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DISCOVERY HEALTH (PTY) LTD

And

DISCOVERY HEALTH MEDICAL SCHEME

Comments on Government Gazette No 35114, No 9706; R. 193 of 2 March 2012

"Short-Term Insurance Act, 1998: Publication of Proposed Amendment of Regulations made under Section 70 for Public Comment"

And

Comments on Government Gazette no 35114, No 9706; R. 192 of 2 March 2012

"Long-Term Insurance Act, 1998: Publication of Proposed Amendment of Regulations made under Section 72 for Public Comment"

Submitted to National Treasury per email to

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1. Introduction

Discovery Health (Pty) Ltd and Discovery Health Medical Scheme (DHMS) (collectively referred to in this submission as "Discovery"), hereby respectfully submit our comments on the proposed amendment of regulations made under section 70 of the Short-Term Insurance Act, 1998; and under section 72 of the Long Term Insurance Act, 1998.

Discovery strongly supports the principles, objectives and the majority of the detailed proposed amendments to the regulations made under section 70 of the Short-Term Insurance Act, 1998; and under section 72 of the Long Term Insurance Act, 1998.

The comments for both sets of regulations are combined into one document because the impact of undesirable insurance products on the medical schemes environment is undeniably negative, regardless of which Act the product may have been launched under, and because the modus operandi of many of these products and their negative impacts on medical schemes are broadly similar.

Our comments focus on the underlying principles of social solidarity that characterise the regulations governing financial products which fund healthcare expenditure. The intention of the current regulatory framework is to ensure that the funding vehicles available for healthcare are not exclusionary, that they provide for cross subsidies (from healthy to sick and between disparate income levels), and do not discriminate on the basis of age or any other factor.

This submission is based on the underlying notion that the above principles remain the cornerstone against which the proposed amendments should be judged. We believe that the proposed amendments to the Long and Short Term Insurance Act regulations are necessary in order to maintain and protect these principles against a rapidly emerging range of insurance products, whose penetration is starting to grow significantly, and whose negative impact on medical schemes is increasing over time.

While it can certainly be argued that insurance based products can in some cases provide lower cost protection against healthcare costs for some individuals than medical schemes, they can only do so by avoiding the full regulatory requirements governing medical schemes. They are not inherently more efficient than medical schemes, but simply offer a less comprehensive product whose price is based on the risks of individual clients, and which can change over time. This means that insurance based products may offer cheaper cover than medical schemes for some individuals at some points in time, but do not provide a long term guarantee of cover at a fixed price. At the same time, the emergence and penetration of these products into the market is causing a number of significant damaging to the entire framework which protects the most vulnerable people, including the aged, those with cancer and chronic illness and those with low

incomes, who are currently effectively and sustainably catered for in the medical schemes environment.

In this submission we intend to demonstrate:

a) The significant and long term damage that is caused to the community rated medical scheme system when risk-rated products "cherry-pick" healthier lives by offering cheaper alternatives to some, or all of the healthcare benefits traditionally offered by medical schemes; and the further damage caused by the fact that insurance products weaken the ability of medical schemes to contract with healthcare providers at affordable rates.

b) The extent to which non-medical scheme insurance products are encroaching into the domain of the business of medical schemes and how this has accelerated since the 2008 Guardrisk ruling[1].

c) That the argument of "value-for-money" in these products is false, or at best a short term advantage, in that it applies only to low risk individuals, for as long as they are low risk. Once these individuals age or develop serious health risks, it is inevitable that cover for these individuals will be repriced at much higher rates, or that they will be excluded from cover. This is the way in which all insurance markets operate, other than medical schemes which are subject to a a regulatory regime based on community rating and open enrolment. Furthermore, these products are currently marketed on the basis of artificially low prices as a result of extremely low claims ratios (the ratio of claims to premiums). These low claims ratios are themselves evidence of poor value for money, in that policy holders are underclaiming due to onerous administrative requirements for the submission of claims. To the extent that claims ratios increase to the levels current offered by medical schemes, it is again inevitable that the prices of these products will increase substantially, further undermining the argument that they offer good value for money.

In addition, we wish to highlight some concerns about the marketing of certain products, with specific reference to the way in which consumers are given false assurances about the extent of their protection against the costs of healthcare.

Finally, we provide specific comments on the detail of the wording of the regulations, and make recommendations. We will comment on the proposed classifications in terms of our view on the threat each product typology poses to the community rating system in South Africa.

[1] Guardrisk Insurance Company Ltd versus Registrar of Medical Schemes (168/07) [2008] ZASCA 39 (28 MARCH 2008)

2. Intent of current health policy and regulatory frameworks

Over the period since 1994, the Department of Health and the Council for Medical Schemes have deliberately created a protected and supportive environment, through the vehicle of medical schemes, to enable access to comprehensive healthcare on a sustainable and affordable basis within the private health sector.

This regulatory regime comprises uniform conditions of entry and pricing for all medical schemes. Schemes are required to apply community rating, to offer open enrolment (except for closed medical schemes), to offer a minimum benefit package, in the form of prescribed minimum benefits, and to structure plan options so as to allow both risk and income cross-subsidisation. There are several other regulatory requirements that medical schemes must meet, including stringent governance, disclosure and solvency requirements. It should be noted that while a risk equalisation fund, and mandatory enrolment, which would complete this framework, have not yet been implemented; the medical scheme environment is nonetheless substantively protective of member interests, and mimics some of the best regulatory elements of international healthcare systems where private health insurance vehicles participate within social and/or national health insurance systems .

The design and effective implementation of this regulatory regime ensures protection for the sick, elderly, low income and otherwise vulnerable people, who in an unregulated market would most likely be prejudiced and therefore at a disadvantage with respect to benefits available, underwriting, pricing and other parameters, when seeking the healthcare that they need.

On the other hand, the regulatory regime for long-term and short-term insurance has a broader mandate of consumer protection, but does not impose health-sector regulatory requirements to address specific health sector challenges.

In the insurance environment, there is no open enrolment, which means that exclusions of the most vulnerable are permitted. There is no community rating, and hence no sharing of risk between those with higher and lower risks over time. There is no obligation to offer a minimum set of benefits, hence the products may be designed in such a way that the healthcare events with the most catastrophic costs are not adequately covered, or may be excluded completely. Because insurance providers are not required to abide by these requirements, they are able to target the young, or otherwise those with low risks, hence compromising the whole concept of risk sharing between young and elderly, wealthy and poor.

At the most fundamental level, the intent of the Medical Schemes Act, and potentially also of the Constitution and of the National Health Act, 2003, is undermined if one can choose to bypass the more stringent regulatory environment of the Medical Schemes Act in favour of a less onerous environment, while still offering a product that overlaps with and undermines those offered by medical schemes.

3. The negative impact of risk-rated health insurance products on a community rated medical scheme environment

The uptake of these health insurance products has wider negative systemic effects, which are well outlined in the supporting documents to the regulatory amendments gazetted.

Insurance products for healthcare that are not obliged to abide by the requirements of the Medical Schemes Act cause damage to medical schemes in three fundamental ways:

1. They reduce the cross-subsidy from healthy to sick scheme members by encouraging the healthy members to pay less into the social risk pool.
2. They weaken the ability of medical schemes to use benefit design tools to encourage more cost-effective behaviour by scheme members.
3. They weaken the ability of schemes to meet the PMB requirements of providing "cover with no copayments" as they undermine the ability of schemes to negotiate affordable and sustainable contractual arrangements with healthcare service providers (referred to in the schemes environment as Designated Service Provider (DSP) agreements).

