**INTERNAL SUMMATIVE ASSESSMENT - Model Answers**

**Qualification: Occupational Certificate: Financial Investment Advisor**

**Module 3: Health care benefits advisory services**

**Learning units: 1- 9**

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| ***INSTRUCTIONS***   * *Complete all questions using black ink.* * *Write legibly in the language agreed, namely English.* * *Label drawings clearly (if applicable).* * *The required mark to be declared competent is 50%.* * *This is a closed book, 3-hour test.* |
| **SECTION A**  **State whether the following statements are True/ False [5 Marks]**   1. A medical scheme provides cover for a specific health event and pays out a predetermined amount. False 2. Medical insurance will give a person peace of mind since it provides cover for all healthcare expenses, whether in a hospital or out of the hospital. False 3. Prescribed minimum benefits focus on treating the condition that the member is already suffering from, rather than preventing the member from getting the disease. True 4. If a member has incurred a co-payment, they can ask the medical scheme to deduct the money from their medical savings account. False 5. Under the National Health Insurance, the rich will subsidize the poor for healthcare services. True   **Multiple choice [5 Marks]**   1. The following are prescribed minimum benefits except: 2. any emergency medical condition 3. a limited set of 270 medical conditions 4. cholesterol, blood sugar and blood pressure tests 5. 25 chronic conditions defined in the Chronic Diseases List (CDL) 6. Who in the list below is not eligible for membership of a medical scheme? 7. The new wife to a husband who remarried after the first wife died and they became the principal member of the scheme. The first wife was the principal member for a restricted medical scheme 8. The grandchild whose parents died because of a car accident when they were 12 years old and now, they were left in the legal custody of their grand parents. 9. A child who is 23 years old and they are still in college after having failed certain courses for two consecutive years and they ended up extending their college years. 10. A child that is born to parents who are already members of a medical scheme. 11. Which of the following Acts is not specific to the healthcare services, in other words it is applicable in other sectors of the economy? 12. Occupational Health and Safety Act 13. Medicine and Related Substances Control Act 14. Pharmacy Act 15. Medical Schemes Act 16. Which of the following is the incorrect statement about medical insurance? 17. Pay directly to the member 18. Payments is related to what the cost of the healthcare service 19. The client makes their own decision as to what they want to use their money for 20. The policies are issued by insurance companies and not medical schemes 21. Which of the following is incorrect about the concept of managed care? 22. Managed health care means clinical and financial risk assessment and management of health care with a view to facilitating appropriateness and cost effectiveness of relevant health services within constraints of what is affordable through use of rules based & clinical management-based programmes. 23. Managed care refers processes or techniques used by any entity that delivers, administers and/or assumes risk for health services in order to control or influence the quality, accessibility, utilization, costs and prices, or outcomes of such services provided to a defined population. 24. Managed care basically ensures that patients or clients have access to quality healthcare that is affordable, by influencing the behaviour of healthcare providers together with the patients themselves. 25. Managed care is a concept that focuses on the quality provision of healthcare to members of medical schemes but does not necessarily control the costs because the scheme has to pay for the healthcare costs of their members.   **Section A = 10 Marks** |

**SECTION B: SHORT AND LONG QUESTIONS**

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**Question 1 (4 marks)**

Differentiate between discretionary and guaranteed benefits in medical schemes.

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| * Discretionary benefits – these are benefits that the scheme is not mandated by the law to provide. They can also be referred to as voluntary benefits. This would then mean that the scheme will require the member to seek preauthorization before the procedure or healthcare service is rendered. * Guaranteed benefits – the scheme is legally bound to provide such benefits. In a nutshell these are prescribed minimum benefits and they must be provided to all members of the scheme irregardless of their benefit option. |

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**Question 2 (3 marks)**

Define the concept of proration of benefits using an example.

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| * The above principle applies to benefits as well. Proration of benefits is applied to any member who joins the scheme any time during the year, other than the 1st of January. Scheme members are allocated specific benefits for a year, from the medical savings account to hospitalisation to dentistry, etc. Therefore, if a member joins the scheme during the year, there is no way they can get benefits for the full year because they are also not going to pay premiums for the full year. This is to protect the risk pool and the existing members. The benefits will be calculated from the time membership begins, until the end of that particular financial year. |

**Question 3 (2 marks)**

Suppose the principal member did not disclose a pre-existing condition for one of their dependants and the scheme decides to suspend or terminate the membership. Who will be affected by this suspension or termination:

1. Principal member only
2. The dependant who had the pre-existing condition only
3. The whole family?

Substantiate your view.

