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# JOINT EXPLANATORY PRESS STATEMENT BY THE NATIONAL TREASURY AND THE DEPARTMENT OF HEALTH ON DRAFT HEALTH INSURANCE PRODUCTS AND MEDICAL SCHEME DEMARCATION REGULATIONS

The Minister of Finance, in concurrence with the Minister of Health, published for public comment the draft Demarcation Regulations ("Regulations") on 2 March 2012. The draft Regulations aim to find an appropriate balance between the role played by certain health insurance products and the need to protect key principles underpinning medical schemes. The public has until 23 April 2012 to comment on the draft Regulations.

The recent public and media statements and comments on this matter have prompted the need to provide a joint statement by the two departments, in an effort to clarify certain potential misunderstandings. Medical schemes and health insurance products are different and it is important for the public to note these differences in order to make wise decisions as consumers of healthcare.

**What it is all about**

The purpose of the draft Regulations is to ensure that health insurance products, including gap cover, do not infringe on the Medical Schemes Act 131 of 1998 which governs medical schemes.

**The differences between medical schemes and health insurance**

Medical schemes are important for enabling access to private healthcare. The risk pooling and cross-subsidisation achieved through medical schemes helps to spread the healthcare costs between the young/healthy and the old/sickly, and thereby enables affordability. The regulation of such risk pooling is critical and common in many countries to achieve social welfare, and not only individual welfare.

Medical schemes are not for profit organisations which operate like trust funds.

Short and long-term insurers providing health insurance products are commercially driven for-profit companies. Medical schemes belong to their members, while health insurance companies are owned by shareholders.

Medical schemes espouse unique principles which can only be found in the Medical Schemes Act. These principles are (i) open enrolment, (ii) community rating, and (iii) a set of prescribed minimum benefits, commonly called PMBs. Open enrolment means that anyone can join a medical scheme and that if you apply for membership, the scheme of your choice cannot turn you away. Community rating means that all members of a medical scheme pay the same monthly contribution for the same benefits. PMBs ensure that members are fully protected against unforeseen and potentially catastrophic health events.

These principles do not apply to health insurance products. Anyone can buy a short- or long-term health insurance policy, but the premium you pay will usually depend on the insurer's assessment of your state of health. Older individuals, or individuals with pre-existing health conditions, will pay more for health insurance cover. At the extreme, health insurance companies may refuse to cover you if they consider that there is too high a risk that you are likely to claim.

Very importantly, medical schemes are not allowed to discriminate against you on any grounds, including your age and health status. Medical schemes are allowed to set your monthly contribution based only on your income or number of dependants, or both.

Medical schemes provide full cover for 300 of the most serious and most expensive health conditions through the PMBs, including any emergency, most cancers, and 27 chronic conditions such as asthma and diabetes, if such service is rendered within the medical schemes network of doctors and hospitals Health insurance products usually provide limited cover which tends to set in only after some time has elapsed; no benefits are guaranteed by any law.

Medical schemes are run by trustees who are held accountable to clear governance principles enshrined in legislation, and effective complaints adjudication processes protect their members in the event of disputes with their medical scheme.

Medical schemes are a form of social security in that the monthly contributions are collected into a common risk pool from which benefits are paid out in accordance with the principle of solidarity, where the young and healthy cross-subsidise the older and sicker members of the same medical scheme, thereby ensuring the financial health and long-term sustainability of the medical scheme.

**The challenge with high healthcare costs**

Various measures are currently being considered by the Department of Health and Council for Medical Schemes to address the critical issue of medical care affordability. This includes, amongst others, the current system of using designated health service providers and the clarification of PMBS. PMBs require medical schemes to pay in full if a member uses the services of designated service providers.

The draft Regulations do not propose the phasing out of all health insurance products, but only those which compromise the key principles of social welfare, solidarity and cross-subsidisation found in medical aid schemes (e.g. gap and top covers). A health insurance policy is not a substitute for being a member of a medical aid scheme.

Given also the recent court decisions, it is important for the public to be made aware that medical schemes are now expected to pay out in full for a PMB condition, provided that the member uses a designated service provider. Consumers should also note that there are different commission structures for the sale of a health insurance policy and a medical scheme policy.

**Please comment**

The draft Regulations are available for comment on the National Treasury (www.treasury.gov.za), the Department of Health (www.doh.gov.za), the Financial Services Board (www.fsb.co.za), and the Council for Medical Schemes (www.medicalschemes.com) websites.

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