



professionals lowers costs and saves time. However, the disadvantage is that you rely on someone else to control your cash flow. There are basically two options:

1. Using a bureau service that stores all the necessary information means that you do not have to handle the day-to-day submissions, and your staff will only handle claims reconciliation and balancing of accounts.
2. A complete bureau service handles all electronic and paper claims and reconciles accounts. This takes care of all administrative aspects of your practice and allows you to concentrate solely on patients.

Both of the above options must be carefully considered. Choose a company that has been in business for a reasonable period, has extensive experience and does not base their fees on a percentage of turnover (which can result in fraudulent claims being submitted to increase monthly figures). As a bureau does not have daily access to patient files, surgery staff must provide sufficient information to reduce rejections and delays as much as possible.

Although the health care profession is forever changing, it is also never-ending - be prepared for a bumpy start, but with the correct choices, you are sure to make valuable contributions to this rainbow nation.

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## LEGISLATION

### SUMMARISED HIGHLIGHTS OF THE LATEST AMENDMENTS TO THE REGULATIONS OF THE MEDICAL SCHEMES ACT: PART II

By Elsabé Klink

The amending regulations to the Medical Schemes Act of 1998 (as amended) were published on 4 November 2002 in the *Government Gazette* and came into on 1 January. All persons or groups entering into managed care agreements from 1 January 2004 will have to be accredited by the Council for Medical Schemes.

This is the second part of the serialisation of the amendments in the SAMJ. SAMA has warned doctors to be vigilant and ensure that schemes adhere to the provisions, especially as far as accounts, managed care agreements, protocols and formularies are concerned.

#### **Regulation 9: Limits on benefits** (9a and b added)

Regulations 9A and B deal with the non-accumulation of unexpected benefits (not savings account benefits) and the reduced contributions for child dependants respectively.

#### **Regulation 10: Savings accounts** (changed)

Ascheme may not pay more than 25% of the total gross yearly contribution of a member into a savings account. The member may not use the savings account to offset contributions, but the scheme may use the savings account to offset debt to the scheme upon the termination of membership. Credit balances must be taken as a cash benefit, subject to taxation laws upon termination and enrolling in a scheme with no savings account option or if the member does not enroll in another scheme.

Savings accounts benefits may not be used to pay PMB costs! Schemes have to provide the Registrar with details concerning its savings accounts.

#### **Regulation 11 and 13: Definitions for waiting periods and late-joiner penalties** (changed)

'Creditable coverage' is defined in view of regulations pertaining to late joiners. A member has had 'creditable coverage' when they were a member or dependant of a scheme; a member or a dependant of an entity exempted from the provisions of the scheme (e.g. another type of health care cover); a uniformed employee of the SANDF or a member of the Permanent Force Contribution Fund. This definition, together with the provisions of subregulation 6a, may alleviate the plight of persons who were insured in, for example, another country under a different system such as NHI. These persons will thus not be penalised when coming into a South African medical scheme. This may also imply that alternative social security arrangements such as stokvels and hospital plans may count as creditable coverage. Subregulation 6 requires a sworn affidavit on the relevant periods s/he was a member or dependant of a medical scheme or 'other relevant entity'.

'Late joiner' is defined as an applicant or adult dependant who is 35+ years of age. It excludes persons who had cover from a date preceding 1 April 2001 without a break of more than three consecutive months since that date. A formula is given in the regulations in terms of which late-joiner penalties are described. The maximum penalties have been lowered.

#### **Regulation 12: Medical Reports** (changed)

If a medical report is required of an applicant in terms of section 29a of the Act, the scheme shall pay to the applicant or provider the costs of the tests and examinations required for the compilation of the report.

#### **Regulation 14: Continued membership** (scrapped)

**Regulation 15: Managed health care** (changed *in toto*. Managed care accreditation only applicable from 1 January 2004)



'Capitation agreement' is now defined as an agreement whereby the scheme pays the person a fixed fee in return for delivery of specified benefits - or for a person arranging the delivery of specified benefits to all or any members of a scheme. SAMA is of the opinion that in negotiating and executing these agreements, the rules of the HPCSA in terms of fee-splitting, farming out etc., also have to be considered.

'Evidence-based medicine' refers to the 'conscientious, explicit and judicious use of current best evidence in making decisions about the care of beneficiaries whereby the actual clinical experience is integrated with the best available external clinical evidence from systematic research'.

'Managed health care' is defined as risk assessment and health care management clinically and financially with a view to facilitating appropriateness and cost-effectiveness of relevant health care services within the constraints of what is affordable, through the use of rule-based- and clinical management-based programmes'.

'Rule-based and clinical management-based programmes' refer to a set of formal techniques designed to monitor the use of, and evaluate the necessity, appropriateness, efficacy, and efficiency of health care services, procedures or settings, on the basis of which appropriate managed care interventions are made.

Medical practitioners are entitled to challenge the scientific basis of these programmes. They should also be able to enter into discussions with schemes (with their peers) on the conclusions reached by means of the use of these programmes. Doctors should also be mindful of dual loyalty situations, and remember that their primary duty is towards their patients.

'Managed health care organisation' refers to a person that has contracted to a scheme in terms of regulation 15a. A 'participating health care provider' is someone who has contracted directly with a scheme or who is delivering a relevant health service to the beneficiaries of a scheme. It should be noted that a 'designated provider' therefore is not necessarily the same as a 'participating health care provider'. One could therefore be a designated service provider without having a managed care agreement with a scheme.

A 'protocol' is defined as 'a set of guidelines in relation to the optimal sequence of diagnostic testing and treatments for specific conditions and includes, but is not limited to, clinical practice guidelines, standards treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways'.

#### **Regulation 15A: Prerequisites for managed care arrangements** (changed *in toto*)

The regulations stipulate that the managed care agreement should be a written contract. Doctors should ensure that these agreements do not violate the HPCSA's policy on perverse incentives or ethical rules on issues such as commission, rentals

of rooms, turnover etc.

The regulations also stipulate that the existence of a managed care agreement does not absolve the scheme from its responsibility towards its members, if any other party to the arrangement (e.g. the provider) is in default with regard to the provision of any service in terms of the agreement.

The limitation of rights or entitlements imposed by a managed care agreement must be submitted to the Registrar of Medical Schemes, 30 days before such limitations are to take effect. This would include limitations in terms of formularies (inclusions and exclusions), protocols and coverage of disease states.

From 1 January 2004, the person with whom the scheme enters into an agreement must be registered as a managed health care organisation with the Council.

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## PRACTICE MANAGEMENT

### MODELS OF PRACTICE MANAGEMENT

Health care costs have risen above inflation over the last decade and have placed health care services beyond the reach of many South Africans.

A key component of managed care initiatives is the reduction in costs and this provides the single most important reason for the introduction of managed care in the South African health care market. Managed health care has grown in the USA, because it allows employers to purchase health care services for their employees at a lower cost than traditional insurance.

The health care sector will in future allow for a combination of fee-for-service and managed care systems. Managed care will probably constitute the main growth area in the private sector. It may also provide the vital interface between the public and private sectors.

Managed care initiatives introduced within the South African market to date have had a variable success rate. Comprehensive initiatives have generally failed due to hostile relations with providers, an American approach to health care delivery, over ambitious plans and the inability to recognise new business requirements. Focused initiatives such as pharmacy benefit management and utilisation management have however yielded beneficial results.

Key features of managed health care delivery systems are: