GEMHEALTH
MEDICAL AID SCHEME

# NEWSLETTER

FEB 2024

## TOPICS FOR DISCUSSION

1. 2024 Benefit changes
2. Fraud, Waste & Abuse (FWA)

Dear Valued member,
Compliments of the new season and Welcome to the first member newsletter of 2024. This newsletter shares important updates and notices, including the 2024 Scheme changes and Benefit Information.

## 1. BENEFIT & CONTRIBUTIONS CHANGES FOR 2024

In December 2024, we communicated the new benefit and premium changes, including the challenges faced by the medical industry and GEMHEALTH, which was the main contributing factor to the 2024 changes. We appeal to all members to support the Scheme as it takes the necessary measures to address the current challenges. Below is a recap of the changes.

### Introduction

Since 2021, the Namibian medical aids, including the GEMHEALTH Scheme, have observed a significant increase in claims utilisation, which resulted in a rapid decrease of the Scheme reserves. At a strategic meeting held in February 2023, the Board took some of the key strategic actions to address and reduce the impact of escalating utilisation. It was suggested by some providers that the change in utilisation has been, to some extent, triggered by ''supplier induced demand,'' where some practices might have opted to claw back some of the losses in income during the lockdown period. The Trustees resolved to re-evaluate and restructure specific benefits offerings to effectively manage and ensure members' continued access to quality healthcare services with the best clinical outcome while ensuring the Scheme maintains its sustainability.

- As a result, we have reviewed the benefits offered, and adjustments have been made for the upcoming financial/benefit year, effective 01 January 2024 to 31 December 2024. These changes are designed to balance the needs of our members while ensuring continued access to essential healthcare services.

- The Trustees used a ''benefit limit utilisation report'' to consider adjusting the benefits limits for the various benefit categories. This was done to ensure that the impact on the members was limited.

### Contribution Increases

- Namfisa has taken note of the challenges that medical aids face in Namibia, and although they have capped the increases of contributions to 9.9% effective 1 January 2024, they allow funds the opportunity to submit a further request for an increase towards the end of March 2024. Such requests will have to include a comprehensive medium-term business plan to show initiatives and interventions of the fund on how to restore the reserve levels and to secure the sustainability of the respective fund.
- Namaf (Namibia Association of Medical Aid Funds) also confirmed its concern about the escalating claims costs and has announced a zero percent increase in Namaf tariffs for 2024.
- The contribution increases for the open funds all amounted to 10.7% to 13%, and after their application for increases and revised benefits were declined by Namfisa, they had to drop it to the 9.9% benchmark guideline issued

by Namfisa. Some funds indicated that they are not able to drop their contribution increase to below 10% and are still considering their options in response to the Namfisa ruling. Following the setting of the benefit structures, the financial status of the Scheme was reviewed by the actuaries in line with the guidelines from Namfisa. This ensures that the financing of the Scheme is fully supported with well-calculated risks and against actuarial assessments. Thus, to cater for the expected continuation in claims costs during 2024, and the utilization of benefits effective 1 January 2024, the Board of Trustees hereby announces:

- **An overall premium increase of 12.5% effective 1st April 2024 will apply, and if annualized over the 12 months that members will enjoy the revised benefits, it amounts to 9.4%.**
- The 2024 benefit and premiums structure is attached as Annexure A:

## How do the 2024 changes affect my benefits?

- It will protect and ensure the long-term sustainability of the Scheme and allow members and their families peace of mind that the Scheme can continue to provide quality care.
- The restructuring primarily focuses on optimising the allocation of benefits to accommodate the evolving and changing healthcare landscape to ensure equitable access for all members.
- While some benefits might have undergone significant adjustments, introducing reviewed benefit limits and co-payments is still based on all members' average utilisation and usage over the past benefit year.
- The 2024 benefits were benchmarked against all the available medical aid funds on the Namibian market. GEMHEALTH benefits still compare very favourably to the available funds on the market.
- The aim was also to ensure we maintain the high quality of service you have come to expect from the GEMHEALTH Medical Aid Scheme.

## Valuable tips to manage your benefits in 2024

### 1. Understand your annual benefit limits and rules.

Don't be uninformed. Your health is essential, so take the time to review your benefit structure and ask questions requiring clarity. Read the information sent to you by the Scheme, and ensure that you attend the member information sessions. This will allow you to best manage your benefits, and ensure that your benefits last longer and minimize out-of-pocket expenses or co-payments.

