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GOVERNMENT NOTICE

DEPARTMENT OF HEALTH

No. R. 540 **30 April 2002**

MEDICAL SCHEMES ACT, 1998 (ACT No. 131 of 1998)

AMENDMENT TO THE GENERAL REGULATIONS MADE IN TERMS OF THE MEDICAL SCHEMES ACT, 1998 (ACT No. 131 of 1998)

The Minister of Health, after consultation with the Council for Medical Schemes, intends, in terms of the Medical Schemes Act, 1998 (Act No. 131 of 1998), to make the regulations in the Schedule.

Interested persons are invited to submit comments or representations on the proposed regulations to the Director-General: Health, Private Bag X828, Pretoria, 0001, within three months of the date of publication of this notice.

Definitions

1. In this Schedule, "the Regulations" means the regulations published under Government Notice No. R.1262 of 20 October 1999, as amended by the following Government Notices: No. R. 570 of 5 June 2000; No. R. 650 of 30 June 2000 and No. R.247 of 1 March 2002.

Amendment of regulation 1 of the Regulations

2. Regulation 1 of the Regulations is hereby amended by the deletion of the following definitions:
   (a) "broker";
   (b) "creditable coverage";
   (c) "enhanced option";
   (d) "hospital treatment";
   (e) "late joiner";
   (f) "managed health care";
   (g) "pre-existing sickness condition"; and
   (h) "public hospital system".

Amendment of regulation 6 of the Regulations

3. Regulation 6 of the Regulations is hereby amended –

(a) by the substitution for subregulation (2) of the following subregulation:

"(2) If a medical scheme is of the opinion that an account, statement or claim is erroneous or unacceptable for payment, it must inform the person who submitted the claim (that is, the member or the relevant health care provider, as the case may be) within 30 days after receipt of such account, statement or claim that it is erroneous or unacceptable for payment and state the reasons for such an opinion.";

(b) by the substitution for subregulation (3) of the following subregulation:

"(3) After the member or the relevant health care provider, as the case may be, has been informed as referred to in subregulation (2), such member or provider must be afforded an opportunity to correct and resubmit such account or statement within a period of sixty days following the date from which it was returned for correction."

Insertion of regulation 6A of the Regulations

4. The following regulation is hereby inserted in the Regulations after regulation 6:

"Disclosure of trustee remuneration

6A. The annual financial statements of a medical scheme shall contain the following information in relation to trustee remuneration, either in the income statement or by means of a note thereto, the amount paid, per trustee, in the following categories:

(a) travelling expenses for attendance of meeting;

(b) accommodation and meals;

(c) fees for attendance of board meetings;

(d) fee due for holding particular office on the board;

(e) fees for consultancy work performed for the medical scheme by a trustee; and

(f) other remuneration paid to a trustee.

Substitution of regulation 7 of the Regulations

5. The following regulation is hereby substituted for regulation 7 of the Regulations:

"**Definitions**

7. For the purposes of this chapter –

'designated service provider' means a health care provider or group of providers who has explicitly contracted with a medical scheme to provide diagnosis, treatment and care in respect of one or more prescribed minimum benefit conditions, and who is identified in the rules of the medical scheme concerned as the designated service provider in respect of that or those conditions;

'emergency medical condition' means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical or surgical treatment, where failure to provide medical or surgical treatment would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

'prescribed minimum benefits' mean the benefits contemplated in section 29(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of –

(a) the Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A; and

(b) any emergency medical condition;

'prescribed minimum benefit condition' mean a condition contemplated in the Diagnosis and Treatment Pairs listed in Annexure A or any emergency medical condition;".

Substitution of regulation 8 of the Regulations

6. The following regulation is hereby substituted for regulation 8 of the Regulations:

"Prescribed Minimum Benefits

8. (1) Subject to the provisions of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

(2)The rules of a medical scheme may, in respect of any benefit option, provide that –

(a) the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition; and

(b) a co-payment or deductible, the quantum of which is specified in the rules of the medical scheme, may be imposed on a member if that member or his or her dependant obtains such services from a provider other than a designated service provider, provided that no copayment or deductible is payable by a member if the service was involuntarily obtained from a provider other than a designated service provider.

(3) For the purposes of subregulation (2)*(b)*, a beneficiary will be deemed to have involuntarily obtained a service from a provider other than a designated service provider, if –

(a) the service was not available from the designated service provider or would not be provided without unreasonable delay;

(b) immediate medical or surgical treatment for a prescribed minimum benefit condition was required under circumstances or at locations which reasonably precluded the beneficiary from obtaining such treatment from a designated service provider; or

(c) there was no designated service provider within reasonable proximity to the beneficiary's ordinary place of business or personal residence.

(4) Subject to subregulations (5) and (6) and to section 29(1)(p) of the Act, these regulations must not be construed to prevent medical schemes from employing appropriate interventions aimed at improving the efficiency and effectiveness of health care provision, including such techniques as requirements for pre-authorisation, the application of treatment protocols, and the use of formularies.

(5) When a formulary includes a drug that is clinically appropriate and effective for the treatment of a prescribed minimum benefit condition suffered by a beneficiary, and that beneficiary knowingly declines the formulary drug and opts to use another drug instead, the scheme may impose a co-payment on the relevant member.

(6) A medical scheme may not prohibit, or enter into an arrangement or contract that prohibits, the initiation of an appropriate intervention by a health care provider prior to receiving authorisation from the medical scheme or any other party, in respect of an emergency medical condition.

(7) If the Registrar is of the opinion that a prescribed minimum benefit condition is insufficiently or inappropriately defined in Annexure A of these regulations, taking into account the objective of the prescribed minimum benefits specified in the Explanatory Note to Annexure A, the Registrar may, by notice in the *Gazette*, clarify or restrict the ambit of any particular prescribed minimum benefit condition, by means of defining more specifically disease states, or procedural or diagnostic codes –

(a) covered by the relevant prescribed minimum benefit condition; or

(b) excluded from the relevant prescribed minimum benefit condition.".

Insertion of regulations 9A and 9B of the Regulations

7. The following regulation is hereby inserted in the Regulations after regulation 9:

"**Non-accumulation of benefits**

9A. A medical scheme may not provide in its rules for the accumulation of unexpended benefits by a beneficiary from one year to the next other than as provided for in personal medical savings accounts.

Contributions in respect of dependants

9B. A medical scheme may in its rules provide that contributions in respect of a child dependant may be less than those determined in respect of other beneficiaries."

Amendment of regulation 10 of the Regulations

8. Regulation 10 of the Regulations is hereby amended –

(a) by the substitution for subregulation (1) of the following subregulation:

"(1) A medical scheme, on behalf of a member, must not pay into a members' personal medical savings account an amount that exceeds 25% of the total gross contribution made in respect of the member during the financial year concerned.";

(b) by the substitution for subregulation (3) of the following subregulation:

"(3) Ownership of the funds deposited in a member's personal medical savings account shall vest with the member and may not be used to offset contributions.";

(c) by the substitution for subregulation (4) of the following subregulation:

"(4) Credit balances in a member's personal medical savings account shall be transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be, when such member changes medical schemes or benefit options."

(d) by the substitution for subregulation (5) of the following subregulation:

"(5) Credit balances in a member's personal medical savings account must be taken as a cash benefit, subject to applicable taxation laws, when the member terminates his or her membership of a medical scheme or benefit option without enrolling in another medical scheme or enrols in another medical scheme or benefit option without a personal medical savings account provision."

(e) by the substitution for subregulation (6) of the following subregulation:

"(6) The funds in a member's medical savings account shall not be used to pay for the costs of a prescribed minimum benefit.";

(f) by the addition of the following subregulation:

"(8) Apart from funds paid into a medical savings account, no portion of a member's contribution may be set aside for the purpose of paying the claims of a particular member and her or his dependants exclusively."

Substitution of regulation 11 of the Regulations

9. The following regulation is hereby substituted for regulation 11 of the Regulations:

"**Definitions**

11. For the purposes of this chapter –

'creditable coverage' means any period in which an applicant or his or her dependant, as the case may be, was a beneficiary of a medical scheme, terminating two years or more before the date of the latest application for membership or admission as a dependant, but excluding any period as a child dependant; and

'late joiner' means an applicant or the adult dependant of an applicant who, at the date of application for membership or admission as a dependant, as the case may be, is 35 years of age or older and has not been a beneficiary of any medical scheme for a period of two years immediately prior to the date of application."

Substitution of regulation 12 of the Regulations

10. The following regulation is hereby substituted for regulation 12 of the Regulations:

"**Medical reports**

12. If a medical scheme requires a medical report to be provided to it by an applicant in terms of section 29A(7) of the Act, the medical scheme shall pay

to the applicant or relevant health care provider the full costs of providing the report."

Amendment of regulation 13 of the Regulations

11. Regulation 13 of the Regulations is hereby amended –

(a) by the substitution for subregulation (2) of the following subregulation:

"(2) The premium penalties referred to in subregulation (1) shall not exceed the following bands:

Number of years, in excess of 30, that an applicant was not a beneficiary of a medical scheme	***Maximum penalty***
5-9 years	0.05 x contribution
10-19	0.25 x contribution
20-29	0.5 x contribution
30+ years	0.75 x contribution

(b) by the substitution for subregulation (3) of the following subregulation:

"(3) Any years of creditable coverage which can be proven by the applicant for membership or admission as a dependant, as the case may be, shall be subtracted from his or her current age in determining the applicable penalty in terms of subregulation (2).";

(c) by the addition of the following subregulations:

"(8) For the purposes of subregulations (3) and (4), it shall be sufficient proof of creditable coverage if the applicant produces a sworn affidavit in which he or she declares –

(a) the relevant period or periods in which he or she was a beneficiary and the name or names of the relevant medical scheme or medical schemes corresponding with such period or periods; and

(b) that reasonable efforts have been made to obtain documentary evidence of such periods of creditable coverage, but have been unsuccessful."

Substitution of regulation 14 of the Regulations

12. The following regulation is hereby substituted for regulation 14 of the Regulations:

"**Continued membership**

14. (1) In relation to restricted membership schemes, eligibility for continued membership in terms of paragraphs (s) or (t) of section 29(1) of the Act does not extend to dependants other than those who were admitted as dependants to the scheme at the time that continued membership was obtained in terms of those paragraphs of the Act.

(2) Subregulation (1) does not prevent a person from applying for admission as a dependant of a person who obtained membership in terms of paragraphs (s) or (t) of section 29(1) of the Act."

Substitution of regulation 15 of the Regulations

13. The following regulation is hereby substituted for regulation 15 of the Regulations:

"**Definitions**

15. For the purposes of this Chapter –

'capitation agreement' means an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme;

'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 the constraints of what is affordable, through the use of rules-based and clinical management-based programmes;

'managed health care organisation' means a person who has contracted with a medical scheme in terms of regulation 15A to provide managed health care;

'participating health care provider' means a health care provider who, by means of a contract directly between that provider and a medical scheme in terms of regulation 15A, or pursuant to an arrangement with a managed health care organisation which has contracted with a medical scheme in terms of regulation 15A, undertakes to provide a relevant health service to the beneficiaries of the medical scheme concerned;

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

Insertion of regulations 15A to 15H of the Regulations

14. The following regulations are hereby inserted in the Regulations after regulation 15:

"**Prerequisites for managed health care arrangements**

15A. (1) If a medical scheme provides benefits to its beneficiaries by means of a managed health care arrangement with another person –

(a) the terms of that arrangement must be clearly set out in a written contract between the parties;

(b) such arrangement must be with a person who has been granted accreditation as a managed health care organisation by the Council; and

(c) such arrangement must not absolve a medical scheme from its responsibility towards its members if any other party to the arrangement is in default with regard to the provision of any service in terms of such arrangement.

(2) To the extent that managed health care undertaken by the medical scheme itself or by a managed health care organisation results in a limitation on the rights or entitlements of beneficiaries, such limitations must be clearly stated in the rules of the medical scheme concerned.

(3) Limitations referred to in subregulation (2) include, but are not limited to: restrictions on coverage of disease states, protocol requirements, and formulary inclusions or exclusions.

Standards for managed health care

15B. If any managed health care is undertaken by the medical scheme itself or by a managed health care organisation, the medical scheme must ensure that:

(a) a written protocol is in place (which forms part of any contract with a managed health care organisation) that describes all utilisation review activities, including a description of the following:

- (i) procedures to evaluate the clinical necessity, appropriateness, efficiency and affordability of relevant health services, and to intervene where necessary, as well as the methods to inform beneficiaries and health care providers acting on their behalf, as well as the medical scheme trustees, of the outcome of these procedures;
- (ii) data sources and clinical review criteria used in decision-making;
- (iii) the process for conducting appeals of any decision which may adversely affect the rights or entitlements of a beneficiary;
- (iv) mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
- (v) data collection processes and analytical methods used in assessing utilisation and price of health care services;
- (vi) provisions for ensuring confidentiality of clinical and proprietary information;
- (vii) the organisational structure (e.g. ethics committee, managed health care review committees, quality assurance or other committee) that periodically assesses managed health care activities and reports to the medical scheme; and
- (viii) the staff position functionally responsible for day-to-day management of the relevant managed health care programmes;

(b) the managed health care programmes use documented clinical review criteria that is based upon sound clinical evidence and are evaluated periodically to ensure relevance for funding decisions;

(c) the managed health care programmes use transparent and verifiable criteria for any other decision-making factor affecting funding decisions and are evaluated periodically to ensure relevance for funding decisions;

(d) qualified health care professionals administer the managed health care programmes and oversee funding decisions, and that the appropriateness of such decisions are evaluated periodically by clinical peers;

(e) health care providers, any beneficiary of the relevant medical scheme or any member of the public are provided on demand with a document setting out –

(i) a clear and comprehensive description of the managed health care procedures; and

(ii) the procedures for appeal against utilisation review decisions adversely affecting the rights or entitlements of a beneficiary; and

(iii) any limitations on rights or entitlements of beneficiaries, including but not limited to restrictions on coverage of disease states; protocol requirements and formulary inclusions or exclusions.

Provision of health services

15C. (1) If managed health care entails an agreement between the medical scheme or a managed health care organisation, on the one hand, and one or more participating health care providers, on the other –

(a) the medical scheme is not absolved from its responsibility towards its members if any other party is in default to provide any service in terms of such contract;

(b) no beneficiary may be held liable by the managed health care organisation or any participating health care provider for any sums owed for services rendered in terms of the agreement;

(c) a participating health care provider may not be forbidden in any manner from informing patients of the care they require, including various treatment options, and whether in the health care provider's view, such care is consistent with medical necessity and medical appropriateness;

(d) such agreement with a participating health care provider, may not be terminated as a result of a participating health care provider –

(i) expressing disagreement with a decision to deny or limit benefits to a beneficiary; or

(ii) assisting the beneficiary to seek reconsideration of any such decision;

(e) if the medical scheme or the managed health care organisation, as the case may be, proposes to terminate such an agreement with a

participating health care provider, the notice of termination must include the reasons for the proposed termination.

(2) A managed health care organisation or a medical scheme, as the case may be, may place reasonable limits on the number or classes of health care providers with whom it may contract to provide relevant health services, provided that –

(a) there is no discrimination against providers on the basis of one or more arbitrary grounds, including race, religion, gender, marital status, age, ethnic or social origin or sexual orientation; and

(b) selection of participating health care providers is based upon a clearly defined policy in respect of cost-containment, quality of care and access.

Setting aside of capitation agreements

15D. The Registrar may approach the High Court to set aside a capitation agreement, if such agreement does not comply with directives issued by the Council with a view to ensuring that:

(a) such agreements are in the interests of the members of the medical scheme concerned; and

(b) such agreement embodies a genuine transfer of risk from the medical scheme to the managed health care organisation, and the capitated payment is reasonably commensurate with the extent of such risk transfer.

Limitation on disease coverage

15E. If managed health care entails limiting coverage of specific diseases –

(a) such limitations or a restricted list of diseases must be developed on the basis of clinical best practice;

(b) the medical scheme and the managed health care organisation must provide such limitation or restricted list to health care providers, beneficiaries and members of the public, upon request; and

(c) provision must be made for appropriate exceptions where a patient is at risk, without penalty to that beneficiary.

Protocols

15F. If managed health care entails the use of a protocol, including but not limited to standard treatment guidelines, disease management guidelines, treatment algorithms and clinical pathways –

(a) such protocol must be developed on the basis of clinical best practice;

(b) the medical scheme and the managed health care organisation must provide such protocol to health care providers, beneficiaries and members of the public, upon request; and

(c) provision must be made for appropriate exceptions where a protocol has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.

Formularies

15G. If managed health care entails the use of a formulary or restricted list of drugs –

(a) such formulary or restricted list must be developed on the basis of clinical best practice;

(b) the formulary must include, as a minimum, all the classes of drugs included in the Essential Drugs List referred to in the Medicines and Related Substances Act, 1965 (Act No. 101 of 1965);

(b) the medical scheme and the managed health care organisation must provide such formulary or restricted list to health care providers, beneficiaries and members of the public, upon request; and

(c) provision must be made for appropriate substitution of drugs where a formulary equivalent has been ineffective or causes or would cause adverse reaction in a beneficiary, without penalty to that beneficiary.

General provisions

15H. (1) Any managed health care contract, contemplated in Regulation 15A, must require either party to give at least 90 days notice before terminating the contract, except in cases of material breach of the provisions of the contract, or where the availability or quality of health care rendered to beneficiaries of a medical scheme is likely to be compromised by the continuation of the contract.

(2) Notwithstanding anything to the contrary in these regulations –

(a) a medical scheme and a managed health care organisation may not use a financial incentive that directly or indirectly compensates any person for ordering, providing, recommending or approving relevant health services that are medically inappropriate;

(b) any information pertaining to the diagnosis, treatment or health of any beneficiary of a medical scheme must be treated as confidential;

(c) subject to the provisions of any other legislation, a medical scheme is entitled to access any treatment record held by a managed health care organisation or health care provider and other information pertaining to the diagnosis, treatment and health status of the beneficiary in terms of a contract entered into pursuant to regulation 15A, but such information may not be disclosed to any other person without the express consent of the beneficiary;

(e) where provision is made by a managed care provider for complaints or appeals procedures or mechanisms, such provision shall in no way impact upon the entitlement of a beneficiary to –

(i) complain to, or lodge a dispute with, his or her medical scheme;

(ii) lodge a complaint with Council; or

(iii) take any other legal action to which he or she would ordinarily be entitled."

Amendment of regulation 17 of the Regulations

15. Regulation 17 of the Regulations is hereby amended –

(a) in subregulation (2), by the substitution for paragraph *(d)* of the following paragraph:

"*(d)* a report prepared by the auditor in the form set out in Part 1 of Annexure C, indicating whether or not the administrator's system of financial control is adequate for the size and complexity of the business of the medical scheme or schemes to be administered.";

(b) by the insertion after subregulation (3) of the following subregulations:

"(4) The Council may, after consideration of an application for accreditation in terms of this regulation –

(a) grant the accreditation, subject to any conditions as the Council may deem fit; or

(b) refuse the application, after providing the applicant with notice and reasons for the intended refusal, and a reasonable opportunity to provide representations to the Council in this regard.

(5) The Council may at any time, after providing an administrator with notice and reasons for the intended action, and an opportunity to

provide representations to the Council in this regard, suspend or withdraw the accreditation of an administrator, if that administrator –

(a) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;

(b) has since the granting of such accreditation, materially contravened or failed to comply with any provision of this Act;

(c) is financially unsound; or

(d) is disqualified from performing administration services in terms of any law.

(6) During the period in which the accreditation of a person is suspended or withdrawn in terms of this regulation, that person may not perform the services of an administrator.".

Amendment of regulation 18 of the Regulations

16. Regulation 18 of the Regulations is hereby amended –

(a) by the substitution for subregulation (1) of the following subregulation:

"(1) Prior to an administrator commencing administrative functions with regard to a particular medical scheme, the medical scheme must enter into a written agreement with the administrator in which the terms and conditions of the administration of the medical scheme are recorded.";

(b) in subregulation (2), by the substitution for paragraph *(e)* of the following paragraph:

"*(e)* that all registers, minute books, records and all other data pertaining to the medical scheme, must at all times remain the sole property of the medical scheme concerned, and that no lien may be held over them by the administrator."

Amendment of regulation 19 of the Regulations

17. Regulation 19 of the Regulations is hereby amended by the addition of the following subregulation:

"(3) In the circumstances contemplated in subregulation (1), the trustees of the medical scheme concerned must take steps to ensure the integrity of all documents, data and information transferred to the new administrator."

Substitution of regulation 21 of the Regulations

18. The following regulation is hereby substituted for regulation 21 of the Regulations:

"**Indemnity and fidelity guarantee insurance**

21. An administrator must take out and maintain an appropriate level of fidelity guarantee insurance."

Substitution of regulation 23 of the Regulations

19. The following regulation is hereby substituted for regulation 23 of the Regulations:

"**Depositing of medical scheme moneys**

23. (1) An administrator must deposit any medical scheme moneys under administration, not later than the business day following the date of receipt thereof, into a bank account opened in the name of the medical scheme.

