AM.

BOARD of
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

23rd April 2012

Re: Submission to Treasury on the draft Short-term and Long-term Insurance Act Regulations

Introduction:

The Board of Healthcare Funders (BHF) would like to thank you for inviting comment on the draft regulations to the Long-term and Short-term Insurance Acts, published on the 2nd March 2012. We believe that the amendments raise several important issues.

The BHF is a representative organisation for medical schemes and administrators, and represents the majority of medical schemes in South Africa, Namibia, Botswana, Zimbabwe and Lesotho.

B·H·F
www.bhfglobal.com

The comments in this document have been canvassed with the BHF Board of Directors, which represents BHF's membership.

This submission deals largely with the insurance products that supplement medical medical scheme offerings, e.g. Gap cover products.

Commentary

We believe, implicitly, that medical schemes are the most appropriate vehicle for healthcare funding, and that the impediments to this occurring should be dealt with by the relevant regulators as soon as possible. However, until such time as the incentives of the supply side can be brought into line with those of the funding industry, there will be a need for supplementary products which allow medical scheme members to mitigate their unfunded risks.

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

The commentary which follows seeks to respond to the rationale for the proposed draft Regulations which asserts that Gap cover and other health insurance products cause harm to medical schemes by drawing young and healthy members away from medical schemes to health insurance products.

To respond adequately to these assertions, it is necessary to consider the root causes of the affordability problem, and the reasons why the market for gap cover products has arisen in the first place.

1. Governing principles

The medical schemes industry is governed under social solidarity principles. The basic tenets of which are:

- Risk cross-subsidization – between the young/health and elderly/sick;
- Community rating – where all members of the scheme are charged the same, regardless of the risk they bring to the scheme;
- Guaranteed acceptance of all applicants;
- Mandatory membership – in order to have as large a risk pool as possible and to avoid anti-selection risks, i.e. where the young and healthy stay out of the system until they are elderly or sick, especially since acceptance is guaranteed.

B·H·F
www.bhfglobal.com

However, the current medical schemes legal framework is missing the essential component of mandatory cover. Subsequently, the practice of anti-selection has been widespread and hence, the critical risk pooling and the spreading of costs between young/healthy and elderly/sickly are absent.

Risk cross-subsidisation is therefore not occurring satisfactorily within the medical schemes environment at present.

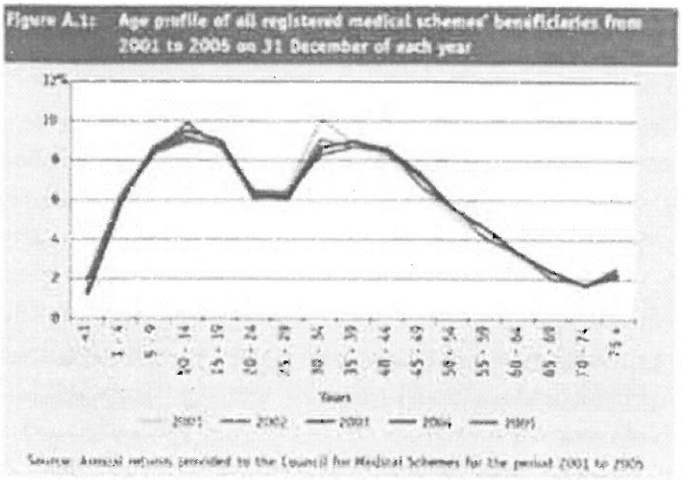
This can be evidenced by examining the Council for Medical Schemes Annual Reports for the past decade – medical scheme beneficiaries younger than 35 are of a much lower proportion. The reverse applies to members older than 35. This imbalance has been a major contributing factor to the massive escalation in

BOARD of
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

private healthcare costs since the late 1990's when the Medical Schemes Act was promulgated. Pertinent here is that the Registrar cites affordability as the major barrier for the young and healthy to buy higher-cost/comprehensive options. Therefore, it cannot be said that Gap cover products are to blame, but rather the many built-in systemic impediments, most of which will be discussed in this submission.