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| * The whole family will be affected because it is the duty of the principal member to disclose all the health information for their dependants. If they are not sure, they would rather ask the broker for more time to go and ask their dependants. |

**Question 4 (8 marks)**

Calculate the late joiner penalty in the following case:

Ntombi is 47 years old. She was a member of her parents’ medical aid scheme until the age of 23, and then had no medical aid cover for 7 years. At 30, she took out her own medical aid for 6 years until moving overseas, where she had medical aid that lasted for 10 years. Upon returning to South Africa, she applied to become a member of a medical aid scheme. The option she selected pays a premium of R2 000. [8]

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| * From the figures above, Ntombi’s years of credible cover amount to 8 years (age 22-23 on her parents’ plan + 6 years as the principal member of her own plan in South Africa * Therefore, using the formula to calculate Ntombi’s late-joiner penalty: * 47 – (35 + 8) = 4. * According to the table, 4 years uncovered = 5% late-joiner penalty. Therefore, Ntombi would pay an additional 5% of her contributions in fees; that is, R100 plus the R2 000 which will add up to R2 100. * If a member was child dependant under the age of 21, that cover is not taken into consideration * Membership to a medical scheme outside South Africa is not considered |

**Question 5 (6 marks)**

How do the following concepts enhance the practice of managed care?

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| 1. Open enrolment  * Anyone cave have access and manage care also promotes access to healthcare  1. Community rating  * It makes healthcare to be affordable to high risk individuals who would not have access to quality healthcare if risk rating was utilised by medical schemes  1. Prescribed minimum benefits  * Members will have access to quality healthcare for all the conditions under PMBs |

**Question 6 (3 marks)**

Name any 3 laws that govern a medical scheme to ensure the eradication of fraudulent behaviours. [3]

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| * Medical Schemes Act * Long-Term Insurance Act * Policyholder Protection Rules * Health Professionals Act * Prevention and Combating of Corrupt Activities Act |

**Question 7 (4 marks)**

What are the rights and responsibilities of a member in a medical scheme?

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| * **Rights of the member** * access to prescribed minimum benefits * change benefit options to suit one’s needs and affordability * to add and remove dependants * to receive scheme rules for free * to cancel membership as long as they provide the appropriate notice * to choose to use a brand medicine instead of a generic * **Responsibilities of the member** * disclose information. All relevant or material facts must be disclosed * disclose all material facts on behalf of all their dependants * pay contributions on time * protect the funds of the risk pool buy ensuring safe keeping of their medical aid card so that no on uses it * to manage their expenses from the medical savings account * to questions certain services that might be rendered by the healthcare professional of which they might not be clear about * responsible for a co-payment cases where they use a provider outside the network or where the prefer a brand drug over the generic that might have been prescribed |

**Question 8 (9 marks)**

Name and describe the three types of utilisation management programs.

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| * prospective review * This is also referred to as pre-authorisation because it is a review that is conducted before a healthcare service is rendered. It provides advance evaluation of whether medical services proposed for a specific person conforms to the provisions of medical scheme options that limit coverage to medically necessary care * concurrent review * This review is conducted during the course of treatment, episode of care or hospitalisation at varied intervals to assist in the care decisions. More effort is generally devoted to reviewing the patient's particular condition and circumstances and exploring, even arranging, alternative modes of treatment. * retrospective review * Therefore, this review is conducted after the service or procedure has been completed to check whether the service that was applied for was provided within the approved guidelines or not. Such a review is often related to payment and may result in denied claims if the assessors realise that there was over servicing for example |

**Question 9 (5 marks)**

Outline the impact of managed care on the members and the administrator with reference to the advantages and disadvantages.

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| **Administrator**   * Cost effective healthcare delivery and improved quality * Benefits planning from available stats. * Reduction of abuse of the healthcare system (the use of protocols, preferred providers etc. * Better control of yearly premium increase (keep them minimal) by containing healthcare costs. * Loss of members due to mismanagement of funds, which may result in increased premiums. * Medical fraud.   **Members**   * Quality care becomes accessible and affordable * Able to make informed decisions about his personal healthcare. * Better health (wellness programs) * Restriction to certain provider (e.g. preferred provider’s model) * Restrictions on benefits cover * Personal exclusions may be applied. * Disclosure of sensitive and sometimes confidential medical situations when obtaining authorization for a service. |

**Question 10 (3)**

Name any 3 places besides South Africa, that practise managed care. [2]

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| * United Kingdom * Netherlands * Switzerland * France * Germany * United States of America * Canada |

**Question 11 (3 marks)**

Give examples of how the following stakeholders can each commit fraud.

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| * Members – doctor shopping, letting someone else use their medical aid card, buying non-medical items from the pharmacy using their medical aid card * Doctors – intentionally providing unnecessary services, altering dates on which services were rendered * Pharmacists – charging for brand drugs after dispensing generic drugs, billing for non-medical items, etc. |

**Question 12 (6 marks)**

What legal recourse is available for healthcare administrators in cases of fraud?

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| * *Internal disciplinary action* – written warnings, suspension, demotion, dismissal, etc. depending on the organisation’s policies and procedures * *Civil prosecution* – the perpetrator will be taken to a civil court and usually they will be asked to pay back whatever they defrauded the company, or they will seize the perpetrator’s assets. * *Criminal prosecution* – the matter will be reported to SAPS and the perpetrator will be prosecuted in a criminal court and this might result in jail time or fines or both jail and a fine. * *Parallel prosecution* – where both civil and criminal prosecution will take place at the same time to allow the company to recoup whatever they were defrauded of, even if the perpetrator will still go to jail * *Deregistration -* Broker/Medical Scheme will be deregistered * *Licence suspension –* the practising license will be suspended |

**Question 13 (6 marks)**

Outline the route followed by a standard claim.

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| * ***Stage 1*** – the member seeks medical attention from a healthcare provider, i.e. a hospital, doctor, therapist, pharmacist, laboratory, etc. * ***Stage 2*** – The provider submits a claim document to the scheme. This is done according to the scheme rules, and the provider needs to make sure that all the information is correct and has been entered. This includes the services rendered, date of service, relevant codes, etc. * ***Stage 3*** – The claim is received by the scheme and it is entered into the system and filed properly according to company policies. This stage is important as it will ensure timely payment of the claim. * ***Stage 4*** – This stage is the actual processing of the claim where it is reviewed to ensure that the provider followed the guidelines of the policy. If everything is in order, as described before, it will then be determined what amount will be paid to the provider and what the member will be liable for. * ***Stage 5*** – Payment is made to the provider; a bill is also sent to the member in case they will be a co-payment. * ***Stage 6*** – A statement will then be sent to the member for all the transactions that will have been performed on the particular claim. |

**Question 14 (4 marks)**

List any four legislations that govern confidentiality in healthcare.

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| * Medical Schemes Act * Protection of Personal Information Act * The Promotion of Access to Information Act * National Health Act |

**Question 15 (6 marks)**

Differentiate between a medical savings account and medical schemes reserve account in detail.

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| Medical savings account   * Up to 25% of member’s contributions * Used for all out of hospital expenses * If not used up in a particular year, it will be carried over to the next year * If membership is cancelled, the money will be given to the member as cash or transferred to the new scheme   Medical scheme reserve   * 25% of the medical scheme’s annual contribution collection * The reserves must always be above 25% * The money must only be utilised during adverse conditions |

**Question 16 (6 marks)**

Justify why restricted benefits offer better value than benefits offered under open medical schemes.

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| * Less contribution increases * No brokers or third parties meaning the cost of commission is cut out * You get tailored benefit designs since the members are well-known to the scheme. A good example is the police force, it is a well-known fact that they are exposed to traumatising situations a lot of times, this then means that they are more susceptible to post-traumatic -stress disorder. Their respective medical scheme will then do good by ensuring that this condition is covered in all their benefit options since nearly every member will need this at least once in their lifetime |

**Question 17 (3 marks)**

Name and describe any 1 principle of economics.

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| * ***Rationality*** * This refers to the fact that an individual will make a decision that best works out for them, given the information at hand. This decision might not be the best long-term decision, but in the meantime, it works because that is what makes sense based on the information available to them. * ***Opportunity cost*** * This is when benefits from one alternative are lost when the other alternative is chosen. In other words, this is the value of what you have to give up in order to choose something else. * ***Marginal analysis*** * This concept is when you think about the next decision to be made. One has to consider the cost of that decision to be made and also the benefits they will reap from the decision. It can also be referred to as the cost-benefit principle. * ***Incentives*** * These are rewards and punishments people experience every day. This is what motivates people to behave in a certain way. Disincentives can also be used to discourage bad behaviour. Incentives can be in two ways: * Extrinsic incentives: these come from the outside of a person, like cash rewards, bonus, social recognition. * Intrinsic incentives: are more psychological and they come from inside the person. Like a person who feels good when they make a difference in the world. |

**Question 18 (9 marks)**

Give 3 examples of services that will be offered under each of the following: primary, secondary and tertiary healthcare under the new national health insurance.

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| Primary healthcare   * Health education and promotion by community workers * Family planning and reproductive health services * Disease prevention * Curative services * Home-based care for patients who need long-term support * Rehabilitation * Palliative services   Secondary healthcare   * Emergency medicine * Internal medicine (cardiology and cardiovascular conditions, dermatology, neurology, infectious diseases) * Nephrology and renal disease, dialysis * Oncology and cancer treatments * Psychiatry * Obstetrics and gynaecology * Paediatrics and neonatology * Surgery * Orthopaedics * Organ transplant (lung, liver, kidney and heart)   Tertiary healthcare   * general specialists in anaesthesiology * general surgery * internal medicine * obstetrics and gynaecology * orthopaedics * paediatrics * psychiatry * radiology * diagnostic services such as pathology |

**Question 19 (10 marks)**

In an essay, outline the impact of fraud of members of medical schemes.

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| * More turnaround time for claims processing as scheme will need to scrutinize and investigate some claims * Limitation in terms of provider choice * Increase in premiums to cover up for the costs of fraud * Required authorisation for previously allowed procedures * Reduced benefits |

**Question 20 (10 marks)**

During your researches, you were required to find out the attitudes of medical scheme members towards their respective schemes. In a short essay, highlight how members view on their benefits, premiums and quality of services provided.

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| * The views could either be positive or negative. Assessor to use their own discretion. |

**Question 21 (15 marks)**

In an essay, describe the National Health Insurance and how the concept is going to function and also change the healthcare system.

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| * This is a financing system that is designed to pool funds for the whole nation in order to enable access to healthcare for all South African citizens, irregardless of their social status. All individuals will be able to access healthcare services without paying because the costs of their care will be funded from the national pool. The NHI will be funded through a number of mandatory pre-payment sources that will be discussed later. * The NHI concept is the same as what medical schemes are currently doing in the sense that it will be a non-profit entity and healthcare providers receive fair rate for their services, except for two notable differences: * The cover will be available to every South African, whether employed or unemployed, low income-earner or high income-earner. * Access to healthcare will not be dependent on how much you are contributing; it will depend on your health care needs. This means that the person who is contributing can actually share a hospital room with one that is not contributing. * *NHI, Private and Public sectors, how will this work?* * NHI will not manage healthcare providers, rather, they will enter into contracts with both public and private healthcare providers for the provision of healthcare services. The current public hospitals and clinics will be made to upgrade their facilities. Only providers who meet a certain criterion will be contracted to NHI. A patient will be able to choose any NHI- contracted providers near them for their regular healthcare provision. * One of the amendments to the National Health Act will be to set up the Office of Health Standards Compliance. This office will make sure there is good quality care from the contracted healthcare providers. They will conduct regular site visits for inspection and provide reports to the Minister. They are the ones who are also responsible for the accreditation process and will issue certificates to providers who meet their standards. That certificate will be public guarantee that standards of hygiene, safety, and respect for patients are being met.   **Medical scheme membership under NHI**   * Medical schemes will not be eradicated, individuals will still be free to continue with their membership, provided they will still afford. However, they will not be allowed to opt out of NHI because the contributions are compulsory. The government will no longer provide tax subsidies for medical scheme members. This will generally lead to few people opting not to be members of medical schemes, except if they will require cosmetic surgery.   **Healthcare services under NHI**   * Primary healthcare * Secondary healthcare * Tertiary healthcare * The benefits will be comprehensive in nature and no one will be told that their benefits are exhausted. No co-payments will be applicable unless if the patient has failed to follow the referral route; starting at the clinic or a GP. * NB: - Temporary residents, foreign nationals (with and without visas), foreign students and tourists will be required to have own medical insurance. |

**Section B = 125 Mark**