(2) When medical scheme moneys, including contributions, are paid by means of electronic funds transfer, such moneys shall be deposited directly into a bank account opened in the name of the medical scheme.

(3) Moneys contemplated in subregulations (1) or (2) shall at no time be deposited in any bank account other than that of the medical scheme.".

Amendment of regulation 25 of the Regulations

20. Regulation 25 of the Regulations is hereby amended by the substitution for paragraph *(a)* of the following paragraph:

"*(a)* a report by the auditor of the administrator in the format set out in Part 2 of Annexure C; and".

Amendment of regulation 28 of the Regulations

21. The following regulation is hereby substituted for regulation 28 of the Regulations:

"**Compensation of brokers**

28. (1) No person may be compensated by a medical scheme in terms of section 65 for acting as a broker unless such person —

(a) is currently accredited by the Council to act as a broker or apprentice broker;

(b) has been issued with a certificate by the Registrar;

(c) is a fit and proper person for purposes of acting as broker or apprentice broker;

(d) enters into a prior written agreement with the medical scheme concerned, of which the nature and the compensation payable to such person is fully disclosed in the financial statements of the scheme concerned;

(e) discloses to the prospective member the name of the medical scheme concerned and the fact that he or she is acting in terms of the agreement;

(f) discloses to the prospective member the registered contributions for the cover;

(g) discloses to the prospective member the nature of the services rendered by the broker;

(h) provides best advice and acts at all times in absolute good faith towards the member, the prospective member and the medical scheme concerned;

(i) provides documentary proof to the member or prospective member that he or she has obtained accreditation from the Council;

(j) discloses to the member or prospective member the compensation payable to him or her, which shall not be in excess of the maximum amount as prescribed in subregulation (2);

(k) complies with the minimum level of services provided for in the accreditation requirements;

(l) in the case of a natural person, complies with the recognised educational qualifications contemplated in subregulation (8) or (9), as the case may be;

(m) complies with any relevant code of conduct for financial service providers published in terms of section 15 of the Financial Advisory and Intermediary Services Act, 2002; and

(n) undertakes not to receive any other incentive, reward or compensation from any other source in addition to the disclosed compensation as contemplated in subparagraph (d).

(2) Payments to a broker by a medical scheme shall be made from funds set aside from an additional premium payable to the medical scheme during the first year following introduction of that member only by those members of a fund who are introduced to a medical scheme by a broker, which premium shall be specified in the rules of the medical scheme concerned and in any marketing material making reference to contributions or fees payable by members.

(3) The maximum amount payable to a broker in respect of the performance of services relating to the introduction of a member to a medical scheme by that broker shall not exceed 3% plus value added tax (VAT) of the contributions payable by that member in the first year following introduction, provided that such commission shall be paid on a monthly basis and upon receipt by the scheme of the relevant monthly contribution in respect of that member.

(4) Subregulation (3) must not be construed to restrict a medical scheme from applying a sliding scale based on the size of the group being introduced provided that the maximum amount in respect of a member introduced as specified in subregulation (3) is not exceeded.

(5) No compensation is payable unless such compensation has been indicated in the rules of the medical scheme concerned.

(6) Any person who has paid a broker compensation where there has been a material misrepresentation is entitled to the full return of all the money paid."

Insertion of regulations 28A to 28C of the Regulations

22. The following regulations are hereby inserted in the Regulations after regulation 28:

"Admission of members to a medical scheme

28A. A medical scheme must not prevent a person from applying for membership of a medical scheme for the reason that that person is not using a broker to apply for such membership.

Accreditation of brokers

28B. (1) Any person desiring to be accredited as a broker must apply in writing to the Council, and the application must be accompanied by –

(a) documentary proof of a recognised educational qualification and appropriate experience;

(b) documentary evidence of having passed a relevant course of study recognised by the Council or enrolment in a course of study offered by an organisation approved by the Council to offer such a course;

(c) in the case of a juristic person, documentary proof and a sworn affidavit that any person employed by the person, or acting under the auspices of the person, who provides or will provide advice on medical schemes to clients, is accredited with Council as a broker or an apprentice broker; and

(d) such additional information as the Council may deem necessary.

(2) A recognized educational qualification and appropriate experience, for the purposes of this regulation, means –

(a) Grade 12 education or equivalent educational qualification; and

(b) a minimum of two years demonstrated experience as broker or apprentice broker in health care business.

(3) Individuals not meeting the qualifications for a broker may apply to the Council for accreditation as apprentice brokers and such applications must be accompanied by documentary proof of –

(a) Grade 12 education or equivalent educational qualification;

(b) agreement by a fully accredited broker to supervise the applicant;

(c) current accreditation of the supervising broker;

(d) enrolment in a course of study offered by an organisation approved by the Council to offer such a course; and

(e) such additional information as the Council may deem necessary.

(4) In the case of a natural person, an application for accreditation as a broker or an apprentice broker must also be accompanied by information to satisfy the Council that the applicant complies with –

(a) any requirements for fit and proper brokers determined by the Council, by notice in the Gazette; and

(b) any relevant requirements for fit and proper financial services providers or categories of providers which have been determined by the Registrar of Financial Service Providers in terms of section 8(1) of the Financial Advisory and Intermediary Services Act, 2002.

(5) In considering an application for accreditation in terms of this regulation, the Council may take into consideration any other information regarding the applicant, derived from whatever source, if such information is disclosed to the applicant and she or he is given a reasonable opportunity to respond thereto.