The graph below is taken from the CMS Annual Report and illustrates the dip in medical scheme membership of those between 19 and 34 years of age. This would not occur if mandatory cover were introduced.



B·H·F
www.bhfglobal.com

By combining open enrolment with non-mandatory membership, medical scheme regulators have provided an unbalanced framework that has significantly contributed to this undesirable scenario.

BHF therefore recommends that there should be a concerted effort by the NDoH and Treasury to introduce mandatory cover, even if it is only introduced for those earning above a certain threshold, in order to bring about proper risk cross-subsidization due to a bigger risk pool.

It stands to reason that the more people who belong to medical schemes, the less the burden on the public health sector.

It is the view of BHF that mandatory cover is in line with the proposed NHI policy as NHI will be mandatory for the entire

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

population, but will be funded by those who are able to. The principles of income and risk cross-subsidization are key to NHI. Mandatory cover to medical schemes could therefore be introduced along these principles.

2. The Prescribed Minimum Benefits

The Prescribed Minimum Benefits pose two fundamental problems for the private healthcare funding sector. One being the structure of the PMBs and the other being the charging/payment of PMBs.

2.a) Structure of the PMBs

The Prescribed Minimum Benefits are a set of benefits which every medical scheme must provide for under all of its options. Introduced in 2000, the PMBs were a laudable attempt on behalf of the State to protect medical scheme members from being 'dumped' onto the public sector once their benefits had run out. However, the PMBs are fundamentally flawed for the following reasons:

B·H·F
www.bhfglobal.com

- The PMBs consist mainly of hospital and specialist-based conditions. These are curative-based, hospi-centric and mostly high-cost interventions which contribute significantly to the spiral in private healthcare costs. WHO has cited that a hospi-centric and curative approach to healthcare are two of three major factors which undermine a health system. (The third being uncontrolled commercialism, which is prevalent within the supply side of the private healthcare system.)

- The CMS Annual Report of 2009/10 states that private hospital costs have increased by 74.6% in the last 10 years, and specialists costs have increased by 58.5% in the last 10 years. (Figures adjusted for inflation).

- Since the PMBs are curative in focus, they do not contain primary and preventative benefits. This is in direct contradiction to national health policy and WHO guidelines, which stress the emphasis on primary and preventative care in order to improve outcomes and to promote efficiency in healthcare spend.

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

- The PMBs are a defined benefit list and therefore cover only certain conditions. They are therefore discriminatory in nature in that if a medical scheme member suffers from a condition outside of the PMBs, they would not necessarily be covered for that condition. For instance, the PMB includes certain cancers while leaving others out. This means that those suffering from a condition not included in the PMBs may not be able to access benefits for that condition. The BHF believes that this is contrary to national health policy, WHO guidelines and the NHI proposals, all of which centre around a set of comprehensive benefits with an emphasis on primary and preventative care.

Therefore, medical schemes have been forced to cover the 'anti-selection' risks mentioned above, whilst attempting simultaneously to manage a monopolised hospital sector brought about by legislation.

To this end, the view of BHF is that, until such time as the structure of the PMBs is reviewed, there is a need for products which allow medical scheme members to mitigate their risk should they not be covered in full, or at all, for a certain condition.

B·H·F
www.bhfglobal.com

2.b) Pricing and charging of PMBs

- Over the past seven years all tariff structures for health services have been scrapped, through various means, e.g. the Competition Commissioner's ruling in 2004; the scrapping of the NHRPL by the High Courts in 2010, etc. This has resulted in there being no reference price or guideline on pricing for PMBs and non-PMBs, and therefore no cap on the quantum which suppliers are permitted to charge for their services.

  In addition, the Registrar of Medical Schemes, has, after 12 years of PMBs being paid in full at scheme tariff, attempted to introduce a new interpretation of the 'in full' component – i.e. that which forces medical schemes to pay for PMBs in full at whatever cost the supplier chooses to charge. This has caused schemes to be faced with an open-ended liability for PMBs, and will continue to force schemes to increase premiums above inflation, and threaten the sustainability of the funding sector.

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

- Due to the structure of the PMBs, the extent of the services which specialists deliver are largely self-determined. Therefore the suppliers are able to determine demand. The term for this is, 'supplier induced demand'. This factor obviously substantially increases utilisation, and therefore costs.

