Financial Planning Institute of Southern Africa
THE PROFESSIONAL STANDARD

Healthcare Needs Analysis

This document is a guideline on aspects that could be taken into account to provide advice to healthcare clients who want to join a medical scheme.

This document serves as a mere guide and should not be used as the definitive and only source of information in implementing any procedures in your business and for advising clients. Your due diligence must be done.

A) Establishing and defining a professional relationship

Disclose the following information to the client:

- List the medical schemes and health insurance products you are accredited with and can provide advice on.
- Accredited with the Council of Medical Schemes and Financial Services Board (FSB)
- Show that you have the necessary experience and the required credits to provide healthcare advice.
- Commission earned and how it is paid.
- On-going services (Service level Agreement).

B) Gathering data from the client via the medical scheme application form and the client's healthcare needs & preferences

	Collect the following general client information	Possible reason
1	Name, ID, Contact numbers and e-mail address	Record purposes
2	Ages of Principal member, spouse and children. A young healthy adult may only require hospital cover for catastrophic events and emergencies. Adults who want to start a family might require good maternity benefits and should they have children, sufficient day-to-day benefits. Adults older than 40 might require sufficient chronic medication cover.	Important to determine medical cover requirements and late joiner penalties when calculating contributions.
3	Number of Dependants and if the dependants are adults or children	Important to calculate the contribution and to determine medical cover requirements.
4	Date of commencement of cover	Paying in advance or arrears.
5	Is the individual currently on a South African registered Medical Scheme has there been a break in membership or is it the first time the individual is applying to join a Medical Scheme	To determine waiting periods, exclusions & late joiner penalties.
6	Is the client part of an Employer Group which enjoys group underwriting dispensation? Employees who join the Employer's selected medical scheme within three months of employment will normally not attract any waiting periods, exclusions or late joiner penalties. Employees of some Employer Groups may not attract waiting periods or exclusions, but employees may attract late joiner penalties even if they join within three months of their employment date.	To determine waiting periods, exclusions & late joiner penalties.

	Collect the following general client information	Possible reason
7	Does the client currently have medical scheme exclusions	Could affect the client's cover.
8	Any company subsidy if the individual is part of an employer group	Affordability
9	Does the client currently have a Late Joiner Penalty. If so, ensure the late joiner penalty has been calculated correctly.	Contribution Calculation Purposes.
10	How much can the individual afford to contribute towards a medical scheme after taking into account if the client receives a medical scheme contribution subsidy from their employer. Also take into account if the client will be able to afford any self-payment gaps before benefits are paid and co-payments which the medical scheme may request to access certain benefits ie MRI and CT scans, scopes and dental treatment in hospital.	Affordability purposes.
11	If the client is registered for tax and paying tax	To determine if client will receive a tax credit.
12	Does the client has a short term insurance solution in place which covers any co-payment or shortfalls the client may have to pay and also covers the difference between what the medical scheme has paid and the actual cost of the specialists' medical expenses, when admitted to hospital.	Shortfalls and co-payments
13	Is the client currently contributing to a savings vehicle in order to have sufficient funds available after retirement to subsidise their medical scheme contributions?	In order to determine if the client is prefunding for their medical scheme contributions at retirement. At retirement members may require extensive medical scheme cover, but may not be able to afford the accompanied contributions.
	Collect the following health related information	**Possible reason**
1	Any medical condition in the past which the individual is aware of	Determine pre-existing condition and possible future cover requirements.
2	Been admitted to hospital in the past 12 months	Determine pre-existing condition and possible future cover requirements.
3	Possibility of any medical procedure required in the near future (e.g. pregnancy, dental, operation)	Determine pre-existing condition and possible future cover requirements.
4	Does the client participate in any event (sport) which may be a risk to the individual's health?	Some medical schemes exclude sport events
5	Any other important information which the client feels that the Adviser should take into account.	Determine medical cover requirements.

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	Client's preference on medical cover and providers				Possible reason
1	Determine the client's preference of where the client want to obtain their medical care:				
		Any private facility	**Within a network of private providers**	**State Facilities**	Determine the client's preference to health care providers.
	Hospitals	Yes / No	Yes / No	Yes / No	
	Chronic Meds	Yes / No	Yes / No	Yes / No	
	Acute Meds	Yes / No	Yes / No	Yes / No	
	Day-to-Day	Yes / No	Yes / No	Yes / No	
2	What level of cover does the client require for cancer?				Options have different levels of cover for cancer.
3	What level of private hospital cover does the client prefer for in-hospital reimbursement for specialists, for example 100%, 150%, 200%, 300%. How will co-payments effect the client's cash flows?				To determine the level of in-hospital cover the client require for specialists.
	Client's preference on Day-to-Day medical cover (Doctors, acute medication, dental, x-rays, blood tests, spectacles, and other out-of hospital medical care).				
1	Does the client require cover for day-to-day medical cost?				Determine if client require day-to-day cover.
2	How much is spent on day-to-day medical treatment per year (e.g. visits to doctors, specialists, dentists, pharmacy, optometrists, physiotherapist, blood tests, x-rays, psychologists or any other day-to-day medical expenses)				To determine the spent on out-of-hospital day-to-day medical expenses.
3	Does the client prefer traditional pooled cover for day-to-day expenses where day-to-day benefits are divided into sub-limits or does the client prefer a medical scheme savings account where all day-to-day funds are paid from the same pool of benefits?				To determine a New Generation or Traditional type of benefit structure.
4	Should the client prefer a medical scheme savings account, does the client require an above threshold benefit? The threshold benefit can provide extended day-to-day cover should a client run out of funds in their medical savings account. The cost of the threshold benefit must be weighed up with possible usage of the threshold benefit. How will a self-payment gap and the cost of the additional risk contribution for the threshold cover, influence the client's cash flow?				To determine if the client require a threshold benefit for high day-to-day medical expenses and the effect it will have on the client's cash flow.
	Client's preferences on chronic medication cover (Medication used for example for asthma, diabetes, hypertension and cholesterol).				
1	Should the client make use of chronic medication, does it form part of the Prescribed Minimum Benefits (PMB) Conditions? If so, is the current medication that the client is using, on the medical scheme Chronic Illness Medicine formulary? It is important to note that there is no guarantee that a scheme will approve a client's chronic condition. The client must apply to have their chronic condition approved after becoming a member of the scheme. The scheme can then decline or accept their chronic condition depending on the schemes entry clinical criteria.				To determine ideal option which will possibly cover their chronic condition?
2	Should the client have a chronic condition which is not part of the PMB conditions, is this condition covered by the medical scheme's extended list of chronic conditions? If so, is the current medication that the client is using, on the medical scheme Chronic Illness medicine formulary?				To determine ideal option and if the client's chronic condition is on the extended list.

