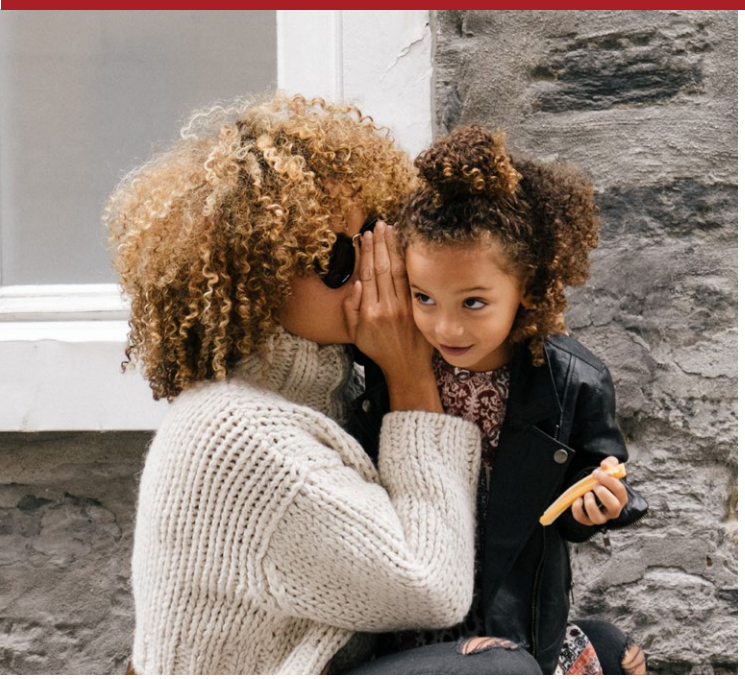
GEMHEALTH
MEDICAL AID SCHEME

# NEWSLETTER
OCTOBER 2021



## TOPICS FOR DISCUSSION

1. Manage & protect your medical aid benefits
2. Pathology Services
3. Types of medical aid fraud, waste and abuse

## MEDICAL AID BENEFITS - WHY IS IT IMPORTANT THAT WE MANAGE AND PROTECT OUR BENEFITS?

Dear Members,

We are fast approaching the last quarter of the year – a period when members may run short of benefits due to the high utilization of benefits characterized with winter months, and might not have sufficient benefit limits to take them up to the end of the year.

As medical aid members, we need to be reminded that being part of a medical scheme and paying monthly contributions, are not the only roles expected from us as members. We have a responsibility to look after the interest of the Scheme and fellow Scheme members at all times. A Medical Scheme is a mutual or solidarity fund, operated on a cross-subsidisation principle. Where members are the only and rightful owners, and all contributions are paid into one risk pool. As medical scheme members, we carry each other based on the founding principle. Thus, the manner in which we utilize our medical aid benefits affects the rest of the members in the pool.

It is therefore critical that we take co-responsibility, protect our scheme to ensure that it remains sustainable and we can enjoy the benefits for many more years

### 1.1 What is my role as medical scheme member?

You will all agree that the main purpose of a medical scheme is to offer good benefits that provide access to quality healthcare. The truth of the matter is that a medical scheme will only be able to continue offering good benefits if it's financially sound. If we look

>>> Continue on next page

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at the current cost of medical expenses, 96% of GEMHEALTH expenditure is paid to member healthcare claims and with such a performance it will be difficult to remain sustainable, without large adjustments in premiums or attempts to address the claims trend without the assistance and co-operation of all members.

As indicated, medical schemes operate on a cross-subsidization principle, which means that a group of members with different healthcare statuses and medical needs all belongs to one pool, and cross-subsidize each other in terms of claims, age and income. It's very important to highlight that the claims behavior of each member and family in the pool affects the rest of the members and impacts the overall performance of the Scheme.

Medical schemes allocate benefits annually at the beginning of a benefit year, which run from 01 January till 31 December of each year. These benefits are allocated to give members peace of mind and to ensure that they are covered, when they require medical treatment. Some members, however, are of the view that if they don't "use their benefits, they'll lose" them. This is a wrong perception and at times, the main reason why some members end up seeking treatment or services that are not medically required, just to ensure that they utilize the medical aid benefits, or choose not to report any possible miss-use of benefits by healthcare providers.

It is important to emphasize that every claim submitted to the Scheme contributes to the overall claims expenditure and impacts every member of the Scheme. To better illustrate what we are trying to explain, visualize the following scenarios and consider the impact it will have on the Scheme.

- 500 members "decide that if they don't claim they will lose their optical benefits" and all decide to claim for spectacles at an average cost of N$3,500, meaning the Scheme has this large amount less available to pay for claims for other medical conditions.
- Member X, giving his card to a family friend, a non –member to go for a doctor consultation, obtain medication, is hospitalised and underwent a procedure.
- Member Y, has 6 children, only two are registered and the four are treated under the names of the two that are registered.

This type of behavior may look normal and acceptable, but the reality is that it impacts everyone in the Scheme and should be avoided at all times. All of the above stated scenarios are cases of fraud, waste and abuse that could have serious consequences should it become known or reported. Members found guilty of such behavior may lose their membership of the Scheme and be prosecuted for fraudulent cases.

### 1.2 What Happens to my benefits if I don't used them: Benefit Accumulator.

Benefits that are not used during a benefit year revert back at the end of the year to the reserves of the Scheme. It directly impacts and contributes to the overall performance of the Scheme for the year and is not lost in any way. To further encourage members to spend their benefits wisely and not for unnecessary services or claims, the Scheme during 2019 introduced a Benefit Accumulator, which is a low claim reward allocated to members whose claims are below a stipulated threshold.

