AW

SUBMISSION TO NATIONAL TREASURY ON:

THE DRAFT REGULATIONS PUBLISHED FOR PUBLIC COMMENT IN TERMS OF THE SHORT-TERM INSURANCE ACT NO. 53 OF 1998, (GOVERNMENT GAZETTE 35114), DATED 2 MARCH 2012.

Date of submitting: **23 April 2012**

Entity submitting: **Xelus (Pty) Ltd**

Xelus has considered the proposed Draft Demarcation Regulations as they pertain to the Short Term Insurance Act (collectively referred to herein as the '**DDR**') published by the Minister of Finance on 2 March 2012 and hereby submits its consolidated comments for consideration.

In preparing this commentary, cognisance was taken of the following existing legislation:

- The Short-term Insurance Act, 1998 ("STIA") including the regulations promulgated thereunder collectively referred to herein as the '**STIA**';
- The Medical Schemes Act, 1998 ("MSA") including the regulations promulgated thereunder collectively referred to herein as the '**MSA**';

This submission is to be read together with statements dealing with matters referred to in documents accompanying the publication of the DDR as well as various other relevant publications, being –

- the media statement entitled *"Minister of Finance releases draft regulations on the demarcation between health insurance policies and medical schemes", dated 2 March 2012 ("the media statement");*
- the document entitled *"Frequently Asked Questions: Demarcation between Health Insurance Policies and Medical Schemes" ("the FAQ document");*

- The Joint Explanatory Press Statement made by the National Treasury ('NT') and the Department of Health ('DoH') on Draft Health Insurance Products and Medical Scheme Demarcation Regulations, dated 16 April 2012;
- The judgement handed down by the Gauteng High Court in the matter between the Board of Healthcare Funders ('BHF') and the Council for Medical Schemes ('CMS') during September 2011 relating to the definition of Section 8 of the Medical Schemes Act (131) of 1998;
- Various publications – Annual Reports, Research Findings, etc. Specific references to such publications are made within this document as footnotes.

1. Introduction

1.1 Distinction between Health Insurance Products

The very first comment we would like to submit under the introduction is a disappointment that there has been limited distinction within the DDR between the various types of health insurance products in the market place.

In the NT Demarcation Working Group, much commentary was provided by SAIA in creating different typologies of cover in order for a reasonable distinction to be drawn on these matters.

Consumers healthcare needs are varied and complex and by attempting to create a simplistic regulatory framework under the DDR will invite much resistance from stakeholders.

Legal action may be invoked to overturn components of the DDR that clearly infringe upon the constitutional rights inferred upon citizens to protect their assets as well as to access healthcare that they are otherwise unable to access.

By and large the insurance industry is mindful of the concerns of the DoH and the CMS in protecting the medical schemes environment but to fully oppose almost all forms of existing health insurance in a blanket fashion is going to draw out this matter in a lengthy and controversial manner.

1.2 Consultation Process

Whilst we are appreciative of this opportunity to provide comment to NT on our views on the DDR, we also contend that subjecting the participants of the working group to confidentiality agreements precluded stakeholders from engaging in meaningful debate and most certainly any form of democratic dialogue.

We also contend that the declaration by NT in the media statement on 02 March 2012 that the DDR were published after *"robust and inclusive consultation with the interested and affected stakeholders"* is demonstrably inaccurate and that the rights of stakeholders to fair and procedural administrative justice have been compromised in the process.

2. <u>Background</u>

2.1 Historical Framework

The existing framework of delivering private health insurance cover to citizens in South Africa is primarily regulated under the MSA with cover delivered via medical schemes.

Up until the late 1980's and early 1990's, medical schemes were capable of delivering an all-encompassing healthcare solution to consumers willing to voluntarily purchase private healthcare cover (as opposed to relying upon state cover).

This provided an ideal framework within which to proffer an alternative to state provided healthcare, fully funded by the citizens making such private contributions.

However, and this matter is fundamental within the context of these DDR, a discord was appearing between private healthcare providers and the medical schemes industry, most notably in the aspect of determining a reasonable level of reimbursement to professional providers which was commensurate with their services, the cost of providing such care and to provide them with a reasonable rate of return.

