



**COUNCIL FOR MEDICAL SCHEMES
REPUBLIC OF SOUTH AFRICA**

CMS 83390

In the appeal between:

**Bonitas Medical Fund
and
B and F**

Appellant

Respondents

APPEAL RULING

Introduction

1. This opposed appeal arises from a ruling of the Independent Dispute Committee made in favour of the respondents regarding the benefit design of the International travel policy cover(travel policy/cover) with special reference to restrictions imposed for treatment of pre-existing medical conditions.
2. The appellant in this appeal was the respondent in the Dispute Committee proceedings while the respondents in this appeal were complainants in those proceedings.
3. The appeals committee is required to determine whether the Dispute Committee did not err in finding that provisions restricting cover for treatment of listed pre-existing medical conditions do constitute unfair discrimination grounded on health history.

Factual Background

4. Mr B and Ms F (respondents) are registered members of Bonitas Medical Fund(appellant). Respondents were represented by Mr R and the appellant was represented by Ms M at the appeal hearing. The appellant offered respondents the travel cover for emergency medical treatment while travelling abroad on leisure or business. The policy stipulates among others, the maximum period of cover, the age of members covered and the maximum funding covered. Relevant clauses of the travel policy provide as follows:

5. Maximum period of cover:

For leisure travel excluding USA is up to 90 days
Leisure travel including USA is up to 45 days
Business travel for the 18-70 years old is up to 45 days

6. Emergency medical treatment for:

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| Main member worldwide, excluding USA is | R5,000,000 |
| Family worldwide, excluding USA is | R10,000,000 |
| Family worldwide including USA is | R500,000 |

Hospitalisation, inpatient treatment, outpatient treatment and prescription medication are covered under this benefit.

7. Emergency medical treatment of pre-existing medical condition:

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| Treatment of a member with the pre-existing medical condition | R200,000 |
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Hospitalization and inpatient treatment only are covered.

8. Aggrieved by the policy benefit design with special reference to the age restriction of members, restrictions for the treatment of pre-existing conditions and the reduction of benefits for travel including the USA, the respondents complained that:

8.1. Exclusion of members below 18years and above 70years from the policy constituted unfair discrimination grounded on an arbitrary ground of age(age discrimination dispute) and sought a directive that the appellant bring its travel policy into line with the law by ensuring that all the members on a particular plan option enjoy the same cover, regardless of their age.

8.2. Restriction of benefits for treatment of members with a pre-existing health condition for treatment of that pre-existing condition constituted unfair discrimination grounded on an arbitrary ground of a member's health history(health discrimination dispute) and sought a directive that the appellant bring its travel benefit into line with the law by ensuring that all the members on a particular plan option enjoy the same cover, regardless of their state of health.

and

- 8.3. The benefit design for travel including the USA was commercially unsound(USA benefit design dispute), and sought a directive that the appellant re-examine its benefits/contracts of insurance to ensure that the travel including the USA was redesigned with market norms such that it does not squander members' fund.
9. The appellant disputed the complaints and advanced reasons. A Dispute Committee was constituted in terms of Rule 28 of Bonitas Medical fund (DC) to adjudicate the dispute. Prior to the DC adjudicating the dispute, the appellant removed provisions which were offending the MSA on grounds of unfair age discrimination. Accordingly, the DC was then left with only two disputes to adjudicate, namely:
 - 9.1. Whether the benefit design which provided for reduction of the family benefit and the travel duration for trips that include the USA transgressed any law; and
 - 9.2. Whether the restrictions on treatment for pre-existing conditions offended against any provisions of the MSA.
10. Regarding the USA benefit design dispute, the DC found that:
 - 10.1. there were no specific allegations or evidence of irregularities relating to the significant difference in the travel cover provided for the USA included travel versus travel to other countries;
 - 10.2. the DC lacked the necessary expertise and jurisdiction to investigate this complaint; and
 - 10.3. the appellant's explanations regarding the USA travel benefit was accepted.
11. Based on these findings, the DC held that the variance in benefits did not appear to be unlawful or improper and accordingly concluded that there was no substance to this complaint. Having read the papers and heard the parties' submissions, I agree with the findings of the DC. The DC's decision regarding the USA travel benefit design was not appealed.
12. Regarding the unfair health discrimination dispute, the DC found in favour of the respondents that indeed the restriction which capped treatment cover for pre-existing conditions offended against the provisions of the MSA, hence this appeal.