(6) The Council must, after consideration of an application –

(a) if satisfied that an applicant complies with the requirements of this Act, grant the application subject to any conditions that he or she may deem necessary; or

(b) if not so satisfied, refuse the application and provide reasons to the applicant for such refusal.

(7) If accreditation is granted by the Council to a broker or an apprentice broker, it shall be granted for twenty-four months, and shall be accompanied by a certificate from the Registrar clearly specifying the expiry date of the accreditation and any conditions imposed by the Council in terms of subregulation (6)(a).

(8) The Council may at any time after the issue of a certificate of accreditation, on application by the broker or apprentice broker or on own initiative add, withdraw or amend any condition or restriction in respect of the accreditation, after having given the relevant broker or apprentice broker a reasonable opportunity to make submissions on the proposed addition, withdrawal or amendment and having considered those submissions, if the Council is satisfied that any such addition, withdrawal or amendment is justified and will not unfairly prejudice the interests of the clients of the broker or apprentice broker, and must in every such case issue an appropriately amended certificate to the broker or apprentice broker, as the case may be.

(9) A broker or apprentice broker wishing to renew his or her accreditation shall apply to the Council for such renewal in such format as the Council may from time to time determine, provided that –

(a) such application for renewal shall be made by the broker or apprentice broker at least three months prior to the date of expiry of the accreditation;

(b) the broker or apprentice broker shall furnish the Council with any information that the Council may require.

(10) The provisions of subregulations (6) to (8) shall apply *mutatis mutandis* to an application for renewal of accreditation in terms of subregulation (9).

(11) A person is disqualified from accreditation as a broker or an apprentice broker if he or she –

(a) is an unrehabilitated insolvent;

(b) is disqualified under any law from carrying on his or her profession; or

(c) has at any time been convicted (whether in the Republic of South Africa or elsewhere) of theft, fraud, forgery or uttering a forged document, perjury, an offence under the Corruption Act, 1992 (Act No. 94 of 1992),

or any offence involving dishonesty, and has been sentenced therefore to imprisonment without the option of a fine.

Suspension or withdrawal of accreditation

28C. (1) The Council may, subject to subregulation (2), at any time suspend or withdraw any accreditation granted in terms of regulation 28B if the Registrar is satisfied on the basis of available information, that the relevant broker or apprentice broker –

(a) no longer meets the requirements contemplated in regulation 28B;

(b) did not, when applying for accreditation, make a full disclosure of all relevant information to the Council, or furnished false or misleading information;

(c) has, since the granting of such accreditation, contravened or failed to comply with any provision of this Act;

(d) has, since the granting of such accreditation, failed to comply in a material manner with any relevant code of conduct for financial service providers published in terms of section 15 of the Financial Advisory and Intermediary Services Act, 2002;

(e) has, since the granting of such accreditation, conducted his or her business in a manner that is seriously prejudicial to clients or the public interest; or

(f) is disqualified from performing broker services in terms of regulation 28(c)(11).

(2) *(a)* Before suspending or withdrawing any accreditation, the Council must inform the broker or apprentice broker concerned of –

(i) the intention to suspend or withdraw the accreditation and the grounds therefor;

(ii) in the case of suspension, the intended period therefor; and

(iii) any terms attached to the suspension or withdrawal, including such measures as the Council may determine for the protection of the interests of the clients of the broker or apprentice broker,

and must give the broker or apprentice broker a reasonable opportunity to make a submission in response thereto.

(b) The Council must consider any such response, and may thereafter decide to withdraw or suspend or not to withdraw or suspend the accreditation, and must notify the broker or apprentice broker of the decision.

(c) Where the accreditation is suspended or withdrawn, the Council must make known the terms of the suspension or withdrawal or subsequent lifting thereof, by means of any appropriate public media announcement.

(3) Despite the provisions of subsection (2), the Council may under urgent circumstances where she or he is satisfied that reasonable ground that substantial prejudice to clients or the general public may occur –

(a) provisionally suspend an accreditation, and impose any terms on such suspension as she or he deems necessary, and inform the relevant broker or apprentice broker of the –

(i) grounds therefor; and

(ii) period of the suspension;

and give the relevant broker or apprentice broker a reasonable opportunity to respond thereto and to provide reasons why the provisional suspension should be lifted or why the period and terms should be changed;

(b) make known such provisional suspension by means of any appropriate public media announcement.

(4) The Council must during the period that the provisional suspension is in force, consider any response contemplated in subregulation (3)(a), and may thereafter decide to --

(a) lift the provisional suspension; or

(b) render the suspension final,

and must inform the broker or apprentice broker accordingly.

(5) The Council must make known the terms of any such final suspension, or the lifting thereof, in any appropriate public media announcement.

(6) During the period that the accreditation of a broker or apprentice broker has been suspended or provisionally suspended, such person may not apply for renewal of the accreditation or reapply for accreditation.

(7) If the accreditation of a broker or apprentice broker has been withdrawn, such person may not reapply for accreditation as a broker or apprentice broker for a period of five years following such withdrawal.

Amendment of regulation 29 of the Regulations

23. Regulation 29 of the Regulations is hereby amended --

(a) by the substitution for subregulation (2) of the following subregulation:

"(2) Subject to subregulations (3), (3A) and (4), a medical scheme must at any time maintain accumulated funds expressed as a

percentage of gross annual contributions for the accounting period under review which may not be less than 25%."