Differences in reimbursement rates between the medical schemes tariffs and private charges of professional providers have been disparate for approximately twenty years, with the difference growing markedly within the past 8 years since

the disbanding of collective provider reimbursement negotiations by the Competition Commission.

The issue of differing rates of provider reimbursement by medical schemes are highly pertinent from the perspective that the existing MSA and its associated regulations do not have a compelling solution to this growing problem.

This matter will be dealt with further in sections 3.1 and 3.2 of this submission.

2.2 Medical Schemes Product Evolution

Prior to the current MSA of 1998, the medical scheme industry did not provide for any form of mandatory minimum cover level (as is currently the case with the Prescribed Minimum Benefits ('PMB')).

Medical schemes prior to the 1990's typically only offered one benefit option – affordability was high and accordingly no distinction of various levels of cover was necessary. Characteristically most benefit options were of a very comprehensive nature.

By the early 1990's the growing cost pressures of private healthcare were starting to impact on the affordability of medical scheme members and schemes responded by providing lower benefit options at reduced contributions.

The annual reports of the CMS have only in recent years started showing the number of various benefit options per medical scheme hence it is difficult to accurately determine the increase in the number of benefit options over the past 20 years.

However, there is a trend of a growing number of benefit options in an attempt to meet differing consumer needs (the number of open scheme benefit options has grown from an average of 5.0 per scheme in 2002 to 6.1 in 2010)[1].

We have also shown below in Table 1 the splits of membership per broad category of cover type from the latest 2010 Annual Report for the 3 largest open schemes in the country – these schemes represented more than 40% of all medical scheme families in 2010.

[1] CMS Annual Report 2010

As can be seen from the Table 1 it is now very evident that the vast majority of members are only able to afford limited benefit options.

Table 1

Benefit Option Type	Discovery	Medihelp	Bonitas
Very Comprehensive	1.1%	21%	-
Comprehensive	21%	23%	1.5%
Partially Limited Benefits	46%	19%	61%
Restricted (by Benefits)	13%	17%	27%
Restricted (by Network Access)	18%	19%	9%

Since the statutory PMB are mainly hospital based services, the retained core benefits within the lower benefit options are mainly for hospital and associated specialists care.

It is also worth noting that the high proportion of Medihelp members (21%) within their most comprehensive benefit option are ex-government employees (state pensioners) who enjoy a 100% government funded subsidy, so there is no cost barrier to retaining such a high level of cover.

Without such subsidy it is highly unlikely that the participation in this benefit option would be anywhere close to 22%.

In any event, most of these members have recently been transferred to the Government Employees Medical Scheme (GEMS) and hence the above distribution of Medihelp members will come more in line with industry norms.

3. Cost Expansion, PMB & Anti-Selection

3.1 Private Hospital Cost Expansion

Subsequent to the promulgation of the MSA in 1998, the three, already dominant, private hospital sector groups saw commercial opportunity in acquiring an even greater share of the existing private hospital market.

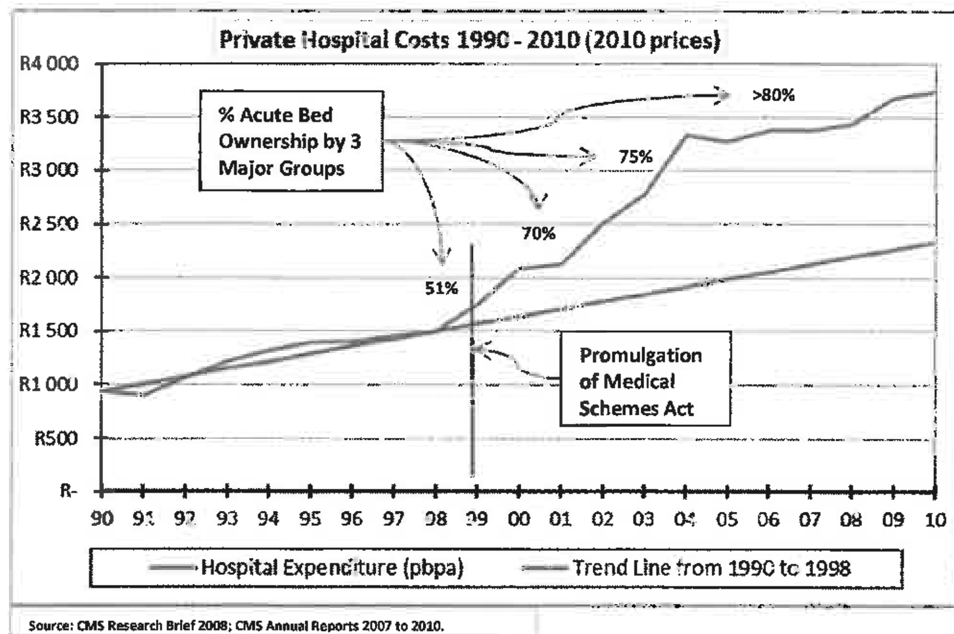
This was predicated on the impending statutory PMB which provided guaranteed curative hospital based care to all medical scheme members.

