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Financial Intermediaries Association
of Southern Africa
Company Reg No: 1999/002724/08

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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 ('Regulations') as gazetted by the Minister of Finance, Pravin Gordhan, on the 2 March 2012.Thank you for the opportunity to comment.

1. Financial Intermediaries Association (FIA)

The Financial Intermediaries Association of Southern Africa (FIA) represents more than 15 000 licensed financial services advisers throughout South Africa. The origins of the FIA date back more than 50 years, with the organisation have recently evolved into a single, united national body representing the bulk of active licensed intermediaries in South Africa's financial services industry. The FIA enjoys a large and steady national membership comprising financial services intermediaries who cover the broad spectrum of Short Term Insurance, Financial Planning, Employee Benefits and Health Care Planning.

The FIA's primary purpose is to represent, protect, promote and further the common interests of its members and their clients. We provide to our members the necessary stature and legitimacy to represent them at the highest levels of the industry, including regulatory bodies and industry associations.

All members of the FIA are authorized financial services providers or representatives of such providers. In terms of the FAIS Act our members must adhere to all the requirements prescribed by the Act and its Regulations. Over a number of years the FIA has been a driving force for change in the South African financial services industry. It has supported financial services reforms, encouraged higher educational standards for financial and health care advisors and introduced a strong independent Code of Ethics as well as a Code of Conduct which is aligned with the General Code in the FAIS Act. One of the key drivers of the FIA is to promote professionalism.

The FIA has a substantial membership that advises consumers in relation to health insurance and medical scheme products. These members are regulated through either the Financial Services Board ('FSB') or Council for Medical Schemes ('CMS') or both in the case of medical scheme intermediaries. Furthermore, our members seek to make available to consumers the most suitable products, based on customers' needs and availability of products in the market. The requirements and obligations as outlined in the FAIS Act are of paramount importance in guiding the manner in which FIA members engage with consumers.

The FIA advocates for an environment that promotes the ability for prudent individuals to secure their assets, both human and financial, against uncontrollable health costs. It is with this view in mind – the interests of consumers at large and our clients - that we raise our concerns with the Draft Regulations on the Demarcation between Health Insurance Policies and Medical Schemes ('Draft Regulations')

2. Points of agreement with the Regulators

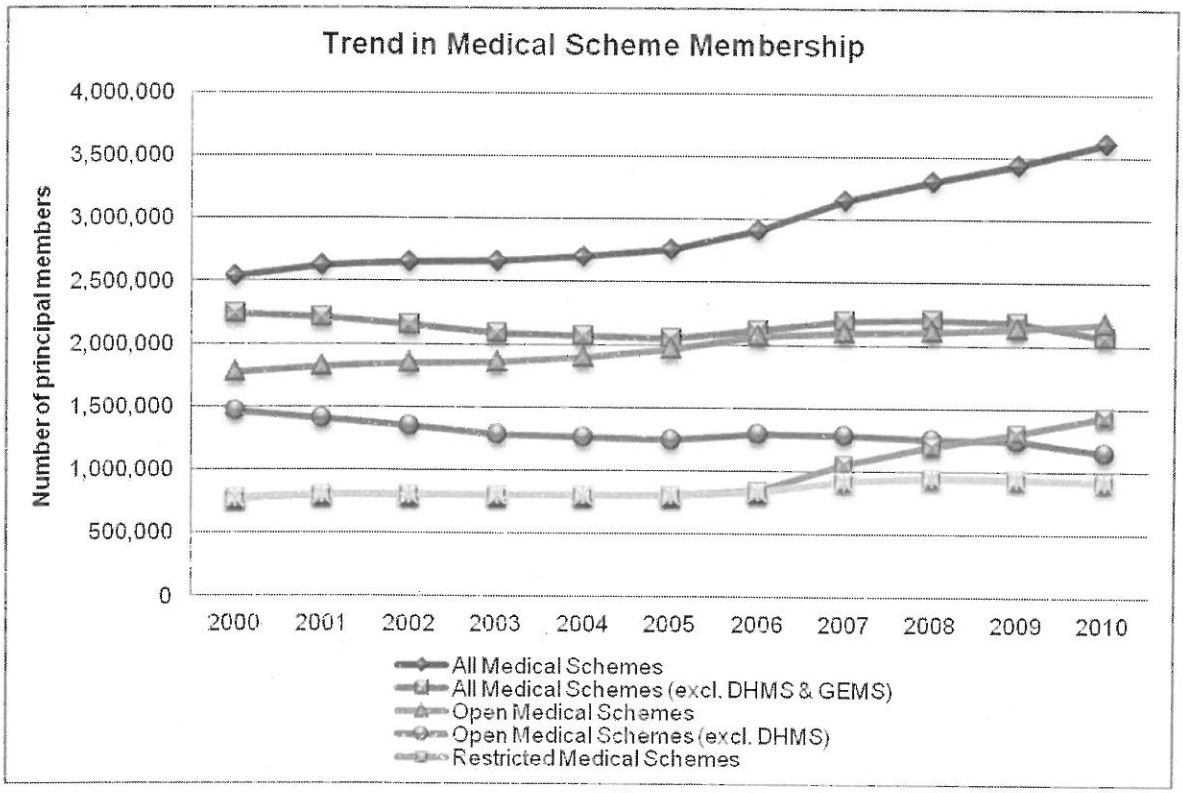
2.1. Objectives of the Medical Schemes Act of 1998

