 to a reported R97.92 billion in 2020. It was however concerned that "some of these medical schemes fall below the 25.0% solvency target yet exhibit high levels of non-healthcare expenditure. This is an area that needs to be continually assessed and reviewed to ensure efficiencies."



The CMS reported at the Principal Officer's Forum on 17 May 2022, that solvency have increased. This trend started in 2017, and seems set to continue:

10. Non-healthcare costs

Administration and co-administration fees paid to third-party administrators were the main component of Gross Administration Expenditure. Gross administration fees include administration fees, co-administration fees, and other indirect fees paid to the administrator.

Table 45: The 10 open schemes with the highest administration fees pampm (2020): industry average R305.54 pampm

Ref. no.	Name of Scheme	Name of administrator	Average members	Administration fee pampm R
1125	Discovery Health Medical Scheme	Discovery Health (Pty) Ltd	1 333 237	336.84
1167	Momentum Medical Scheme	Momentum Health Solutions (Pty) Ltd	153 064	330.12
1202	Fedhealth Medical Scheme	Medscheme Holdings (Pty) Ltd	76 215	309.26
1491	Compcare Wellness Medical Scheme	Universal Healthcare Administrators (Pty) Ltd	20 791	282.71
1141	Health Squared Medical Scheme	Agility Health (Pty) Ltd	19 063	247.52
1087	Keyhealth	Professional Provident Society Healthcare Administrators (Pty) Ltd	32 747	225.01
1464	Suremed Health	Momentum Thebe Ya Bophelo (Pty) Ltd	1 047	220.55
1512	Bonitas Medical Fund	Medscheme Holdings (Pty) Ltd	335 425	217.75
1506	Medimed Medical Scheme	Momentum Thebe Ya Bophelo (Pty) Ltd	5 685	206.11
1486	Sizwe Medical Fund	3Sixty Health (Pty) Ltd	47 575	198.86

pampm = per average member per month

The 10 schemes with the highest remuneration of Principal Officers are also named in the Report: GEMS), Bestmed, Medshield, POLMED, Bonitas, Discovery Health Medical Scheme, Transmed, Sizwe, Umvuzo and LA Health. The remuneration ranges from R4.3million to R9.1 million. The schemes to the left have the highest trustee remuneration levels.

The CMS Industry report names the following schemes as having higher than the average broker fees of R82.75 per average beneficiary per month: Hosmed, LA Health, Discovery Medical Schemes, Sizwe and Bonitas.

Medical schemes are also reported to have recovered R263 million through forensic investigations.[xix]

11. References

[i] CMS Industry Report, 2021, Section7(a)
[ii] CMS Industry Report, 2021, Section 7(b) to (d).
[iii] CMS Industry Report, 2021, Page 34.
[iv] CMS Industry Report, 2021, Page 34.
[v] CMS Industry Report, 2021, Page 36, page 119.
[vi] Statistics South Africa Quarterly Labour Force Survey, Quarter 2: 2022 available at: https://www.statssa.gov.za/publications/P0211/P02112ndQuarter2022.pdf.
[vii] CMS Industry Report, 2021, Page 12.
[viii] StatSA 2022 *General Household Survey* 2021 (Statistical Release P0318).
[ix] These are risk factor data from medical schemes to estimate changes in scheme risk profiles and estimate the costs of prescribed minimum benefits, and formed part of the CMS's Risk Equalisation Find shadow process. See, for example: https://www.hfassociation.co.za/images/docs/CMS/CMSCircular42of2018.pdf.
[x] Annexure M, Annexures to the Industry Report, 2021.
[xi] CMS Industry Report, 2021, page 43.
[xii] CMS Industry Report, 2021, Pages 27 – 33.
[xiii] Pathologists, radiologists, anaesthetists.
[xiv] Include, for example, physiotherapists, occupational therapists, orthotists and prosthetists, psychologists, dieticians, etc.
[xv] P CMS Industry Report, 2021, age 42.
[xvi] http://section27.org.za/wp-content/uploads/2019/05/2019-IEJ-S27-Health-Fact-Sheet.pdf.
[xvii] CMS Industry Report, 2021, Annexure L.
[xviii] https://www.medicalschemes.co.za/research-note-1-2022-funding-of-healthcare-services-by-medical-schemes/.
[xix] CMS Industry Report, 2021, page 73.