Graph 1 below shows the massive increase in private hospital costs since 1998 on a per beneficiary per annum basis (blue line) alongside the change in the proportion of acute hospital bed ownership by the three main hospital groups in SA (i.e. Netcare, Mediclinic and Life).

It is very clear that the cost explosion coincided with the promulgation of the MSA and the subsequent increase in bed ownership, which has placed massive pressure on medical schemes.

The red line in Graph 1 shows an extended trend line of private hospital costs during the 1990's. It is clear that the costs since 1998 have far exceeded this historical trend.

Graph 1



These onerous cost pressures and subsequent contribution increases have been a catalyst for benefit option downgrades[2] as illustrated in Table 1.

In 2004 the Competition Commission made a ruling that set aside the industry tariff structure which was used collectively by medical schemes to negotiate reimbursement of providers.

[2] Source: CMS Annual Report 2010

Subsequently schemes lost negotiating power and an alternative tariff, the National Health Reference Price List ('NHRPL'), was set up under the auspices of the DoH. This, however, remained a voluntary tariff and schemes could in any event not collectively negotiate on reimbursement price determination.

A sample of a small scheme's billing was undertaken in 2008 by CMS in a research brief[3], and it concluded the following:

" . . . these increases were sparked by the intervention of the Competition Commission, which prohibited the central negotiation of tariffs. This, coupled with the publication by the HPCSA[4] of a de facto tariff schedule at 300% of the NHRPL, upset the balance of market forces setting prices in the market . . . . Also see figure 5.3 for an example of specialist billing experienced by a small medical scheme."

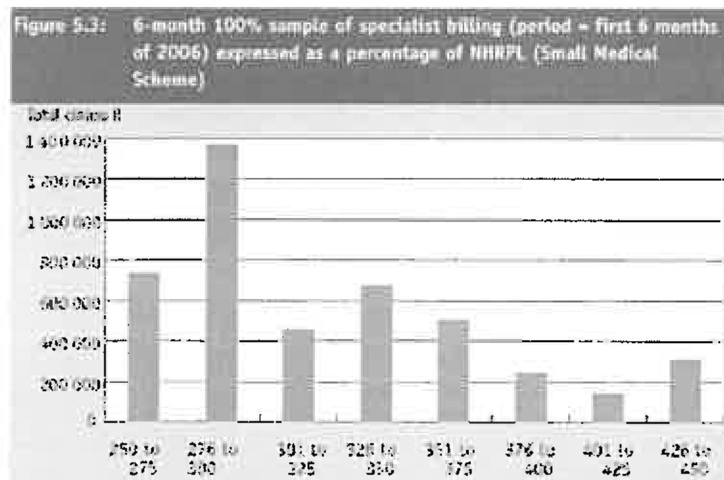


Figure 5.3: 6-month 100% sample of specialist billing (period – first 6 months of 2006) expressed as a percentage of NHRPL (Small Medical Scheme)

As can be seen from the above graph (Figure 5.3), 100% of these accounts were in excess of 250% of the NHRPL.

Two comments are worth noting regarding the above extracts:

- The above analysis was undertaken using 2006 claims data – however, at this stage the NHRPL tariff no longer exists. This leaves the supply side of the industry even less inhibited from a price perspective.