(b) by the addition of the following subregulation after subregulation (3):

"(3A) Notwithstanding the provisions of subregulation (3), a medical scheme which is registered for the first time after the coming into operation of these regulations must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than –

(a) 10% during the year in which the scheme was registered;

(b) 13,5% during the year after the year of registration;

(c) 17,5% during the second year after the year of registration; and

(d) 22% during the third year after the year of registration."

(c) by the substitution for subregulation (4) of the following subregulation:

"(4) A medical scheme that for a period of 90 days fails to comply with subregulations (2) or (3) must notify the Registrar in writing of such failure, and must provide information relating to –

(a) the nature and causes of the failure; and

(b) the course of action being adopted to ensure compliance therewith.".

Amendment of regulation 30 of the Regulations

24. Regulation 30 of the Regulations is hereby amended --

(a) by the substitution for its heading of the following heading:

"**30. Limitation on assets**";

(b) by the deletion of subregulation (3), the existing subregulations (4) to (8) becoming subregulations (3) to (7) respectively;

(c) in subregulation (4), by the deletion of the definition of "regulated market".

Amendment of regulation 31 of the Regulations

25. Regulation 31 of the Regulations is hereby amended by the substitution for paragraph *(b)* of the following paragraph:

"*(b)* application for approval of an organisation to offer a course of study to apprentice brokers, in terms of regulation 28B(3)(d): R2000,00."

Insertion of regulation 32A of the Regulations

26. The following regulation is hereby inserted in the Regulations after Regulation 32:

"Value added tax

32A. The amounts specified in regulations 31 and 32 in respect of fees payable and penalties, respectively, are exclusive of value added tax (VAT)."

Amendment to Annexure A of the Regulations

27. Annexure A of the Regulations is hereby amended –

(a) in the part entitled "Brain and Nervous System," by the substitution for Code 950A of the following:

"Code: 950A

Diagnosis: Benign and malignant brain tumours, treatable

Treatment: Medical and surgical management which includes radiation therapy and chemotherapy";

(b) in the part entitled "Eye," by the substitution for Code 950B of the following:

"Code: 950B

Diagnosis: Cancer of eye & orbit – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(c) in the part entitled "Gastro-intestinal System," by the substitution for Code 950F of the following:

"Code: 950C

Diagnosis: Cancer of the gastro-intestinal tract including oesophagus, stomach, bowel, rectum, anus – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(d) in the part entitled "Skin and Breast" –

(i) by the substitution for Code 954J of the following:

"Code: 954J

Diagnosis: Cancer of skin, excluding malignant melanoma – treatable

Treatment: Medical and surgical management, which includes radiation therapy";

(ii) by the substitution for Code 953J of the following:

"Code: 953J

Diagnosis: Malignant melanoma of the skin – treatable

Treatment: Medical and surgical management, which includes radiation therapy";

(e) in the part entitled "Female Reproductive System," by the substitution for Code 954M of the following:

"Code: 954M

Diagnosis: Cancer of cervix – treatable

Treatment: Medical and surgical management, which includes radiation therapy and chemotherapy";

(f) in the part entitled "Haematological, Infectious and Miscellaneous Systemic Conditions," –

(i) by the substitution for Code 168S of the following:

"Code: 168S

Diagnosis: #HIV-infection

Treatment:[1] HIV voluntary counselling and testing
Co-trimoxazole as preventive therapy
Screening and preventive therapy for TB
Diagnosis and treatment of sexually transmitted infections
Pain management in palliative care
Treatment of common opportunistic infections
Prevention of mother-to-child transmission of HIV
Post-exposure prophylaxis following sexual assault.

(ii) by the substitution for Code 910S of the following:

"Code: 910S

Diagnosis: Multiple myeloma and chronic leukemias

Treatment: Medical management, which includes

[1] Note: comment is requested on this formulation of the benefit for HIV, in addition to other possible alternative formulations, such as the wording of the existing benefit; and a treatment making provision for the provision of anti-retroviral therapy when clinically indicated.

chemotherapy and radiation therapy";

(g) in the part entitled "Mental Illness," –

(i) by the substitution for Code 182T of the following:

"Code: 182T

Diagnosis: Abuse or dependence on psychoactive substance, including alcohol

Treatment: Hospital-based management up to 3 weeks/year";

(ii) by the substitution for Code 901T of the following:

"Code: 901T

Diagnosis: Acute stress disorder accompanied by recent significant trauma, including physical or sexual abuse

Treatment: Hospital admission for psychotherapy / counselling up to 3 days, or up to 12 outpatient psychotherapy / counselling contacts";

(iii) by the substitution for Code 908T of the following:

"Code: 908T

Diagnosis: Anorexia nervosa and bulimia nervosa

Treatment: Hospital-based management up to 3 weeks/year or minimum of 15 outpatient contacts per year";

(iv) by the substitution for Code 903T of the following:

"Code: 903T

Diagnosis: Attempted suicide, irrespective of cause

Treatment: Hospital-based management up to 3 days or up to 6 outpatient contacts";

(v) by the substitution for Code 902T of the following:

"Code: 902T

Diagnosis: Major affective disorders, including unipolar and bipolar depression

Treatment: Hospital-based management up to 3 weeks/year (including inpatient electro-convulsive therapy and inpatient psychotherapy) or outpatient psychotherapy of up to 15 contacts";

(h) by the insertion of the following part after the part entitled "Mental Illness":

"**CHRONIC CONDITIONS**

Diagnoses:

Addison's Disease
Anti-coagulating therapy
Asthma
Bipolar Mood Disorder
Bronchiectasis
Cardiac Failure
Cardiomyopathy
Disease
Chronic Renal Disease
Coronary Artery Disease
Crohn's Disease
Cushing's Disease
Diabetes Insipidus
Diabetes Mellitus Type 1 & 2
Dysrhythmias
Chronic Obstructive Pulmonary
Epilepsy
Glaucoma
Haemophilia
Hyperlipidaemia
Hypertension
Hypothyroidism
Multiple Sclerosis
Osteoarthritis
Parkinson's Disease
Rheumatoid Arthritis
Schizophrenia
Systemic Lupus Erythromatosis
Ulcerative Colitis

Treatment: Diagnosis, medical management and medication

(i) in the Explanatory Notes and Definitions to Annexure A –

(i) by the insertion after note (2) of the following note:

"(2A) In respect of treatments denoted as "medical management" or "surgical management," note (2) above describes the *standard* of treatment required, namely "prevailing hospital-based medical or surgical diagnostic and treatment practice for the specified condition." Note (2) does not restrict the setting in which the relevant care should be provided, and should not be construed as preventing the delivery of any prescribed minimum benefit on an outpatient basis or in a setting other than a hospital, where this is clinically most appropriate."

(ii) by the insertion after note (8) of the following note:

"(9) In respect of Code 902M (Diagnosis: Infertility), 'medical and surgical management' shall be limited to the following procedures or interventions:

(a) hysterosalpingogram

(b) the following blood tests:

a. Day 3 FSH/LH
b. Oestradiol
c. Thyroid function (TSH)
d. Prolactin
e. Rubella
f. HIV
g. VDRL
h. Chlamydia
i. Day 21 Progesterone

(c) laparoscopy

(d) hysteroscopy

(e) surgery (uterus and tubal)

(f) manipulation of ovulation defects and deficiencies

(g) semen analysis (volume; count; mobility; morphology; MAR-test)

(h) basic counseling and advice on sexual behaviour, temperature charts etc.

(i) treatment of local infections."

Substitution of Annexure B of the Regulations

28.The following Annexure is hereby substituted for Annexure B of the Regulations:

"Annexure B

Limitation on Assets

Item	**Categories or kind of assets**	**Maximum Percentage of**

		Aggregate Fair Value of Total Assets of Scheme
1.	(a) Inside the Republic – Deposits and balances in current and savings accounts with a bank or mutual bank, including negotiable deposits, and money market instruments in terms of which such a bank or mutual bank is liable, as well as margin deposits with SAFEX:...................... (i) Per bank .... (ii) SAFEX .... (b) Territories outside the Republic – Deposits and balances in current and savings accounts with a bank including negotiable deposits, and money market instruments in terms of which such a bank is liable	100% 20% 5% 0%
2.	Bills, bonds and securities issued or guaranteed by and loans to or guaranteed by – (a) Inside the Republic .... (i) a local authority authorized by law to levy rates upon immovable property (per local authority)... ... (ii)Development Boards established under the Black Communities Development Act, 1984 (Act No. 4 of 1984)....................................... (iii) Rand Water Board....................................... (iv) Eskom... ...... (v) Land and Agricultural Bank of South Africa... (vi) Local Authorities Loans Fund Board.............	100% 20% 20% 20% 20% 20% 20% 20% 0%

	(vii) SA Transport Services................................. (b) Territories outside the Republic	
3.	Bills, bonds and securities issued by and loans to institutions in the Republic approved by the Registrar... - Per institution..	100% 20%
4.	Immovable property and claims secured by mortgage bonds thereon. Units in unit trust schemes in property shares and shares in, loans to and debentures, both convertible and non-convertible, of property companies. (a) Inside the Republic - .... (i) Per single property, property company or development project .... (b) Territories outside the Republic............................	 10% 2.5% 0%
5.	Preference and ordinary shares in companies excluding shares in property companies. Convertible debentures, whether voluntary or compulsory convertible and units in equity unit trust schemes with the objective to invest mainly in shares. These investments are subject to the following limitations: (a) Inside the Republic .... (i) Unlisted shares, unlisted convertible debentures and shares and convertible debentures listed in the Development Capital and Venture Capital sectors of the Johannesburg Securities Exchange.......... (ii) Shares and convertibles listed on the Johannesburg Securities Exchange other than the Development Capital and Venture Capital sectors...	 40% 5%

	(aa) Per one company with a market capitalisation of R 2 000 million or less... (bb) Per one company with a market capitalisation of more than R 2000 million (b) Territories outside the Republic	40% 10% of the equity portfolio 15% of the equity portfolio 0%
6.	(a) Inside the Republic, listed and unlisted debentures and any secured claims against an insurance company in terms of a short-term policy of insurance................ (b) Outside the Republic	5% 0%
7.	Any other assets not referred to in this Annexure	2.5%

Amendment to Annexure C of the Regulations

29. Annexure C of the Regulations is hereby amended --

(a) by the insertion immediately above the first *pro forma* report of the words:

"Part C 1";

(b) by the substitution for the heading of the first *pro forma* report of the following heading:

"Report of the independent auditors of .... (name of administrator) to the Registrar of Medical Schemes in compliance with Regulation 17(2)(d) under the Medical Schemes Act, 1998";

(c) by the insertion immediately above the second *pro forma* report of the words:

"Part C 2".