The combined impact of these three effects is that the ability of medical schemes to provide for the sickest members and the most catastrophic healthcare costs will be severely compromised over time by the increasing emergence of health insurance products through reduced premium income to schemes, rising healthcare inflation even beyond the current high inflation pressures, and increased difficulty in sustaining health provider networks and DSP arrangements.

In this section we will draw on Discovery's experience to demonstrate these risks. We will show:

1. The extent to which medical schemes rely on a large number of relatively healthy members to cross-subsidise the healthcare costs of a relatively small number of unhealthy members.
2. Using this, we will illustrate how a small reduction in the contribution from the healthy members can have a substantial impact on medical scheme inflation.
3. We will demonstrate a real case study from the Discovery Health Medical Scheme that illustrates where the existence of gap cover gave rise to exactly this reduction in contribution to the social risk pool.
4. We also include evidence of the trend towards opting out of scheme cover, which is most pronounced amongst the young and healthy, and which is being aggravated by the emergence of health insurance products.
5. We will then provide numerous examples that illustrate the rising incidence of top-up cover and the consequent lower plan choices of members applying to DHMS.
6. We will show how gap cover products undermine the ability of medical schemes to mitigate rising inflation through benefit design instruments such as co-payments and deductibles.
7. We will demonstrate the risks to the existing DSP arrangements caused by the proliferation of health insurance products paying gaps to cover healthcare provider tariffs.

A short note on terminology

We will explore the various products offered by insurance companies in section 4, but we will use the following phrases in this section:

"Gap products" are those that pay the policy–holder or the healthcare provider the shortfall between what the medical scheme is prepared to pay for the service, versus what the healthcare provider actually charges that person. These products, which may also be referred to as "top-up cover" when they pay for above annual limit services, are described in more detail in section 4 but are sold only to members of medical schemes.

"Replacement products" encourage the opting out of medical schemes. This includes products that market themselves as being very similar to medical schemes (described in sections 4.1 (a) and (e)); and hospital cash plans (section 4.1(f)).

3.1 The importance of cross-subsidies between the sick and the healthy within a medical scheme

Using DHMS data, we can illustrate the important role of cross-subsidies within a medical scheme system. We have classified the 2.3m people who were members of the DHMS in 2011 into groups based on a high level classification[2] of their expected claims – which is an excellent proxy for their state of health.

This exercise allows us to demonstrate the importance of maintaining the balance between healthy and sick in order to prevent cost spirals in this system.

If we summarise members of DMHS into "healthy" and "sick" according to this classification system, we see the following:

[2] The classification system used is a Discovery Health propriety adaptation of the John's Hopkins ACG system

Table 1: Balance between sick and healthy in a typical medical scheme

Classification by state of health (RUB)[3]	Avg no of people in DHMS during 2011	Proportional split of the schemes members	Avg monthly net risk premium[4] per person	Avg monthly risk claims per person	Avg monthly contribution to cross-subsidy per person	Total annual contribution to cross-subsidy from this group (R bn)
Healthy (RUB 0 – 3)	2,094,933	91%	719	358	361	9.070
Sick (RUB 4-5)	206,594	9%	1,029	4,720	-3,691	-9.174
Grand Total	**2,301,527**	**100%**	**743**	**746**	**-3**	**-0.077**

This table highlights the key feature of a community rated system:

1. The total scheme net risk premiums for 2011 were approximately R20,5bn compared to total claims of R20.6bn.[5] The scheme's total claims exceeded premiums by R77m in 2011.

2. 91% of members can be classified as "healthy". These members contribute more to the scheme than their expected claims. In 2011 these members contributed a total of R9.07bn to cross-subsidise the sick group.

3. 9% of the members benefit from the cross-subsidy. These members can be classified as "sick". The expected claims from these members vastly exceed the risk premium that they pay. In 2011, these members required R9.172bn in cross-subsidies from the healthy group.

It goes without saying that the 9% of 'sick' DHMS members is not constant from year to year, but changes as members age, develop chronic illness or cancer, or have serious health incidents such as trauma or serious medical events. The cross subsidy inherent in medical schemes is thus a 'lifetime' and dynamic subsidy in which those who are healthy in the present subsidise those who are ill, and have the guarantee that should they become ill at any time in the future, they would then benefit from the same subsidy from the healthy members of the scheme. A community rated, open enrolment system is thus designed to ensure that the sickest members are not subject to prohibitive premiums or the risk of being excluded. They pay substantially less in contributions than their expected claims costs.

It is important to note that the above example demonstrates the magnitude of the financial impact and the extent of the cross subsidy only for the members of DHMS. When this is extrapolated to the entire industry of over 8.5 million people, the actual extent of the cross

[3] RUB is an abbreviation of "Resource Utilisation Band" which is terminology derived from the John's Hopkins system of classification

[5] Total contributions less Medical Savings Account contributions and expense loading

[5] R743 per month x 2,301,527 people x 12 months

subsidy is clearly much greater, as is the potential negative impact of the sale of health insurance products which undermine the very concept of cross subsidisation that underpins medical schemes.

The table also illustrates the opportunities for a risk-rated insurer. A short or long term insurer that is not bound by the rules that govern medical schemes has the following competitive advantages when offering health insurance products:

1. It can exclude or limit cover to policy holders deemed to be higher risk (i.e. the "sick" in table above). As can be seen, insurers would still be able to target over 90% of the market. It can charge a premium for an individual based on the actual risk that they represent. In the above table, an insurer would be able to offer cheaper premiums for all the healthy members, based on their lower expected claims.
2. It is not obliged to offer the full PMB package, which allows it to limit claims costs by providing fewer benefits than a medical scheme is obliged to cover and limit the likelihood of being exposed to the full costs of the very expensive medical conditions such as cancer.

This means that the short or long term insurer providing health insurance products is able to provide healthier people with much cheaper cover, either as a top-up or as a substitute for medical scheme benefits.

3. However, while this may be attractive to the majority of people in the short term, the consequence is that approximately 9% of the sickest and most vulnerable people face either extremely high premiums or are excluded from cover. It is also critical to note that today's 90% healthy population does not stay constant. Today's healthy individual can be tomorrow's individual with a serious health risk, and this individual faces the risk of losing their cover through health insurance products, either through exclusion of future cover for their specific risk, or through repricing upwards of their premiums.

Later in this document, section 5, we demonstrate that health insurance products do in fact exclude people from cover on the basis of their health risks.

It is also important to note that while current health insurance product providers may not currently risk rate or underwrite in an aggressive manner, nothing in the legislation governing these products prevents such underwriting and risk rated pricing in the future.

Another direct consequence is that the costs of medical scheme cover are further increased through compromising medical scheme arrangements to mitigate inflation, such as DSP networks and certain benefit instruments, such as deductibles and copayments.

While these health insurance products may thus appear to offer good value for money for a healthy member in the short term, the lack of a guarantee of future cover at an affordable premium severely undermines the true value of this product for individuals over the medium to

long term. For this reason, we argue that the value proposition on which these products are sold is illusory and misleading to consumers.

3.2 The impact of "buy-downs" caused by gap cover products

So called "gap" products or any other form of top-up insurance which offer cover for some of the healthcare expenses that can be covered by medical schemes provide opportunities for healthier members to buy down to cheaper medical scheme options, and to supplement differences in benefits with a cheaper insurance product. We will show a real example of this further below.

In downgrading, it is the low claimers who are more likely to leave the higher plans with richer benefits, and to buy down to cheaper plans with fewer benefits. These are the very members who generate a surplus in the scheme by claiming less than they pay. When they downgrade, their premium and therefore their surplus contribution to the scheme reduces, often substantially. This process leaves more sicker members and fewer healthier members in the higher benefit options, thus worsening the risk pool of the plan they are downgrading from, and profoundly undermining the cross-subsidies (towards sicker members) that are intrinsic to the plans.