  Further to this, in 2008 the HPCSA removed the ethical tariff ceiling charge of 300% thereby paving the way for providers to determine their own maximum billing amounts based upon market demand.

[3] Source: CMS Research Brief No 1 of 2008

[4] HPCSA – Health Professions Council of South Africa

Since medical specialist services in particular remain in high demand, it is now not uncommon to see charges in excess of 400% of the old NHRPL.

The following comment was made in 2011 by the CMS regarding medical specialists[5] - *"[the increases] cannot be rationally explained but might be attributed to market failures inherent within the private healthcare market"*.

- The above graph shows that 100% of the billing sample was above 250% of NHRPL.

  Whilst it was acknowledged by CMS in the research brief that a 100% sample was unlikely to be evident across the entire industry it nonetheless emphasised that a 100% rate was possible in small medical schemes since they do not have the volumes and hence negotiating power to influence specialist charges.

  Of the medical schemes in 2010, 42% are classified as small (less than 6,000 members)[6].

A cursory overview of the latest 2010 CMS Annual Report indicates that the majority of the 319 benefit options available across all medical schemes cover in-hospital expenses at 100% of their scheme tariff[7].

Table 2 below again examines the 3 largest open schemes in SA – this time it shows the proportion of total members by the level of in-hospital cover provided. As previously mentioned these 3 schemes cover more than 40% of all members in the industry.

Table 2

In-Hospital Cover Level	Discovery	Medihelp	Bonitas
100% of Scheme Tariff	51%	100%	90%
150% of Scheme Tariff	-	-	9%
200% of Scheme Tariff	48%	-	-
300% of Scheme Tariff	1%	-	1%
Greater than 300%	-	-	-

[5] Source: CMS Circular 54 of 2011
[6] Source: CMS Annual Report 2010
[7] Although the NHRPL has been set aside, most schemes have used the last available set from 2006 and applied inflation related increases to these figures in order to create their own tariff.

As can be seen the vast majority of members are inadequately covered. A bare minority of less than 1% overall have access to in-hospital cover greater than 200% and typically such options are extremely expensive.

Many medical schemes also have no alternative option within their benefit range to buy higher cover, i.e. all benefit options cover in-hospital services at 100% of scheme tariff (eg Medihelp as shown above).

In fact, many medical schemes have <u>never</u> had benefit options offering anything more than cover at 100% of tariff.

Members of these schemes therefore do not have the option of upgrading their benefit option in order to insure themselves better against the high cost of in-patient medical specialist costs.

The absolute vast majority of options that do offer cover higher than 100% only extend such cover to either 150% or 200% which, as is outlined in Figure 5.3 above, remains insufficient in any event to provide comprehensive cover.

The DDR, alongside the press release of 16 April 2012 in particular, made continuous reference to the detrimental effects of Gap Cover products on medical schemes.

As is well known Gap Cover products serve to cover the inherently entrenched shortfalls that have been outlined above.

These cost shortfalls can be countered by using the designated service providers of medical schemes (i.e. a 'DSP') and/or reliance on the PMB payment 'at cost' ruling.

These 2 measures are, however, not universally available to all members and they do not provide for comprehensive cover on all in-patient medical services.

Empirical evidence attained from medical schemes dictate that they do not have nor are they capable of constituting networks of specialist DSP. In such events, the PMB dictate that such services must then be paid for at cost.

However, many major surgical procedures are not a PMB.

According to the Council for Medical Schemes 2010 Annual Report, only **51%** of private hospital admissions accounted for PMB conditions. Members are therefore not afforded the 'at cost' PMB protection for the remaining **49%** of hospital admissions.

So in the event that medical schemes do not have network providers ('DSP') they are not able to provide an all-encompassing solution for members (i.e. only for 51% of admissions).

The extract below is from the CMS Annual Report 2010 and clearly shows the proportion of admissions that were PMB as a proportion of total admissions.