The benefit accumulator allocation can exclusively be used by the member to finance any of his/her, including beneficiaries', healthcare expenses. This includes amongst others any co-payments on medication or at medical practices, cover for treatment or services that are excluded in terms of the Scheme rules, cosmetic surgery, second pair spectacles or sunglasses etc. This is not only an incentive for members, but a gesture from the Scheme to recognize members for their low claims and reward them. Check with Prosperity Health Client service for more

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details and/or to confirm your savings in your Benefit Accumulator savings wallet.

### 1.3 How does the Claims performance of members or the Scheme affects future Contribution Increases?

Medical aid contribution and benefits are reviewed on an annual basis. Factors such as medical inflation, utilization trends, new facilities that opened or new technology, benefit changes and the past year performance are considered during the annual actuarial review process. In a scenario where the previous year claims performance of the Scheme was within the budget forecast, it resulted in lower or no increase in contributions. If we look at the 2020 financial year as an example, where the Scheme had a very good claiming year compared to the previous financial/benefit year the Board of Trustees announced a 0% increase in contributions for 2021.

# PATHOLOGY TESTS

According to Namibian statistics, the number of members registered on medical aids have been decreasing over the past few years. On the other hand, the number of providers over the same period had increased. These new healthcare providers include most disciplines and amongst others new GPs, pharmacies and pathology laboratories. The increase in new healthcare providers are one of the contributing factors to the increase in services and utilisation that drives the claims costs. The large number of additional costs with a shrinking membership base, also indicate the potential risk for over servicing and services being generated to compliment the income of some practices.

"Over service" refers to unnecessary medical tests, avoidable procedures, inefficient duplication, and prescription of excess medication. Over service is thought to produce wasteful expenditures on healthcare that add little to no value to a member's health. The main reason for "over service" is attributed to the profit motive.

When healthcare providers are paid on a fee-for-service basis and for performance i.e., the more they "see or provide a service" to patients, the higher the claims and the income of the practice. One of the main areas of concerns we have observed is the increase in the number of Pathology tests conducted, which have resulted in a steep increase in pathology costs over the past few years.

Members are cautioned to ensure that they understand the type of tests to be conducted in relation to their treatment. As members are always surprised or shocked to learn about the number of tests done and the costs, after the claims have been submitted, processed and paid by the Scheme. In some instances, the entire annual benefit limits are utilized, and members end up with large co-payments that they have to pay out-of-pocket. Don't repeat blood tests every month or two, make sure you obtain and keep a copy of your blood tests to provide to the next doctor should you visits one.

# FRAUD, WASTE & ABUSE

Healthcare fraud is one of the fastest growing crimes. It is estimated that between 5-15% of medical claims submitted to medical fund/ schemes are due to fraud, waste and abuse. Looking at the current escalation in Scheme cost, the topic of fraud waste and abuse is critical, it does not only affect the Scheme but also the member as it off-sets against your benefit limits and also threatens the long term sustainability.

## 2. What is Fraud, Waste & Abuse:

### FRAUD

Defined as the wrongful or criminal deception intended to result in financial or personal gain, fraud includes false representation of fact, making false statements, or by concealment of information.

"The intentional deception or misrepresentation that a person or entity makes, with the knowledge that the misrepresentation could result in some unauthorized benefit or payment for which no entitlement would otherwise exist… either for the persons own benefit or for the benefit of some other party. Health care fraud is one of the most complex form of financial fraud to detect, monitor and prevent"

### WASTE

Defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the Scheme. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems, or controls.

Overutilization of services or other practices that, directly or indirectly, result in unnecessary costs to the healthcare system. It is not generally considered to be caused by criminally negligent actions, but by the misuse of resources.

Refers to the extra-costs incurred when healthcare services are overused.

### ABUSE

Defined as excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. Abuse can occur in financial or non-financial settings.

It refers to practices that are inconsistent with sound medical practices and result in unnecessary cost to a medical scheme, or reimbursement for services that are not medically necessary.

# FRAUD, WASTE & ABUSE

## 4. Some Examples of Fraud , Waste & Abuse in Healthcare

- Billing for services never rendered which may entail usage of genuine patient information improperly obtained.
- Billing for more expensive services or procedures than actually provided or performed, for example, falsely billing for higher prices treatment than actually provided.
- Unnecessary medical services may be engaged merely to generate additional revenue via payments.
- Falsification of patient diagnosis and medical records to justify tests, surgeries or other procedures that are not medically required.
- New applicant's non-disclosure of pre-existing conditions.
- Claiming for fillings when cosmetic dental work has been performed.
- Unnecessary blood work being sent to labs.
- Pharmacies may bill medication but other items were truly dispensed.
- Collusion between Health Care Providers and Members may claim for services not rendered and split the proceeds between them.

> COLLUSION, in regard to FWA, it refers to a secret illegal cooperation or conspiracy to deceive others.

## 5. What can members do to mitigate the risk of FWA?

- Members should protect their medical aid and ID details at all times.
- Beware of "free offers" or "extras" offered as it may be a means to add services offered to bill against benefits. Do not accept services not required.
- Know their Scheme Rules and attend member education sessions.
- Review Remittances.
- Contact the Scheme if member suspects they may be a victim of health care fraud.

In conclusion, we would like to highlight that Fraud, Waste & Abuse (FWA) harms you and your Scheme. Members should report any suspicious incidents involving GEMHEALTH Medical Scheme to the toll free fraud hotline YOUR VOICE on 083 380 0169 or via the website www.yourvoice.debeersgroup.com.

*All matters reported will be investigated and treated with the utmost confidentiality.*

GEMHEALTH
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Administered by PROSPERITY HEALTH