C) Analysing and evaluating information collected and identify the ideal medical scheme

	Identify the appropriate medical scheme and medical scheme option by making use of the Council for Medical Schemes Annual Report	Possible reason
1	Number of members on the different medical schemes for each of the past five years for the different medical scheme	Identify a trend in membership growth or loss.
2	Average ages of members for each of the past five years for the different medical scheme	A higher claims ratio can be expected from schemes with a membership with a higher average age. If there is an average age increase trend over the past five years, this could result in higher claims for the scheme and so contribution increases.
3	The pensioner levels for each of the past five years for the different medical schemes.	A higher claims ratio can be expected from schemes with a membership with a higher pensioner level.
4	The solvency levels & reserves per beneficiary per month for each of the past five years of each of the different schemes	Scheme lower than the required legislated 25% solvency levels could have higher future increases to reach the legislated 25% solvency level. A decreasing solvency level can also indicate claims and running cost exceeding contributions and could result in higher future increase if trend is not diverted.
5	Membership growth for each of the past five years of each of the different schemes	A medical scheme growing with members with a low average age is beneficial for the scheme and keeps the schemes average age stable.
6	The underwriting & operating result for each of the past five years for each of the different schemes and each of their options. This is also to determine the level of cross subsidisation between options and the effect thereof on members on these options.	Should schemes continuously make losses, this can result in higher than normal medical scheme increases in the future.
7	Medical scheme increases and the average contribution and benefits paid by the scheme per beneficiary per month for each of the past five years of each of the different schemes.	Determine if scheme has a history of stable increases and increases within the CPI + 3% guideline.
8	The percentage of members who are government employees. They could leave the medical scheme to join the Government Employees Medical Scheme (Gems). This should be compared for each of the past five years of each of the different schemes. (This information is not found in the Council for Medical Schemes Report, but could be obtained directly from the medical scheme.)	Schemes with a high exposure of Government employees who might still join GEMS could result in a loss of members to the scheme.
9	Compare the schemes Global Credit Ratings. (This information is not found in the Council for Medical Schemes Report, but from the Global Credit Ratings. Not all medical schemes subscribe to this rating agency.)	To determine the schemes claims paying ability.
10	Does the scheme have contracts in place with Public Service Providers? This is relevant should the scheme have options which make use of the state as a preferred provider.	This is important should the client select an option which makes the state the preferred provider.

	Identify the appropriate medical scheme and medical scheme option by making use of the Council for Medical Schemes Annual Report	Possible reason
11	If any of schemes currently have Governance problems, i.e. under curatorship or options not approved by the Registrar of Medical Schemes.	To ensure the client is aware of any scheme issues.
12	Inform client of the service levels of the different medical schemes	Client need to be aware of any service level issues of schemes.
13	The administration-, manage care fees and all other non-healthcare costs for each of the past five years of each of the different schemes.	High non-healthcare costs contribute to the running cost of the medical scheme. This must be evaluated in conjunction with the member service levels of the scheme and the overall medical scheme contribution.
14	Compare the contributions and the benefits of the different options of the medical scheme which meet the client's medical scheme needs.	To determine which scheme will cover the clients health care needs.
15	Compare underwriting conditions (three months waiting period, one year pre-existing medical condition exclusion and late joiner penalties.)	To determine which scheme have favourable underwriting conditions.
16	Compare benefit exclusions of the different schemes and exclusions on their options	To determine if a specific benefit will not be covered on a specific option

D) Developing and presenting your recommendation and/or alternatives

Taking all above into account, the financial planner should offer a recommendation that addresses the client's healthcare & financial needs and medical scheme preferences. The financial planner should explain the recommendation and the aspects which were taken into account so that the client can make an informed decision. Should the client not accept your recommendations, then the financial planner should provide alternatives and also the implications for not accepting the recommendation.

E) Implementing your recommendation or the client's alternative

Agree with the client what will be implemented and over what time period. Ensure to follow-up with the medical scheme and client to ensure goals are achieved and client are informed of changes in the medical scheme benefits and contact people at the scheme. Also assist client with any billing problems to ensure that cover is not cancelled by the scheme due to discrepancies.

F) Monitoring the client's membership with the medical scheme

Inform the client when you will again meet to determine if the medical scheme and option selected is still appropriate. Members of medical schemes can change their option every 1 January of a year and so need to be informed on the following year's contribution and benefit changes. Client's health can also change and the financial provider need to ensure that the client is on the most suited medical scheme option to ensure appropriate medical cover.