Low claimers who downgrade will actually use much the same cover in the new plan (as they did in the old one) but now pay a lower premium, so produce a smaller surplus in their new plan, and therefore undermining scheme finances and cross-subsidies within the whole scheme.

The consequence of this approach on a medical scheme can be shown as follows:

If we assume some downgrading using the table above and the following conservative assumptions:

- 4% of the healthy members choose a lower plan and we assume the lower plan premiums to be 30% lower. We will also assume that the claims of these members will be 5% lower – representing the lower benefits available on these plans.
- The sick members are unable to buy down as there are no compelling insurance products available for these members at an affordable price, and they require the richer benefits of the more costly medical scheme plans.

The consequences are illustrated below:

Table2: Balance between sick and healthy after some members downgrade

Classification by state of health (RUB)	Avg no of people in DHMS during 2011	Proportional split of the schemes members	Avg monthly net risk premium per person	Avg monthly risk claims per person	Avg monthly contribution to cross-subsidy per person	Total annual contribution to cross-subsidy from this group (Rbn)
Healthy (RUB 0-3)	2,094,933	91%	711	353	357	8.982
Sick (RUB 4-5)	206,594	9%	1,029	4,720	-3,691	-9.174
Grand Total	**2,301,527**	**100%**	**739**	**746**	**-7**	**-0.192**

It can be seen that even this small change has the effect of reducing the contribution to the cross subsidy within the scheme by approximately R88m in the context of DHMS. (The cross subsidy from the healthy group has reduced from R9.07bn in the previous example to R8.982bn in this example). In order for the scheme to be in the same position as it previously was, the scheme would need to increase its total premiums by an additional 0.5% - which is very significant in the context of annual scheme increases typically in the range of CPI plus 3-5% which currently prevail in the market.

Case study – the impact of "gap cover" and buy-downs on DHMS

In order to provide a factual example of the impact described above, we have a taken an example of a large employer group that applied to join DHMS.

This large employer with over 2000 employees (referred to here as Employer A) joined Discovery Health Medical Scheme from another medical scheme. The group had been on the most comprehensive option at their previous medical scheme, which is similar to the DHMS Classic Comprehensive plan option. With advice from the financial intermediary, Employer A's employees chose a lower plan option (Classic Priority) and supplemented this with a "gap cover" product when joining DHMS.

The intention of the combination of the Classic Priority plan and the gap cover product was to replicate the benefits offered by the DHMS Classic Comprehensive plan at a lower cost.

From the perspective of the employer, this structure ostensibly represents good value in the short term. The client was able to save 16% in premiums immediately, while the combined offering of a lower DHMS plan plus gap cover was argued to "maintain" benefits at a similar level to what was offered before, on the higher plan of the previous scheme.

From a community rated perspective, however, the outcome is extremely negative. The scheme collected much less in premiums when members chose the lower plan type, but still experienced a similar level of overall claims as the expected impact of the deductibles in the Classic Priority Plan was mitigated by the "gap cover".. DHMS requires an additional R3.4m cross subsidy than it would have if these members had remained on the higher plan choice. This increased subsidy will need to be made up in future through higher premium contribution increases on all members of the medical scheme.

Expected impact of this group on DHMS if members had chosen the Classic Comprehensive Plan

Total annual net premium paid to DHMS	R33.1m
Total premium paid into the risk pool	R24.8m
Total expected claims paid by DHMS from the risk pool	R29.9m
Total commission paid to financial intermediary from DHMS	R0.8m
Total cross-subsidy required[6] by this group from the DHMS risk pool	-R5.1m

Actual impact on DHMS, based on members choosing the Classic Priority plan

Total annual premium paid to DHMS	R26.9m
Total premium paid into the risk pool	R20.1m
Total claims paid by DHMS from the risk pool	R28.6m
Total commission paid to financial intermediary from DHMS	R0.8m
Total cross-subsidy required[7] by this group from the DHMS risk pool	-R8.5m

Impact on the intermediary and employer of the Priority plan + gap cover option

Total premium paid to gap cover provider	R0.9m
Total commission paid to financial intermediary from gap cover provider	R0.1m
Total premium paid by employer (gap cover plus DHMS)	R27.8m
Total commission earned by financial intermediary (gap cover plus DHMS)	R0.9m

The option of gap cover has been made available to the employer, who has been able to enjoy a cheaper premium at the expense of the rest of the members of the scheme.

This option of combining a lower cost plan and a gap cover product would not have been available to:

a) Individuals who are very sick
b) Groups with a very high proportion of sick and pensioner members

[6] Surplus is generated by premiums paid into the risk pool less the claims and expenses paid from the risk pool
[7] Surplus is generated by premiums paid into the risk pool less the claims and expenses paid from the risk pool

This is, of course, a single example. We will demonstrate in section 4 various examples of how this approach has become more common in both the individual and group marketplace.

In addition, the negative impact on the scheme is likely to be much more severe as we do not capture the impact of using health providers who charge higher tariffs than the DHMS rate. We also do not capture the impact of bypassing DSP networks for PMB treatments, which may manifest as higher tariff payments, or also include the financial impact of compromised DSP networks.

It does not require much imagination to understand the broader systemic impact of this trend if it were to expand to a significant extent. It would dramatically reduce the premiums collected by the scheme, but would not reduce claims costs. Cross subsidies would be undermined, and premiums would need to start escalating rapidly to ensure that the scheme was able to maintain solvency.

Thus, while this one employer and its employees are gaining in the short term, their actions can clearly be seen as 'free riding' on the rest of the scheme. If the trend were to continue and to expand, these same members and their employer, would face rapidly rising medical scheme premiums, and the short term 'benefit' they have gained would be rapidly eroded.

Even more immediately, if this specific group were to experience a material number of high cost events or health risks during the year, it might well find that some of its employees were either excluded from further gap cover, or the premium for the entire group might rise significantly. Thus, the short term benefit enjoyed by the group could also be quickly lost due to its own claims experience.

3.3 The impact of replacing medical scheme cover with insurance products

Within the short and long term insurance environment, we have also observed the emergence of various products that are sold not as 'gap cover' products, but as alternatives to medical scheme cover. We provide more detail of these in section 4.1(e).

The impact of losing a small proportion of the "healthy" lives in a community rated system can be illustrated by showing what would happen if DHMS were to lose only 2% of its current healthy members to such alternative products:

Table 3: Balance between sick and healthy after some members opt out

Classification by state of health (RUB)	Revised number of people if 2% of healthy leave	Proportional split of the schemes members	Avg monthly net risk premium per person	Avg monthly risk claims per person	Avg monthly contribution to cross-subsidy per person	Total annual contribution to cross-subsidy from this group (R bn)
Healthy (RUB 0-3)	2,053,034	91%	719	358	361	8.891
Sick (RUB 4-5)	206,594	9%	1,029	4,720	-3,691	-9.174
Grand Total	2,259,628	100%	739	748	-9 5	-0 259

Once again, it can be seen that a small change has the effect of reducing the contribution to the cross subsidy. In this case the "lost" cross subsidy is worth approximately R180m, which would need to be recovered by an additional 1% increase to the medical scheme premium.