### 2. Register on the Member Portal/Mob-App for easy online access and communication.

Register on the Mobi-App or portal and gain access to your medical aid profile. This tool will assist you in keeping track of all claims processed on your medical aid, including your available benefits, tracking claims payments, making changes, registering dependents, etc. To register, please go to www.gemhealthmedical.com.na or contact client services for assistance.

### 3. Remember to pre-authorise in-hospital or primary practitioner services

Pre-authorisation is required for all hospital admissions to ensure your stay will be covered. Always ask if any co-payments or sub-limits will apply and what you can do to avoid these. This will allow you beforehand to be informed if there are any co-payments you will have to pay out of your pocket. Do not hesitate to request reduced rates from your doctor, as doing so can result in cost savings.

### 4. Obtain quotations on planned treatments.

Members may also request a quotation from the practice/doctor and ask the Administrators to confirm benefits to compare the fee against the Scheme tariffs. If significant co-payments are due, members could consider seeking a second quotation. Members are advised to consider a second opinion and ask for a rebate.

### 5. Use Generic Medication

Generics have the same active ingredients as brand-name drugs but are less expensive, so request these whenever you can. Generics attract lower or no co-payments, and your

benefits last longer.

### 6. Use chronic medicine on the Scheme formulary.

Regarding chronic medication benefits, the golden rule is to use the medication listed on the Scheme's formulary. This ensures that the medication is covered 100% and that no levy or co-payment is applicable. However, a surcharge may apply depending on the pharmacy you buy your medicines from. This surcharge is an out-of-pocket expense that you will have to pay. If you wish to reduce the surcharge, you can ask the Administrator for a list of pharmacies that charge lower rates. This will help you save money, and the decision is ultimately yours.

### 7. Be aware of consulting after hours at hospital ER departments.

It is important to note that consulting at Emergency Room facilities or Casualties after hours is necessary for an emergency. However, some members prefer after-hours consultations for convenience, assuming that such claims will be covered under the In-hospital benefit and won't count towards their number of GP consultations. This assumption is incorrect. Claims made after hours are paid from your day-to-day benefits, and the fee charged for after-hours is much higher than a consultation during the day at your doctor's practice.

**Impact of benefits:**

After-hours consultations are classified as GP consultations and are payable from day-to-day benefits. It's important to note that after-hours treatment is generally more expensive than a standard consultation. In addition to the doctor's consultation fee, the hospital charges an extra facility fee which is paid from the day-to-day benefits. We want to advise our members to avoid using an ER facility (Casualty) whenever possible, except in emergencies.

### 8. Take advantage of the screenings and preventative care the Scheme medical aid covers.

- Remember: Prevention is always better than cure. Early diagnosis can save your life.
- Preventative screening benefits include tests such as cholesterol, glucose, high blood pressure, mammograms, flu, and pneumococcal vaccines.
- Please take note: Effective January 1st, 2024, members will be rewarded points for any of these preventative tests, which will be paid into their Benefit Accumulator savings account. The Benefit Accumulator savings can be used to fund any healthcare expenses or co-payments


Considering the current escalation in Scheme costs and the number of incidents recorded by the Scheme in recent months, it is critical to address the issue of fraud, waste, and abuse (FWA). We must highlight the adverse impact of FWA on the Scheme and caution members about the potential consequences if they are found guilty of contravening the scheme rules on FWA.

### 1. What are Fraud, Waste, & Abuse?

**Fraud,**
Fraud is defined as the intentional misrepresentation of an important fact submitted to support healthcare. Claim for repayment by a medical scheme. Deliberate misinterpretation of claims, services or costs.

**Abuse,**
Abuse, Inconsistent delivery of health services with sound medical practices resulting in claims with no legal entitlement. Services are done purposefully, and the matter can be addressed through compelling administration.

**Waste**
Waste is the overutilisation of services and misuse of resources that may result in unnecessary costs to the medical scheme. Generally, it is not

associated with criminally negligent actions but is extravagant, careless and needless. E.g. unnecessary admissions, high caesareans, over-service. A provider and patient/member issue.