The appeal

13. The respondents case is that the appellant has breached the Community Rating Principle, a fundamental principle on which governance of medical schemes is founded and further that the appellant has violated Section 24(2)(e) which prohibits unfair discrimination based on a member's health condition. In the main, the appellant disputes existence of discrimination emanating from the pre-existing health condition policy provisions.
14. In their submissions on appeal, the parties shared a common view in broad terms that:

- 14.1. The offering of an international benefit is discretionary and does not form part of the compulsory cover a scheme must provide;
- 14.2. All benefits of the international travel must nevertheless comply fully with the MSA, including the community rating principle;
- 14.3. The MSA does not provide for blanket prohibition on discrimination, the prohibition is against unfair discrimination;
- 14.4. All members belonging to the same benefit option plan must have access to the same benefits;
- 14.5. International travel benefit cover provides for special category of claims which are contractually regulated subject to compliance with the MSA.

Legal framework

15. The respondents submit that the appeal should be adjudicated through the prism of the Community Rating principle and Section 24(2)(e) of the MSA. It is common cause that The community rating principle provides, amongst others that:
 - 15.1. All members belonging to the same benefit option must be treated the same, and must pay the same for such cover; and
 - 15.2. No person may be unfairly discriminated against.
16. Section 24(2) (e) enjoins the Registrar to register a medical Scheme upon being satisfied that the Medical Scheme does not or will not unfairly discriminate directly or including race, age, gender, marital status, ethnic, or social origin, sexual orientation, pregnancy, disability and state of health.
17. Section 32 of the Medical Schemes Act 131 of 1998 provides that the rules of a medical scheme are binding on the medical scheme concerned, its members, officers and a person who claims any benefit under the rules or whose claim is derived from a person so claiming.

Definition of pre-existing health condition and analysis of related provisions

18. The subject of appeal is a finding that the policy provides for discrimination emanating from the pre-existing health condition. Accordingly, provisions relating to pre-existing health condition require scrutiny.
19. In the papers before the DC and this appeals panel, there appears to have been a confusion regarding interpretation of provisions that impose restriction for the treatment of listed pre-existing conditions. The confusion has since been settled during the appeal hearing when the parties ultimately struck a common ground that the policy capped emergency treatment for a pre-existing condition at R200 000.00 for treatment of a member with that condition.
20. The travel policy defines pre-existing medical condition /pre-existing condition as “any past or current medical condition that has given rise to symptoms or for which any

form of treatment or prescribed medication, medical consultation, investigation or follow-up/check-up has been required or received during the 12 (twelve) months prior to the commencement of cover under this policy and/or prior to any trip, and any cardiovascular or circulatory condition (e.g.heart condition, hypertension, blood clots, raised cholesterol, stroke, aneurysm) that has occurred at any time prior to commencement of cover under this policy and/or prior to any trip.”

21. It is clear from the definition that a pre-existing condition falls into two broad categories namely:
 - 21.1. any medical conditions including symptoms for which a member received or required medical consultation, medical investigation, medical treatment and or prescribed medicine, within 12months before commencement of the International Travel policy; and
 - 21.2. any cardiovascular or circulatory condition that has occurred at any time prior to commencement of cover under the policy and/or prior to any or trip.

22. The net effect of the cover for pre-existing condition against cover for other health conditions is that:
 - 22.1. Any member without a listed pre-existing condition is entitled to emergency medical treatment for hospitalisation, outpatient treatment and /or prescribed medication for treatment of any health condition including any of the pre-existing health conditions listed in the policy, at up to R5 000 000.00(main member), or R10 000 000.00(family) whichever is applicable;
 - 22.2. Any member with a listed pre-existing condition suffering any other disease except that pre-existing condition is entitled to emergency medical treatment for hospitalisation, outpatient treatment and /or prescribed medication for treatment at up to R5 000 000.00(main member), or R10 000 000.00(family) whichever is applicable; and
 - 22.3. Any member with a listed pre-existing condition suffering that pre-existing condition, is entitled to emergency medical treatment for hospitalisation and treatment as an inpatient for the treatment of that pre-existing health condition at up to R200 000.00.

23. The above shows that members who belong to the same benefit option plan are treated differentially for the treatment of listed pre-existing health conditions. Members without pre-existing conditions are entitled to up to R5 000 000.00 or R10 000 000.00 for inpatient, outpatient and prescribed medication treatment of listed pre-existing conditions, members with a pre-existing condition and not suffering from that pre-existing condition are entitled to up to R5 000 000.00 or R10 000 000.00 for inpatient, outpatient and prescribed medication treatment of any other listed pre-existing condition and members with a pre-existing condition and suffering from that pre-existing condition are entitled to up to R200 000.00 funding restricted to inpatient treatment only.