	Open schemes	Restricted schemes	Consolidated
		2010	
Number of beneficiaries visiting a private provider at least once in 2010			
General practitioner	746.7	780.3	760.8
Dentist	216.9	247.9	229.9
Private nurse	8.3	10.1	9.0
Number of beneficiaries visiting a private facility at least once in 2010			
Beneficiaries admitted to hospital*	195.5	167.6	184.6
Beneficiaries admitted for emergency	44.6	42.2	43.6
Admissions**	239.4	194.6	220.6
Same-day admissions	18.4	72.4	41.2
Total admissions	257.8	267.3	261.8
Beneficiaries admitted to hospital for PMBs	96.3	93.8	95.3

(The figures above are based upon average no of admissions per 1,000 beneficiaries)

However, in stark contrast to this, the joint press release of 16 April 2012, stated that *"PMBs ensure that members are* ***fully protected*** *against unforeseen and potentially catastrophic health events"* [own emphasis added].

It is therefore a considerable inaccuracy to state that members are fully protected by the PMB for in-patient services.

Further to this matter of being *"fully protected"*, the same press release also offered assurance that the PMB provides cover for *"most cancers"*. We would argue as to which rational consumer would be secure in the knowledge of being covered for *"most cancers*[8]*"*.

We reiterate that there is no solution for a member who happens to suffer from a cancer that is not a PMB.

[8] The term "most cancers" was used in the joint press release of 16 April 2012.

3.2 Payment of PMB at Cost

The one critical aspect of reliance on the protection provided by PMBs is the current legal action being taken by the representative body of medical schemes, the Board of Healthcare Funders ("BHF").

Medical schemes have currently been compelled by the CMS to pay for PMBs at cost in accordance with Section 8 of the MSA which states that, for PMB treatment and diagnosis, schemes must make *"payment in full"*.

However, most medical schemes are not in agreement with this ruling, due to the ambiguous wording in the MSA, and subsequently took the matter to the High Court in 2011 via BHF in an attempt to get the practice overturned.

However, the judgement handed down ruled that the BHF did not have the 'legal standing' to bring the case to court, surprising given that the BHF represents 95% of medical schemes. Subsequently the application was dismissed.

However, it is very important to note though that <u>no ruling was made</u> on the validity of the ambiguous wording *"payment in full"*. This case is still being pursued by the BHF in the High Court, seeking final clarity on the matter.

The pertinence to the DDR is that the CMS and DoH are making use of the PMB as an alternative solution to members for having Gap Cover, offering them a commitment of protection.

In the event that the High Court rules against the CMS, there will be <u>*no protection at all*</u> for members for in-patient costs that exceed the scheme tariff.

On this basis we believe it to be disingenuous to defend the DDR by using aspects of the PMB that remain subject to legal interpretation.

3.3 Anti-Selection[9]

A further provision of the MSA that appears to be universally accepted without question is the matter relating to cross-subsidisation between the young/healthy and old/sick.

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[9] Anti-selection is the practice of remaining uninsured whilst young/healthy and only becoming insured later when you are old/sick.

It is obviously acknowledged that medical schemes practice community rating and open enrolment in accordance with the MSA since these practices are legally required.

However, cross-subsidisation is not legally entrenched within the MSA since it is missing the necessary regulatory framework in order to achieve this, i.e. mandatory cover[10].

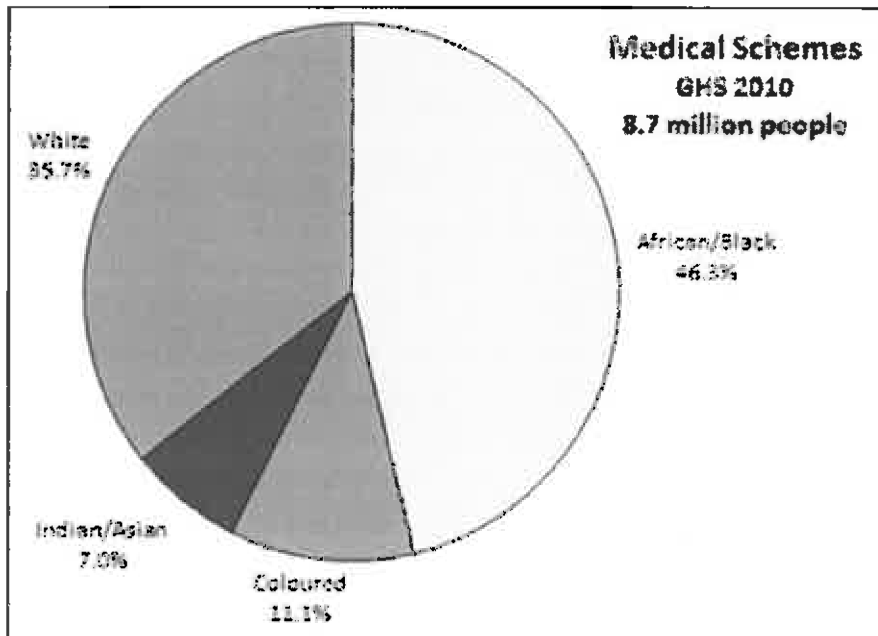
No real evidence of the existence of this apparent cross-subsidisation has been presented and it has therefore been assessed and analysed by ourselves.