As shown below, schemes already suffer from systemic anti selection by those at higher risk ; i.e – there is tendency for people who develop a serious condition, or anticipate significant health risks in the near future to join schemes more frequently than the general population. This is shown in the fact that the demographics of schemes are skewed towards the elderly and high risk populations, relative to national demographics. This fact, which arises from the combination of open enrolment and community rating, in the absence of mandatory scheme membership, makes the medical scheme environment vulnerable to negative external pressures. The growing proliferation of health insurance products represents a significant pressure which, as argued above, poses a material risk of undermining the ability of medical schemes to continue to provide a lifetime guarantee of full cover, at community rated premiums, in the medium to long term.

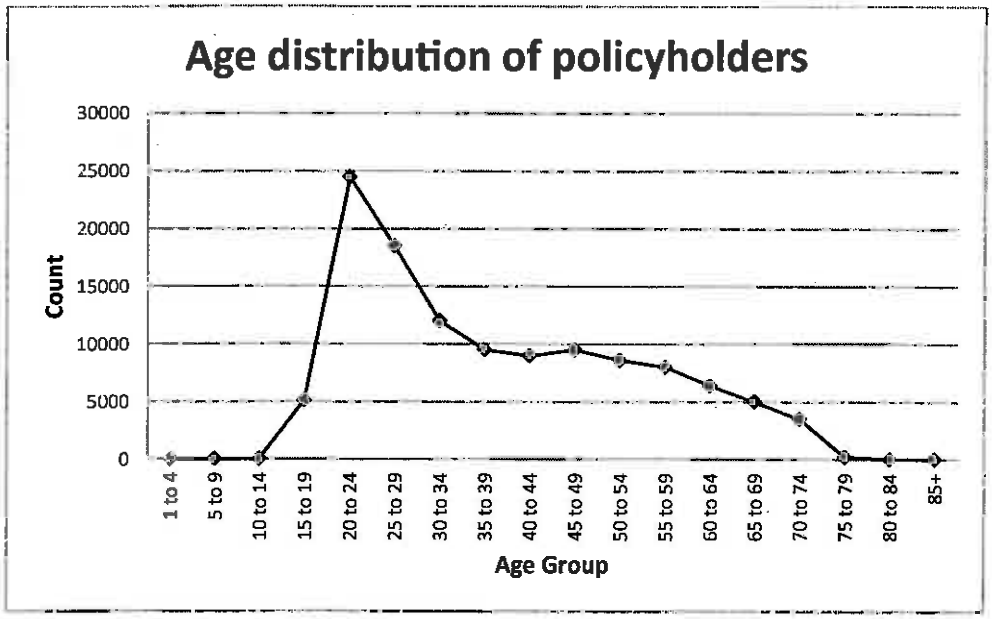
Case Study – the impact of substitution

Hospital cash plans are widely offered in the long term insurance industry. They typically pay the life insured a pre-determined amount after discharge from the hospital, based on the number of days spent in hospital.

While there is no explicit relationship between these products and medical scheme cover, the hospital cash plans are widely perceived as substitutes for such cover. The demographic profile of those who

hold such policies shows that the highest uptake is by young adults under the age of 35 years, as shown in the graph below[8].

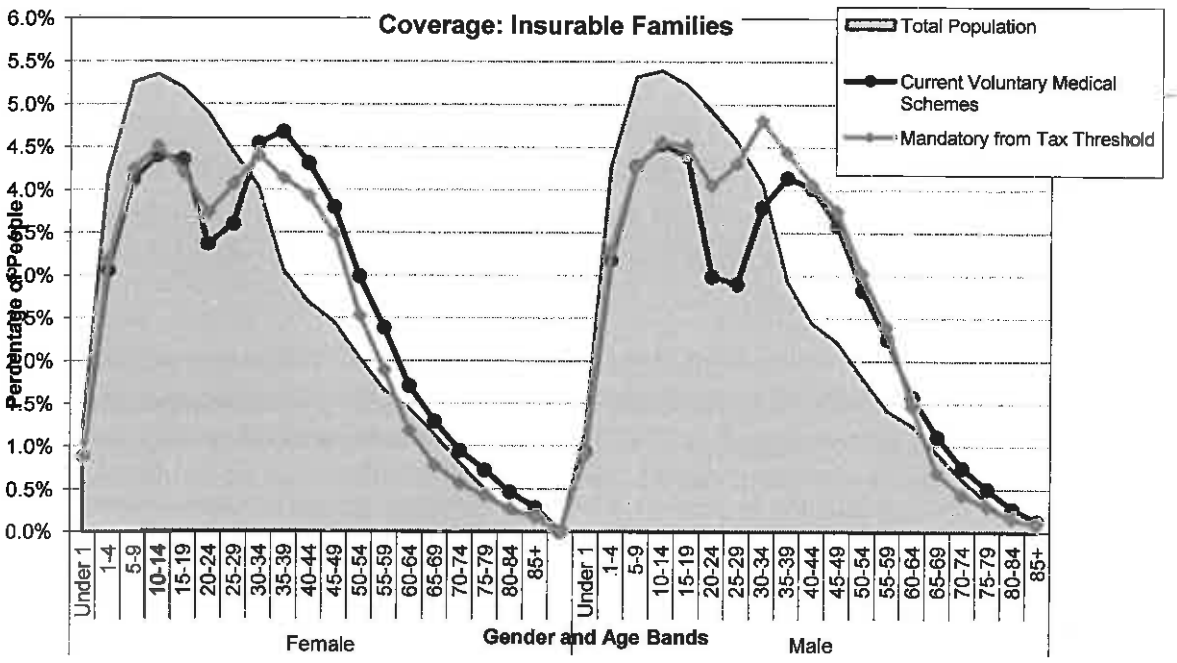
Chart 1: Age distribution of hospital cash plan policyholders



[8] From ASISA research, 2011.

This is in sharp contrast to the demographic distribution of those who do hold medical scheme cover, as shown by the graph below for both women and men[9] where there is a significant dip in membership between the ages of about 19 to 35 years.

Chart 2: Age distribution of medical scheme members



The above analysis implies that medical schemes are under-represented by the following percentages in each of the following age groups based against the expected membership if medical scheme membership was mandatory.

Age band	% under-representation
20-24	22.2%
25-29	27.6%
30-34	9.9%

Given the demographic distribution of the industry, and using the DHMS claims and contribution experience as a proxy for the industry, the impact of this under-representation can be simulated. The table below shows a cross-subsidy opportunity cost of nearly R44 (R35 + R-8.9) per person per month. This is approximately equivalent to a 5% saving for the medical scheme environment as a whole.

[9] Innovations in Health System Finance in Developing and Transitional Economies; Advances in Health Economics and Health Services Research, Vol. 21, pg 159 – 196; 2009.

Table 4: Estimated impact of mandatory membership on DHMS

Age Group	Avg monthly net risk premium (DHMS experience)	Avg monthly risk claims per person (DHMS experience)	Current industry split		Mandatory industry split	
			Split of membership by age	Avg monthly contribution to cross-subsidy per person	Split of membership by age	Avg monthly contribution to cross-subsidy per person
Children (under 20)	211	337	34.1%	-126	34.6%	-126
20-34 year olds	**808**	**502**	**21.2%**	**306**	**25.4%**	**306**
Other adults (up to 60)	1,024	818	35.0%	206	33.6%	206
Pensioners (over 60)	1,122	2,177	9.7%	-1,054	6.5%	-1,054
Grand Total	**710**	**719**	**100%**	**-8.9**	**100%**	**35.0**

Although no causal association can be proven between the overrepresentation of young adults in hospital cash plans, and their underrepresentation in medical schemes , it is eminently reasonable to infer that younger, healthier people stay out of medical schemes as they do not anticipate extensive day to day or chronic medical needs, and many of these are likely to choose a hospital cash plan instead of medical scheme cover, in case of unexpected hospitalisation which can occur at any age, for example from a motor vehicle accident. Clearly this should be discouraged, as it fundamentally compromises the solidarity framework of medical schemes for both risk and income pooling.

