Ay

Dear Dr Sheoraj

SUBMISSION ON DRAFT REGULATIONS ON THE DEMARCATION BETWEEN HEALTH INSURANCE POLICIES AND MEDICAL SCHEMES

This submission is in response to the invitation by National Treasury relating to the draft Demarcation Regulations ("the Regulations") as gazetted by the Minister of Finance, Pravin Gordhan, on 2 March 2012.

1. NMG Consultants & Actuaries (Pty) Ltd

NMG Consultants & Actuaries (Pty) Ltd ("NMG") consults to employers, members of medical schemes and has broker contracts with the majority of the open medical schemes in South Africa. NMG also provides actuarial consulting services to various medical schemes. NMG operates in an environment where medical scheme costs are escalating faster than earnings and promotes the ability of prudent individuals to insure themselves against uncontrollable health costs. It is with this view in mind - the interest of consumers and our clients - that we raise our concerns in regard to the Draft Regulations on the Demarcation between Health Insurance Policies and Medical Schemes ("the Draft Regulations").

We note that this submission is limited to the commentary regarding "gap cover" products and that other product demarcation has not been considered as part of this submission.

This submission is made recognising that the Draft Financial Services Laws General Amendment Bill 2012, addresses the legislative gaps envisaged within these draft regulations and that any concerns raised in relation to these regulations would have a resulting impact on the relevant sections of Draft Financial Services Laws General Amendment Bill, 2012.

2. Points of agreement with the Regulators

2.1. The objectives of the Medical Schemes Act of 1998 ("the Act")

The ideals and principles of the Act - in particular the creation of a framework that gives protection to current and future members of medical schemes - is commendable and needs to be protected. These ideals include the broader social solidarity principles such as:

- Increasing access to quality healthcare for all South Africans, by removing unfair obstacles to membership of medical schemes.
- Reducing the burden on the State by ensuring that medical scheme members, who have inadequate benefits for serious illnesses, are adequately protected through the regulation of Prescribed Minimum Benefits.
- Guaranteeing life-long membership, regardless of age or health status, as provided by guaranteed acceptance and limited underwriting.
- Financially sustainable medical schemes as measured through criteria such as solvency requirements.

The need for cross-subsidy within the risk pool is fundamental to the sustainability of the medical schemes environment as created by the Act. Voluntary participation on medical schemes for the broader population, as we currently have, compromises this fundamental element.

2.2. Medical scheme membership remains stagnant

There are numerous reasons for the stagnant membership growth within the medical scheme environment and it would be simplistic to attribute this lack of growth to a single factor. The reasons are inter-linked, complex and in their simplest form, include:

- Participation is generally voluntary and no regulatory requirement exists for any specific group of South Africans to participate in a medical scheme.
- Unavailability of affordable products to suit the needs of the majority of South Africans, many of whom find cost to be a barrier.
- The comprehensive list of benefits which medical schemes must cover under the Prescribed Minimum Benefits as governed by the Act prevents medical schemes from introducing more affordable options.
- The product structure, processes and procedures to access medical scheme benefits has become increasingly complex as medical schemes grapple with containing costs, thus alienating some customers.

2.3. Affordability is the main barrier to entry

One of the most comprehensive researches conducted on the barriers to entry for medical scheme membership relates to the work done by the Ministerial Task Team on Low Income Medical Schemes, in 2003. The findings show that although there was generally a desire by low-income earners to participate in medical schemes, the costs were prohibitive.

3. Concerns with the Draft Regulations

3.1. The Regulators in this case have assumed that health insurance products attract a better profile of member, when compared to medical schemes:

The experience of NMG has been contrary to the view that the 'young and healthy' opt out of medical schemes in favour of self-insuring or health insurance products. The reality has been that after completing full Needs Analysis for our medical scheme clients, the so called 'young and healthy' often select to only cover themselves in case of trauma by selecting the lowest benefit options within medical schemes. It is rare for this profile of member to further protect themselves for risks that lie outside of that which the medical schemes provide, such as 'gap cover' products.