Numerous CMS publications, the media statement issued by the Minister of Finance on 02 March 2012 and the joint press release of 16 April 2012 make reference to the possible undermining by health insurance products of the ostensibly <u>existing</u> cross-subsidisation between the young/healthy and old/sick.

These publications state further that without this apparently vital element, medical schemes would be undermined and hence become unstable.

However, once analysis is made of the existing age profile of medical schemes, it is abundantly apparent that the cross-subsidisation <u>does not exist</u> to any significant degree.

<u>Graph 2</u>



[10] Mandatory Cover ensures cross-subsidisation by compelling all citizens to partake within the insured risk pool.

Graph 2 above shows the 2010 splits of medical scheme membership by race group[11]. The only significance of splitting the membership into the race groups is that SA's 4 classified race groups have rather different age distributions within each population.

This is significant in determining the age distribution of the 'potential population' that is available for medical schemes from which to draw membership.

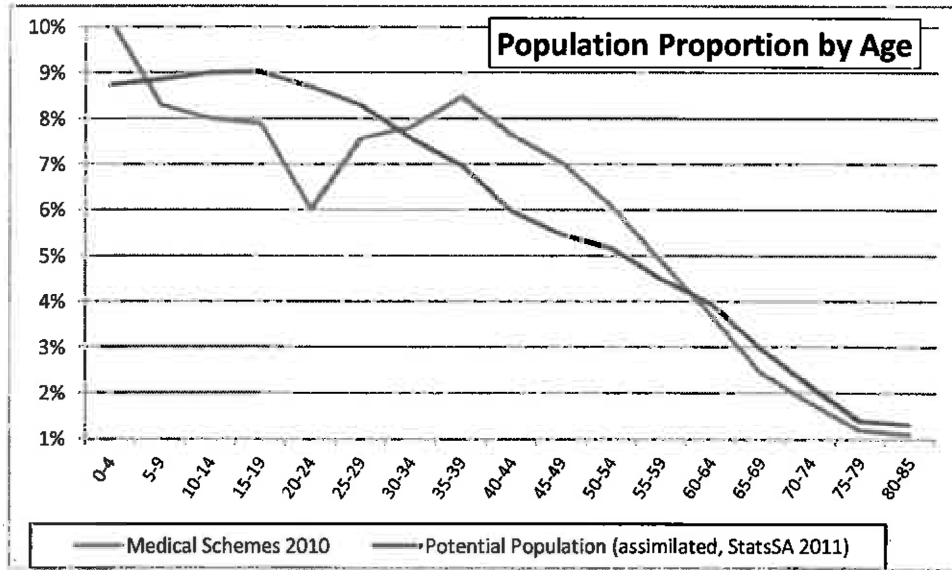
Graph 3 below compares the age distribution of existing medical scheme beneficiaries with the age distribution of the 'potential population'.

The 'potential population' in Graph 3 below is made up of the current age distributions of the 4 race groups (Black, White, Coloured, Indian/Asian[12]) in similar proportions to those of existing medical scheme beneficiaries (as shown above in Graph 2).

As can be seen from Graph 3 below, medical scheme beneficiaries are substantially underrepresented in the age categories 5 to 34 when compared to the potential population ratios and are, inversely, considerably overrepresented in the age categories 35 to 64.

The two distributions are only similar from age 65 upwards.

Graph 3



[11] Source: Innovative Medicines SA: NHI Policy Brief 21
[12] Source. StatsSA, 2011

It is well known that age is a significant driver of health costs, especially in tertiary services such as specialist and hospital costs.