## 2. How does FWA affect me as a member?

As a member of a medical aid scheme, it is essential to understand that a medical aid scheme is a mutual or solidarity fund, whereby all members share in the risk and cost through cross-subsidization within the pool of members. Members and the Employers pool their monthly contributions into the Scheme. The Scheme uses all contributions to finance the health needs of all its members and pay for non-healthcare services.

However, if fraudulent claims are submitted to the Scheme, higher claims will be paid and the following measures will be implemented to curb the high expenses and addition the;

- The scheme has to fund the excess claims from the reserves
- Scheme have to introduce high co-payments on specific benefit disciplines
- The scheme has to review and cut or reduce benefits

It is estimated that 10-20% of medical claims submitted to medical funds/schemes are due to fraud, waste, and abuse.

## 3. Scheme Rules on FWA

According to Rule 10.4, on Abuse of rights, falsified claims, misrepresentations and non-disclosure of material information" of the Scheme. In terms of this rule, the Board may take the following actions:

10.4.1 The Trustees may exclude a member from the benefits or terminate the membership of a member or Dependant whom the Trustees have found contravening the provisions or rules rules of the scheme by :

10.4.2 presenting false claims for reimbursement

10.4.3 abuse of benefits, committing a fraudulent act or misrepresentation

10.4.4 being registered simultaneously on Gemhealth Medical Aid Scheme as a member or Dependant and another registered medical aid fund in terms of the Medical Aids Act no. 23 of 1995, including PSESMAS (the Public Service Medical Aid Scheme).

10.4.5 making false declarations or knowingly failing to disclose material facts when applying for membership in terms of Rule 6 (Membership) or applying for a dependant under Rule 7, which may require the member to confirm their status and or any requests that would have caused the Board not to impose any limitations or specific exclusion on their Benefits.

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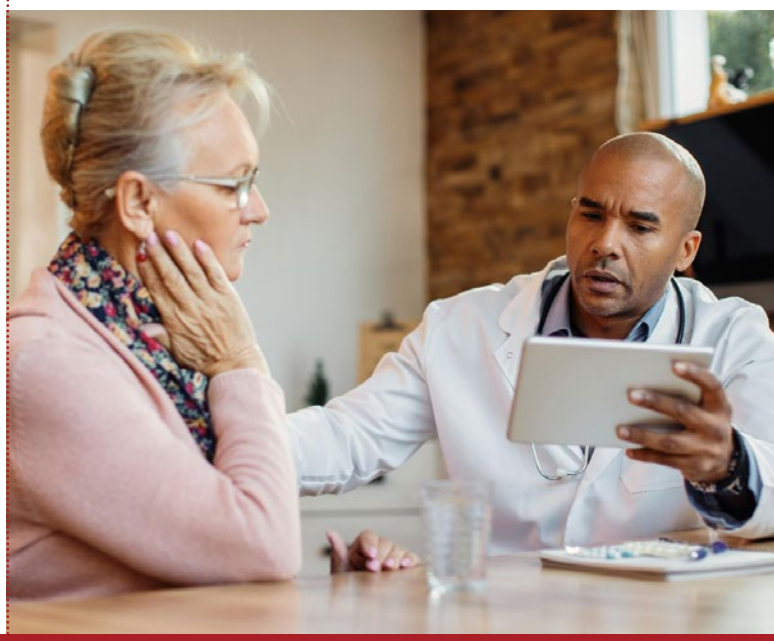
## 4. Examples of Fraud

### 4.1. Pharmacy/Medication:

- Fake prescriptions
- Supply consumer goods billed as medication
- Billing for branded medication but supplying generic
- Member's co-payment on medication billed as OTC

## 5. Report fraud, waste and abuse

Please send any cases of suspected FWA to any Trustees, Principal Officers and or Administrators. You may also use the Namdeb Group anonymous whistleblowers lines on:



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In conclusion, we understand that changes to benefits can cause uncertainty, and the Scheme and Prosperity Health are committed to providing clarity and support to members. Our dedicated team is available to assist if you have any questions or require further information regarding these adjustments.

The Scheme values your membership and trust in the GEMHEALTH Medical Aid Scheme, as your well-being remains our priority, and we assure you that we are dedicated to offering members comprehensive coverage at the best rates that will keep the Scheme sustainable.

Thank you for entrusting the Scheme as the healthcare provider to you and your family. Please work with us to protect the Scheme and the member's interests.