The ideals that Medical Schemes Act of 1998 (MSA), in particular the creation of a framework that gives protection to members and future members of medical schemes - is commendable and needs to be protected. These include the broader social solidarity principles such as:

- Increasing access to quality healthcare for South Africans, by removing unfair obstacles to membership of medical schemes.
- Reducing the burden on the State for medical scheme members who have inadequate benefits for serious illnesses as achieved through the regulation of Prescribed Minimum Benefits.
- Guaranteed 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 MSA. The voluntary participation on medical schemes for the broader employed population, as we currently have, compromises this fundamental element. It is therefore encouraging that there are plans to further secure the environment by introducing some form of mandatory participation for all employed people in South Africa.

2.2. Medical scheme membership trends



In the 10 year period from 2000 to 2010, the number of medical scheme beneficiaries has grown by 24% from 6.7 million in 2000 to 8.3 million in 2010.

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

- Participation is generally voluntary and there is no regulatory requirement for any specific group of particularly employed South Africans to participate on a medical scheme.
- Unavailability of appropriately priced products to suit the needs of the majority of South Africans, many of whom find cost to be a barrier.
- The MSA provision in respect of Prescribed Minimum Benefits for all options has had the unintended consequence of increasing the entry cost to medical schemes.
- The product structure, processes and procedures to access medical scheme benefits have become increasingly complex as medical schemes grapple with containing costs, thus alienating some consumers.

2.3. Affordability is the main barrier to entry

One of the comprehensive research projects on the barriers to medical scheme membership is the work done by the Ministerial Task Team on Low Income Medical Scheme. The findings were that, although there was generally a desire by low-income earners to participate in medical schemes, the costs were prohibitive. It must be noted, that at the time of the research, we had not yet experienced the current proliferation of health insurance products.

3. Concerns with the Draft Regulations

3.1. The Draft Regulations have assumed that health insurance products attract a better ('young and healthy') profile of member, when compared to medical schemes:

The collective experience of FIA members has been contrary to the view that the 'young and healthy' opt out of medical schemes in favour of health insurance products. The reality has been that after completing full Needs Analysis for our clients (as required by FAIS Act), the so called 'young and healthy' often select cover for trauma only by selecting the lowest level of benefit options within medical schemes. It is rare for this profile of member for whim affordability is a major consideration to further protect themselves for risks that lie outside of those 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 shortfalls in their medical scheme cover, and sometimes after being on 'high benefit and cost options' within medical schemes. 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 predisposed 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, correctly so as it could potentially compromise the medical scheme risk pool, whose ability to do the same has been restricted by the MSA. In the experience of FIA members, the health insurers have been circumspect in their use of this ability. In fact, the 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 adopted by health insurers when compared to what medical schemes are allowed to impose as penalties, is that health insurance premiums can be loaded or discounted based on claims experience - and this is applied in many instances.

4. The needs of consumers

4.1. 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%**

*The data above is as per the Council for Medical Schemes Annual Report, year ending 2010.

5. Expert opinion if Draft Regulations are passed as is

5.1. Health care provider will not reduce prices

In an environment where provider fees are not regulated, the prohibition of health insurance will only prejudice members. For now, there is no trend that demonstrating that providers will alter their charging to be in line with the various scheme tariffs. If the Draft Regulations are passed as they are, many consumers, even if they are on a 'high benefit and cost' plans on a medical scheme, will be severely 'out of pocket' due to the difference between what providers charge and the level at which medical scheme tariffs are set.

5.2. Member dissatisfaction and increased burden on the State

As more and more members become disgruntled with the inability of medical schemes to provide sufficient cover, especially for the low frequency and high cost claims, these members will opt out. It is likely that the slow growth of medical scheme membership will regress and we could end up with fewer people enjoying membership of medical schemes. This trend will invariably increase the burden on the State as people who were previously on medical schemes will begin to demand care from the State.

6. Conclusions

The Department of Health Discussion Paper on National Health Insurance (NHI) recognises that when NHI is ultimately implemented, medical schemes are likely to evolve to include top-up insurance. It is therefore counterintuitive to implement legislative developments that may have to be reversed at a later stage.

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

Kind Regards,