- However, it must be stated, that even if there were a tariff schedule for PMBs, which was binding on all suppliers, there would still be 49% of claims which are not PMB related, which would not fall under the compulsory tariffs. Medical scheme members would therefore not be afforded the protection of a tariff for 49% of hospital and specialist claims.

- While it is possible for medical schemes to restrict members to acquiring cover from network doctors (also called 'designated service providers') in return for payment in full on invoice, there is no legal obligation on doctors to enter these networks. Furthermore, since medical specialists in SA remain in high demand, they have little incentive to enter any networks. Many medical schemes therefore simply do not have networks of medical specialists.

B·H·F
www.bhfglobal.com

The above points regarding PMBs highlight a few of the systemic factors which have contributed to the lack of affordability which many medical scheme members and potential members encounter.

As illustrated above, the existing medical schemes regulatory structure is by far the single biggest impediment to achieving the stated aim of risk pooling and cross-subsidisation which would bring about greater affordability.

The BHF view is that, until sufficient reform of the private sector has been introduced to ensure affordability and non-discriminatory PMBs, there is a need for supplementary products which will assist in providing for the gaps within the system. Gap cover products in particular only cover costs that medical schemes do not cover – ironically a consequence of the systemic problems.

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

Even if all medical scheme members were forced to subscribe to a fully comprehensive benefit option, there may still be a shortfall. An example of this scenario is as follows: Approximately 90% of anaesthetists charge 300 – 450% of the former National Health Reference Price List (NHRPL). Even the most comprehensive medical scheme options pay out only 200 – 300% of the former NHRPL. Therefore there would still be a shortfall which members must be at liberty to cover through an insurance product, should they so wish.

A situation where a medical scheme member is without benefit for a certain disease/condition due to the structure of the PMBs and not be permitted to obtain cover for that disease/condition, can never be justified.

If medical scheme members were forced to subscribe to fully comprehensive options, i.e. high-cost options - they may opt out of the system altogether. Given that the CMS Report states that younger and healthier members subscribe to low-cost options due to affordability, it is the view of the BHF therefore that if supplementary products, such as Gap cover, are outlawed, many members would not be able to afford to enter the medical schemes market at all, and would simply become a burden on the state.

B·H·F
www.bhfglobal.com

This would simply lead to a loss of protection for members rather than increasing the number of people on medical schemes.

If Gap cover is outlawed, schemes may increase their hospital benefits in but may decrease their out of hospital benefits. This is in direct contradiction to national health policy which, as stated earlier in this submission, emphasises and encourages benefits for primary and preventative care.

3. Specific comments:

3.a) Please provide an explanation on what basis HIV/AIDS has been singled out.

3.b) The draft Regulations outlaw top-up cover. However, the NHI Green paper recognises top-up cover and suggests that medical schemes may choose to offer such products. The reasons for outlawing these products is therefore questionable.

BOARD *of*
HEALTHCARE
FUNDERS
of SOUTHERN AFRICA

(Association Incorporated
under Section 21
Registration number
2001/003387/08)

3.c) The draft Regulations state that all insurance products would have to be approved by the Registrar for Medical Schemes, amongst others.

The BHF would like clarity on the way in which the Registrar plans to increase the CMS' capacity and who would fund this increase in capacity, since there are currently thousands of these sorts of products on the market.

3.d) If hospital cash insurance plans are to remain, we believe that the way in which they market their products should be regulated. The BHF believes that marketing of these products often misleads the public into thinking that they are adequately covered and that the benefit paid is linked to a health service, when in fact it is just a cash amount, not linked to a health service.

4. Conclusion

Once again, we would like to stress that It is BHFs view that medical schemes are the most appropriate vehicle for healthcare funding but until such time as the incentives of the supply side can be brought into line with those of the funding industry, there will be a need for supplementary products which allow medical scheme members to mitigate their unfunded risks.

Once again, we thank you for the opportunity to submit comment and trust that the comments we have made will be taken into consideration.

Yours sincerely,

B·H·F
www.bhfglobal.com