It is our experience that the need for additional cover is often found in members that have previously experienced gaps in their medical scheme cover, where schemes have reduced their cover from 300% in-hospital cover to 200% or from 150% to 100% and sometimes after being on 'high benefit and cost options' within medical schemes where affordability becomes an issue. This profile of member often includes:

- Young people in their 'child-bearing' years
- People with chronic illnesses and those likely to be hospitalised at some point
- Those pre-dispositioned to certain illnesses as a result of family history.

3.2. The Underwriting decisions of health insurance products

The ability for health insurance products to be able to underwrite poor risk is of concern to the Regulators. We agree with this concern given that it could potentially compromise the medical scheme risk pool, whose ability to underwrite has been restricted by the Act. NMG's experience is that the health insurers have been circumspect in their use of underwriting, although we recognise that legislation needs to protect individuals in the situation if this changes in future. Currently products have tended to apply penalties that are aligned to those available to medical schemes in the form of:

- Waiting periods; and/or
- Condition specific exclusions.

The largest deviation, when compared to what medical schemes are allowed to impose as penalties, relates to the fact that health insurance premiums can be loaded or discounted based on claims experience - and this is applied in many instances.

This concern could be overcome by further regulations that align the underwriting decisions of health insurance products to those of medical schemes.

4. The needs of consumers

4.1. Currently gap cover offers medical scheme members the only alternative of being comprehensively covered for all in-hospital events. The gap cover providers invariably design their product offering around the shortfalls inherent in scheme products and not as an alternative to medical schemes.

Without it, shortfalls which arise as a result of the difference between the medical scheme rate and the provider costs would have to be met by members on an out-of-pocket basis and in most of these cases members simply cannot afford the relevant shortfalls.

4.2. Should health insurance products be prohibited, the majority of medical scheme consumers will be exposed to shortfalls or 'gaps' in cover. An analysis of the top 29 largest medical schemes (both open and closed membership schemes) who offer 177 different benefit options indicate that the majority of members (67%) are covered at 100% of the respective scheme rate. These 29 medical schemes cover almost 3 million of the 3.6 million main members on medical schemes as at 31 December 2010. Furthermore, very few of them have any established contractual agreements with specialists to guarantee full cover when in hospital.

The table below shows the large number of members who are exposed to service providers charging in excess of the medical scheme rates. These are the members who purchase gap cover to protect themselves against in-hospital expense shortfalls.

Re-imbursement category	Number of options at rate	Number of main members	Percentage of sample members
100% options	118	2 075 170	70%
120- 125% options	4	85 928	3%
150% options	8	32 292	1,5%
200% options	34	681 224	23%
300% options	13	51 993	2,5%
Totals	**177**	**2 926 607**	**100%**

5. Issues which should be considered when reviewing the demarcation

5.1. Re-insurance of benefits

The re-introduction of re-insurance of benefits by medical schemes will assist schemes in providing benefits such as "gap cover" within the medical scheme itself.

5.2. Strict guidelines regarding product structure

The gap cover product structure needs to be more carefully controlled to cover **only** the gap between what the Scheme's reimbursement rate is and what the provider charges for in-hospital events. All the auxiliary benefits which compromise the scheme option structures i.e. co-payment cover and extender benefits should not be allowed as this directly drives incorrect purchasing behaviour.

5.3. Doctors will not reduce prices – No reference pricing

In an environment where doctors' prices are not regulated, the prohibition of health insurance will prejudice members. For now, there is no trend that demonstrates that doctors will alter their billing to be in line with the various scheme tariffs.

6. Conclusions

NMG supports further regulation of the industry. With certain changes to product structure we believe that gap cover products fulfil a role in providing the medical scheme members with more comprehensive medical cover.

There are health insurance products that have been designed to compliment the medical scheme environment. Should these products be prohibited, members of medical schemes will ultimately be more vulnerable.

Yours sincerely