9. Notwithstanding, the appellant maintains that there is no discrimination for any member who has any of the pre-existing conditions listed in respect of that pre-existing condition, as all members who have pre-existing conditions will be treated exactly in the same manner. The appellant is missing the point that the cause of complaint is not differential treatment among members with pre-existing conditions, the cause of complaint is differential treatment among members within the same benefit plan, namely those who while on international travel suffer any listed pre-existing condition for the first time and those who suffer the pre-existing condition which they historically had..
10. Based on the analogy of the definition of pre-existing condition above, I find that the pre-existing condition provisions do indeed provide for discrimination between members with pre-existing conditions and those without pre-existing conditions.

Whether the differentiation is not unfair

11. Arguing against the respondent's contention that the discrimination is arbitrarily unfair, the appellant submits that the medical schemes' legal right to offer different benefit options, accepts that there will be differentiation between members. To this argument, the respondents correctly submit that discrimination is permitted with respect to benefits between benefit options within any particular scheme, but not within the same benefit option plan as is the case in the present appeal.
12. To support its submission that differentiation including restriction of benefits between members is allowed the appellant referred to restrictions of benefits such as the 3-months general waiting period and 12-months conditions specific waiting period for applicants for the medical aid scheme membership. The respondent dismisses this submission as irrelevant. The appellant is missing the point that the cited restrictions are expressly legislated and do not negate prohibition against differential treatment of members within the same option plan. The appellant's analogy in this respect can thus not hold.
13. The appellant advances risk management as one of the reasons for curtailing benefits related to pre-existing condition treatment. The respondents' cause of complaint is the appellant's election to not treat all members in the same benefit option plan the same. Accepting that the appellant is entitled to design its scheme in a manner that mitigates its risk exposure, the respondents correctly argue that when doing so, the appellant still has an obligation to treat all members the same like for instance providing for a lower but equal threshold cover for the treatment of any listed pre-existing condition in respect of all members on that plan irrespective of a member's healthcare history.
14. The respondents submit that substantially adverse conditions to members with pre-existing conditions are triggered by the member's past or present health condition and relies on section 24(2)(e) for a submission that the discrimination is arbitrarily unfair on

grounds of health. The appellant submits in its heads of argument that the MSA prohibits unfair discrimination of an arbitrary nature (such as ... , or simply having a healthcare condition such as diabetes (as opposed to any other disease). Accordingly, medical schemes may not discriminate against persons simply on such a ground". This argument fully supports the respondent's submission supported by the MSA that differentiation based on health condition constitute an arbitrarily unfair ground In the present case, a differentiating factor to the quantum and nature of treatment offered is the current or historical health condition of a member. In the circumstances, a conclusion that the pre-existing provision in the policy provides for arbitrarily unfair treatment of one category of members within the plan is inescapable.

15. Relying on Section 32 of the MSA the appellant contends that benefits (treatments) under the international benefit option are accessed subject to the terms and conditions applicable thereto, which terms and conditions form part of the registered benefit options, and therefore form part of the contractual terms and conditions between the member and the Scheme. its relationship with the members is contractual and binding in terms of Section 2 of the MSA.
16. The appellant relies on the fact that the rules are registered with the provision of treatment for pre-existing conditions incorporated in the travel policy. It is settled that approved rules are deemed to be fully compliant with the MSA and related legal instruments. Understanding that registration of rules is not conclusive proof of the rules compliance with the MSA, the appellant withdrew provisions which were offensive on grounds of unfair discrimination based on age, *mero motu* before the dispute was subjected to adjudication. The onus to rebut the deeming provision rests on the party challenging the affected provisions of registered rules, in the present case, the onus rests on the respondents.
17. The factor differentiating the quantum of funding and nature of treatment offered among members in respect of treatment of pre-existing health condition is a member's health status or history and section 24(2)(e) classifies health history as an arbitrary ground for discrimination, it thus follows that the differentiating is offending against the MSA. It is also settled that in the event of inconsistencies between provisions of the MSA and provisions of the registered rules, provisions of the MSA shall prevail.
18. The respondents have tendered sufficient evidence to make out a case for rebuttal of the deeming provisions that the rules of the scheme are fully compliant with the MSA. In the result reliance on the fact that the rules incorporating the plan were approved and therefore binding is not accepted and should thus be rejected.

Conclusion:

It is found that the DC was correct in finding that appellant's rules providing for the capping of treatment funding of a pre-existing condition and imposing restriction of the treatment to inpatient only are arbitrarily unfair and thus offend against the MSA

Ruling:

- a) The appeal is dismissed
- b) The ruling of the Bonitas Dispute Committee made on 11 August 2023 is confirmed and upheld

DATED THE _____ DAY OF JULY 2024

Ms M Ramagaga

Concurring : Dr T Mabeba, Dr X Ngobese, Dr S Naidoo, Dr K Chetty, Ms P Beck