3.4 The negative impact on scheme design and compliance with PMBs

Many short-term health insurance products claim to fill in "gaps" in medical scheme coverage. However, in many cases, these so called "gaps" are deliberate elements of the design of some benefit options within medical schemes which have been deliberately implemented to incentivise members to make cost-conscious choices in using the healthcare system. This results in lower overall costs for the benefit option, and thus to reduced premiums. For instance, co-payments on certain, more elective procedures discourage unnecessary utilisation of these procedures and restricts their use to those members with true clinical necessity (e.g. the Discovery Priority plans). These options are priced lower than equivalent options precisely because of the positive effects of co-payments and deductibles on utilisation patterns. When health insurance products are sold to members of these types of plans, they eliminate the incentive effect of the plan design, thereby increasing utilisation and claims against the medical scheme. This undermines the ability of the scheme to offer these cost effective plans at lower premiums.

DHMS and certain other large schemes have contracted arrangements with the vast majority of GPs and specialists, and with all hospitals, which provides full cover to members using these providers with no copayments or gaps. Where members choose to use doctors that are not contracted, they will encounter a copayment. In this situation, these "tariff gaps" arise from members voluntary choices, and their presence encourages members to use providers with whom the scheme has contracted at a better rate, and for whom there will be no member shortfall. This allows the scheme to use the collective purchasing power of members to contract with doctors at tariffs that are fair to doctors but affordable for schemes. However, a proliferation of gap cover products has the potential to undermine the ability of schemes to use their purchasing power to this effect, since doctors may opt out of contracted arrangements, and/or may insist on charging members with gap cover higher tariffs, thus undermining the positive impact of their contractual arrangements with the schemes. Therefore, this kind of cover can undermine the ability of schemes to comply with PMB legislation, as well as with scheme benefit designs for encouraging member cost-consciousness, thus contributing to price escalation in the medical schemes environment.

Case Study – the impact of gap cover products on scheme design and PMB compliance

Example 1:

DHMS dentistry benefits include copayments to encourage the more cost-effective choice of place of service. The copayments are highest in a hospital setting, lower in a day-hospital setting and there is no copayment when the procedure is performed in the doctor's rooms. If more DHMS members were to choose the lower cost settings, the overall costs to the risk pool of the dentistry benefits would reduce, and all members would benefit.

However, there currently exists a "Dentistry gap cover" which covers any deductibles or co-payments for in-hospital dentistry including wisdom teeth and maxilla facial surgery. These products clearly encourage members to utilise higher cost places of service, in this case the hospital setting for dentistry, and therefore directly increases the claims costs experienced by the medical scheme, again increasing inflationary pressures and driving up premiums.

Example 2:

DHMS has introduced Delta plans which are based on a negotiated network of more cost-effective hospitals. Members who choose this plan benefit from materially lower premiums but face a high copayment if they make use of non-network hospitals. Hospitals are willing to discount their rates in order to be part of the Delta network in anticipation of receiving an increase in market share relative to non network hospitals. This type of product design allows schemes to contain medical inflation by effective negotiation in which they use their collective purchasing power of a large membership to negotiate discounted rates in return for the promise

of higher volumes of patients. This is currently working very effectively for DHMS in the case of its Delta plans.

However, one of the gap cover providers has extended their Elite and Comprehensive product ranges to cover the co-payments associated with Delta plans.. The Business Report of 28 October 2011 includes the following excerpt; "A third new offering is designed to complement the Discovery Health Delta Plan. Here *Supplier S* will cover the co-payment liability of R4 550 that Delta Plan subscribers incur when they do not use a hospital in the Delta network." This product directly undermines the intent of the Delta plan structure by covering the co-payment. If many Delta plan members purchase this gap cover product, there will be no shift of members to these lower cost hospitals. The scheme will not gain the saving from members using the hospitals which have offered the discount. And furthermore, hospitals will withdraw from these agreements over time, and the scheme will not be able to sustain the discount agreement with the hospitals that do not gain in market share. Over time, this type of gap cover product will thus erode the ability of schemes to offer discounted premiums based on network plans. At present, DHMS has over 500,000 members on one of its discounted plans based on provider networks.

Example 3:

In order to meet the regulated obligation to pay for Prescribed Minimum Benefits (PMBs) in full, medical schemes establish Designated Service Provider (DSP) networks which are networks of healthcare providers who agree to provide these services at a rate that is affordable to the medical scheme. These DSP contracts would require that doctors do not charge more than the agreed tariff, otherwise the scheme cannot meet its PMB requirements.

However, if doctors believe that a large proportion of their patients have cover (through a gap cover product) against the doctor charging a higher rate, then they are incentivised to leave the DSP agreement.

3.5 Conclusions on systemic harmful impacts

In summary, if structural incentives in the environment (like the availability of gap cover) lead to downgrading or substitution, this creates a serious risk of undermining the solidarity framework which underpins the entire intent of medical scheme regulation. And critically, it actually undermines schemes' generation of surplus within and between plans, leading to increased solvency pressures, lower benefits and higher premiums than would otherwise be required.

In general, downgrades and substitution are harmful to medical scheme finances, and to the sicker members of schemes, because medical schemes rely on the cross-subsidies from the healthy in order to maintain a community rated premium for the sick and vulnerable.

As shown above, a small change in the contribution from healthier members towards the scheme surplus can have a significant impact in terms of increasing costs for the remaining members of the medical scheme.

This in turn has further effects, leading to reduced benefits than would otherwise be possible or higher prices than would otherwise be necessary. Higher prices turn away prospective members who are often young and low risk. If these potential members were more inclined to join, the combination of their contributions and relatively low claims could actually reduce contributions for *all* members.

In addition to the inflationary impact of downgrading and substitution, the insurance products also undermine the techniques available to schemes to control costs, such as benefit design and network negotiation. This is turn also puts the DSP contracts at risk, which means that schemes would find it increasingly difficult to comply with the "payment in full" requirement of the PMBs.

These arguments apply to all types of short term health insurance cover, from gap cover to full service plans that could be perceived to be equivalent to medical scheme coverage. They apply equally to similar products offered in the long term insurance environment, such as hospital cash plans. Any product that can either encourage buy-down to lower plans, or opting out of medical scheme cover poses a material risk and should therefore be deemed harmful to the medical schemes environment, and should hence be disallowed, as is proposed by the draft regulations.

4. Growing incidence of non-medical scheme products that encroach into the domain of the business of medical schemes and how this has accelerated since the 2008 Guardrisk ruling.

Previous sections have highlighted the potential for harm to the community rated system posed by insurance products (both long and short term). While it is difficult to directly separate the impact of insurance products from several other factors impacting medical schemes, we will provide evidence that:

1. There are many product typologies currently offered in the market under both short and long term insurance licenses that encourage buy-downs or substitution.

2. The variety of products and their support from specific financial intermediaries has grown since the 2008 Guardrisk ruling.

4.1 Typologies

The typical characteristics of all these products are that they permit underwriting, particularly in terms of age; they impose waiting periods (which are waived for compulsory group participation); and there are exclusions on several conditions.