If we examine any typical age distribution of medical costs, it is obvious that the lowest costs occur in the younger age groups which are the most underrepresented amongst medical scheme beneficiaries.

Clearly, as costs accelerate with age, it becomes too risky to remain uninsured and therefore there is a higher than normal representation of members in the age groups from 35 upwards of medical scheme beneficiaries.

The only exception is the high risk and cost often associated with birth - and hence again we witness an over representation of young infants in the medical scheme population[13].

These scenarios are classic examples of anti-selection.

Nonetheless, in contrast to all of the above, continuous reference is made to the existence of cross-subsidisation within the medical schemes industry as if it were an undisputed fact.

From the above we can readily witness that there is ***not a well-balanced degree*** of cross-subsidisation currently occurring within the medical schemes industry.

If this was the case, then the 2 age distributions in Graph 3 would approximate each other, which they clearly do not.

However, if the cross-subsidisation is as vital as is advocated under the auspices of the DDR, how is it possible that the current medical scheme environment is in existence, let alone stable?

In fact, the medical schemes industry remains very stable, with overall reserve levels well above the statutory requirement of 25% (2010: 31.6%)[14].

It can therefore only be concluded that the inferences of an existence of substantial cross-subsidisation within the medical schemes environment is based upon anecdotal observations that cannot be substantiated.

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[13] CMS data shows age categories of younger than 1 year and then from 1 to 4 years. However, StatsSA data only provides a category from 0 – 4 years so no direct comparison is possible for infants younger than 1 year.
[14] Source: CMS Annual Report 2010

The accusation against health insurance products of potentially removing the supposedly existing cross-subsidisation is therefore unfounded since you cannot remove something that does not exist.

The media statement issued on 02 March 2012 as well as the press release of 16 April 2012 made several references as to the unconditional necessity of the DDR in order to preserve the apparent cross-subsidisation within medical schemes and hence its stability.

It is thus reasoned within this submission that the degree of cross-subsidisation within the medical schemes environment is incorrectly overestimated, based upon assumption rather than hard evidence.

Hence the ostensible need to protect it by issuing the DDR is equally exaggerated.

This presumptive error calls into question the fundamental foundation upon which the DDR have been constructed.

4. Conclusion

In concluding this submission we reiterate that the DDR have unfortunately not created sufficient distinction between various health insurance products.

Our submission relates to the recognition of Gap Cover products and we conclude that they do not provide any form of cover that competes with medical schemes nor do they in any way influence members to discard their medical scheme membership.

The contention that Gap Cover forces members to downgrade benefit options is also challenged on the following grounds:

- No substantive evidence has been presented to substantiate such claims.
- Evidence that is available from the CMS[15] shows that affordability is the single biggest factor involved when downgrades do occur.
- A 2012 survey[16] indicated that 84% of members did not downgrade their benefit option when they took out a Gap Cover product. In fact a further 3% upgraded their benefit option.

[15] CMS Annual Report 2010
[16] Catalyst Pulse Survey – March 2012

- In the same survey, 97% of members understood that Gap Cover was an additional benefit over and above their medical scheme.

We further determine that the assurances offered to members of protection via the PMB are inaccurate, in that it offers partial levels of cover.

Given the widespread billing by specialist providers in excess of medical scheme tariffs, the constitutional rights of members to protect themselves against such inherently entrenched risks are being undermined by the DDR.

Further to the above aspect of the PMB, since the payment 'at cost' element of PMB services remain subject to legal challenge from the BHF, it is inappropriate to proffer the PMB as an alternative means of protection to members.

Finally the apparently numerous assumptions as to what extent cross-subsidisation is occurring within medical schemes, is distinctly dubious. Since this particular contention also forms the foundation upon which the apparent need for the DDR have been drafted, there remains ample scope to challenge the rationale behind the DDR.

For the substantive reasons set out in this submission, an abandonment of the draft Demarcation Regulations are required in order to create an alternative, inclusive and encompassing set of regulations, established through a more complete, transparent and, in particular, evidence-based process.

This will better serve the members of medical schemes who are significant stakeholders in this matter.

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