A survey of several short-term and long-term insurance products offering health coverage has led us to categorise several major product types. Most products fit into one of these six categories.

a. Direct payments to providers for medical services

Where a facility is provided to pay the healthcare provider directly with a banking card regardless of the tariff charged. The marketing material refers to "members" and has different plan types with health benefits. The marketing material for these products positions the insurance as being similar to a medical scheme, except that the prices are targeted at lower income earners (e.g. A product where the most basic plan is sold at R229.50 per month). The card is promoted to employers as "a highly competitive option to ensure their staff's wellbeing." This product encourages opting out of medical schemes altogether. It is most appealing to low income earners, who tend to be younger and healthier. The negative impact of choosing this type of product is only evident to them when they do need healthcare and the benefits fall far short of what is required.

b. Indemnity cover for health events, not aimed at a covering a payment gap

The key feature of these products is that the payments are not predetermined amounts, but they are intended to reimburse the policy-holder for actual medical costs incurred.
There is a variety of health events covered, including out-of-hospital consultations, unlimited chronic medication formulary cover, cancer treatment, in-hospital dentistry, radiology and pathology investigations.
These products may also be perceived as substitutes for medical scheme cover, thus encouraging opting out.

c. Products designed to supplement medical scheme plans

These products are explicitly designed to "link" to medical scheme plans, more often than not, without any knowledge or cooperation from the medical scheme. Discovery Health Medical

Scheme (DHMS) knows of products which openly position themselves as "gap cover" that addresses tariff differences between the DHMS rate and what the provider charges. One of the marketing messages explicitly states the following:
"Are you aware that Discovery's Keycare option has several listed exclusions? Keycare GAP will assist you with this shortfall"
They also provide cover for copayments for specific procedures as specified plan benefits; and extend to cover for day-to-day sub-limits related to oncology or dialysis treatments. Such products strongly encourage buy downs, with consequent negative impact on the sustainability of the scheme as a whole.

A variation of this product type is policies that cover the medical expenses incurred when an annual or benefit limit has been reached by a medical scheme member, sometimes called "top-up cover".

d. Products that are represented as being linked to a medical scheme

Some more established industry players offer both medical scheme cover and gap cover, and market their products jointly and/or encourage financial intermediaries to present these two very different products as though they are not only linked, but complementary. Again, these are products that encourage buy downs.

e. Products that are represented as being adequate replacements for medical schemes

There are medical insurance products that have designed marketing material and insurance benefits to very closely mimic medical schemes, the only difference being that the premium is much lower than medical scheme premiums (which must be priced to include the cost of PMB coverage, as well as cross subsidies between the sick and the healthy). These products encourage opting out of medical scheme cover with harmful impact on both the consumer (in the longer term), and the medical scheme environment as a whole.

f. Products that pay for hospitalisation (hospital cash plans)

These products are offered mainly by the long term insurance industry. Benefits are payable to the policy holder per day of hospitalisation, the amount payable is pre-defined and is not contingent on actual costs incurred. As shown in section 3.6 these products appeal mostly to those between the ages of 19 and 35 years. Their capacity to encourage opting out of scheme coverage is demonstrated.

The typologies described above are not exhaustive, but focus only on products that demonstrably have harmful effect on the community-rated medical schemes environment.

4.2 Increasing incidence of downgrading due to parallel short-term health insurance cover

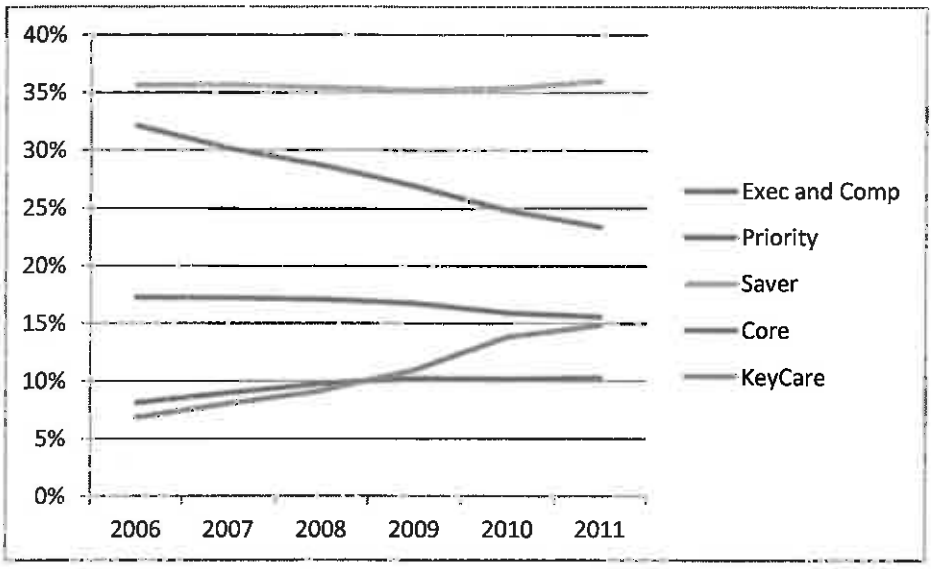
Below, we are able to demonstrate the extent to which gap cover is has led to downgrading in parts of DHMS. We respectfully request policy makers to note The that data on medical insurance policy uptake and the demographics of clients is not readily available, as the market has not been subject to regulatory scrutiny. In an attempt to overcome this limitation, Discovery illustrates the situation based on its own experience in the market where we encounter sale of gap cover products alongside scheme plans. Obviously, however, we would not encounter the other types of short term insurance product in these interactions, since they would not entail a parallel medical scheme plan.

While the take up of gap cover is not yet at critically threatening levels, the trend is clear and will in the long-term have negative effects on the medical schemes environment, for the various reasons laid out above. Such effects are more than likely evident in other schemes in the industry already. Indeed they may even be more severe, given that smaller schemes are less able than DHMS and some other large schemes to give their members protection from gaps in cover for medical doctor bills, through contracted arrangements with specialists, meaning that gap cover would be even more attractive for members of these schemes.

Overall downgrading observed

In graph below, we show the downgrading trends observed in DHMS. These data clearly show increases in membership from year to year in the benefit plans most attractive to those purchasing parallel gap cover, i.e. KeyCare and Priority. Simultaneously, the scheme is witnessing declines in the proportion of total membership in its Executive and Comprehensive plans. While some of this pattern is due to affordability issues, at least a portion of it can be ascribed to the impact of the sale of gap cover and related health insurance products. In the next sections, we outline evidence of the extent to which gap cover products in particular are increasingly associated with downgrading.

Chart 3: Downgrading trends in DHMS



Plan mix comparison of brokers selling gap cover with other brokers

Through normal market interactions with brokers and clients, Discovery is aware of certain brokers who appear to frequently sell gap cover alongside Discovery plans. We are also aware that certain Discovery plans are more susceptible to being sold with gap cover than others. For instance, the Priority plans have deductibles which are meant to encourage appropriate member behaviour; however some gap products appear to be designed precisely to fund these deductibles. This not only encourages buy downs to these cheaper plans by those who would normally have purchased a higher plan, but it also undermines the very design of the plan which uses deductibles to encourage members to consider healthcare events carefully and to avoid frivolous use of healthcare services.

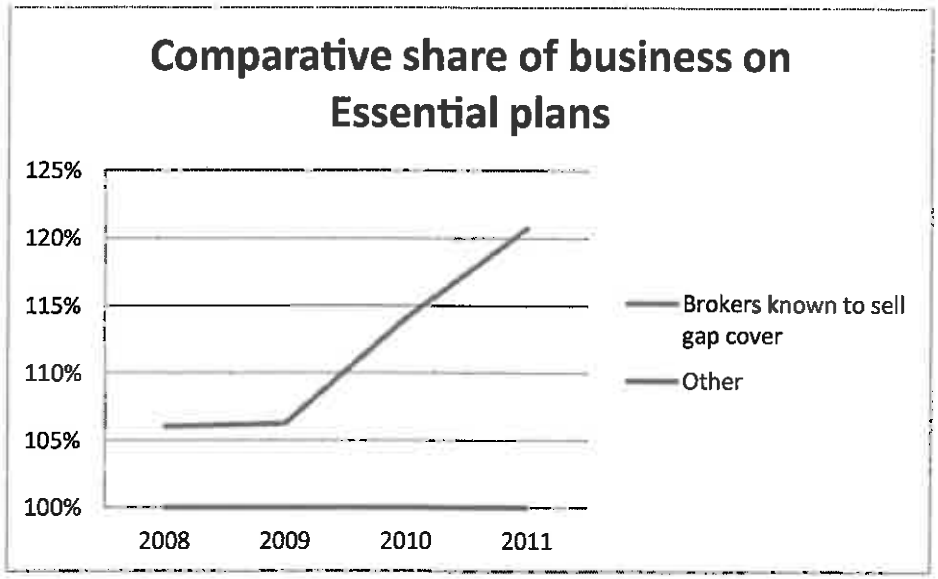
Also, the Essential plans provide a lower rate of reimbursement (100% of the Discovery rate) for specialists, than for instance the Classic plans which fund at 200%, so we would expect to find gap cover sold to a greater extent alongside Essential plans.

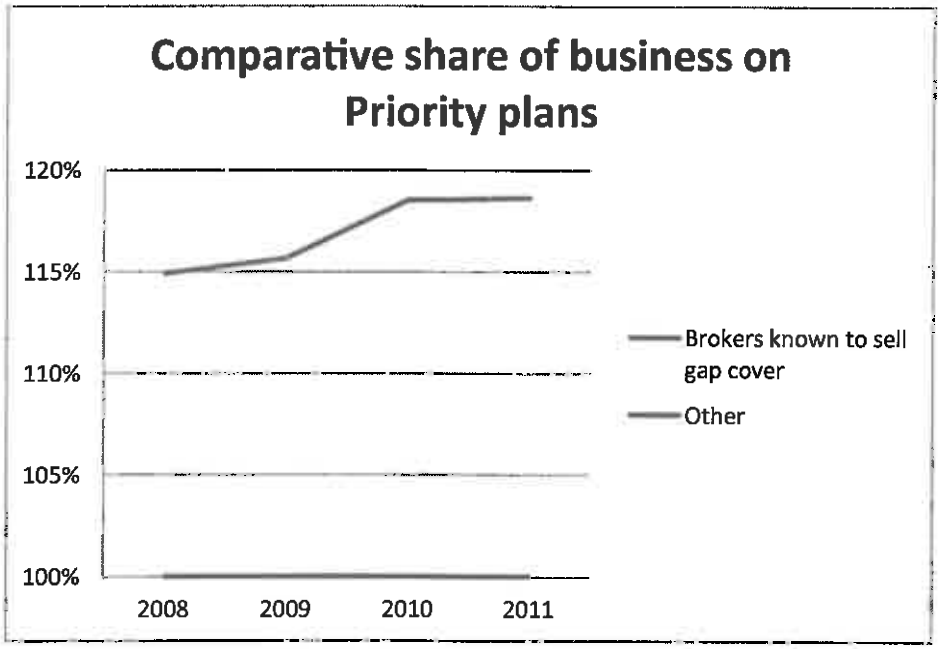
It is possible to evaluate the plan mix sold by our survey of gap cover brokers compared to other brokers, to determine trends. We do indeed find that brokers, who are known to sell gap cover, also sell more Essential and Priority plans as a share of their total Discovery business, compared to other brokers. And furthermore, this trend has been increasing over the last few years, as gap cover products have gained traction in the market.

The graph below shows that in 2008, the share of Essential business sold by the sample of gap cover brokers was 6% higher than for other brokers. By 2011 the share of Essential business was 21% higher than the other brokers. Similarly, indicated in the next graph, gap cover brokers sell more

Priority business as a percentage of their book, and the difference compared to other brokers is increasing.

Chart 4: Examples of financial intermediary trends





These views may in fact understate the issue, as it is very likely that the 'Other' broker category includes brokers selling gap cover unbeknown to Discovery.

Plan mix over time of brokers selling gap cover

We can also consider the change in plan mix between Comprehensive Plans (where the richer benefits make gap cover less attractive) and Priority Plans (for which parallel gap cover has been developed in the market) for two brokers known to be selling gap cover over a selected period of time. The graphs show the increases in the sale of Priority plans relative to Comprehensive over time.

Chart 5: Broker A trend:

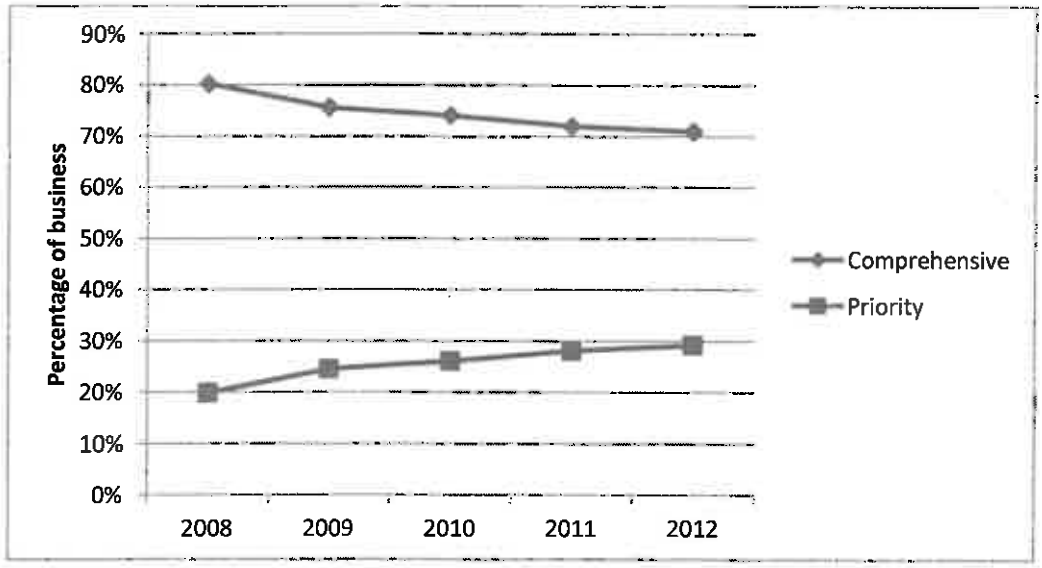
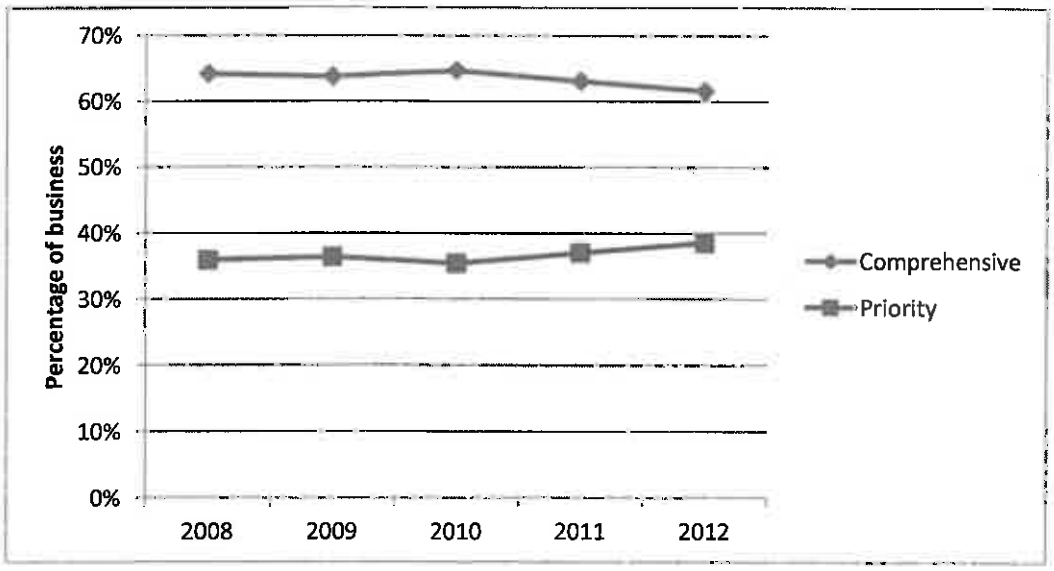


Chart 6: Broker B trend:



Plan mix over time within employers where gap cover was known to have been marketed to employees

We are aware of specific situations in which brokers have actively marketed gap cover options along with underlying Discovery plan types at the time that a new employer group joined DHMS or at the annual year-end training sessions with employees of DHMS corporate clients. A few examples are shown below, suggesting strongly that gap products facilitate buy-downs of cover within a group, towards plan types that tend to generate more gaps (Priority, Essential). The year where we became aware the gap was offered is circled.

Chart 7: Employer A trend

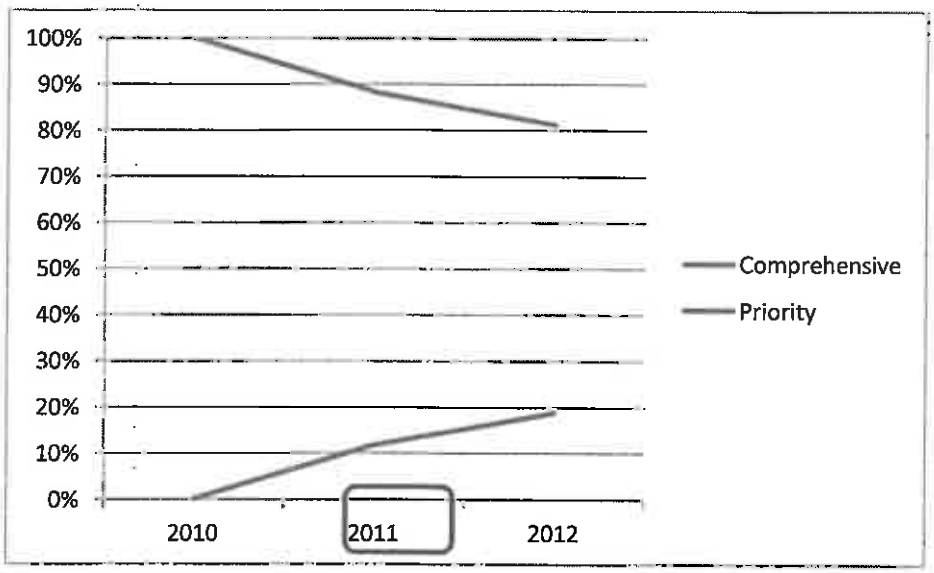


Chart 8: Employer B trend

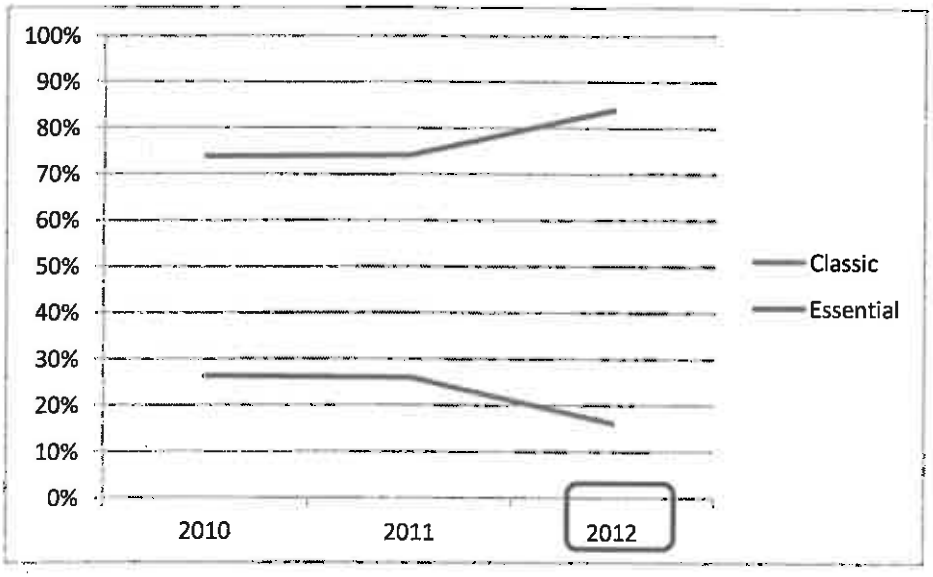
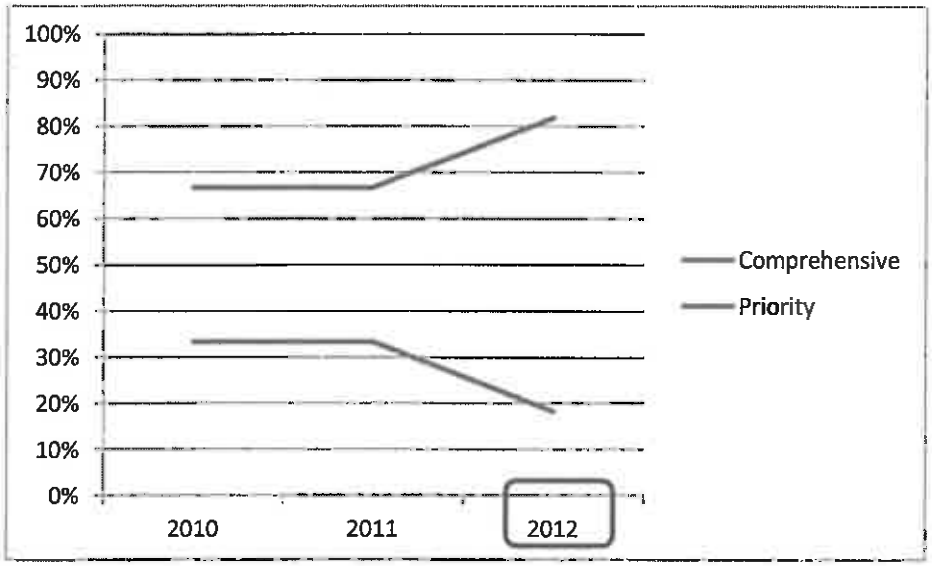


Chart 9: Employer C trend



It is clear that gap cover co-selling is starting to lead to a situation where members are taking lower coverage plans, and over time this will lead to the destructive effects outlined in the previous section.

Once again we acknowledge that affordability constraints may well be playing an important role in these plan purchase decisions by employers. However, it seems clear that there is an association between these patterns and the sale of gap cover and related health insurance products by brokers.

4.3 Increasing uptake of these products

Since data is not collected by regulators in respect of these product types, it is difficult to get a sense of their penetration or trends. Use of Google Insights indicate increasing web searches for key words like 'gap cover' relative to searches for 'medical scheme' in South Africa.

Chart 10: Indexed trend in Google searches for 'gap cover'

Growing at 15% a year on average.

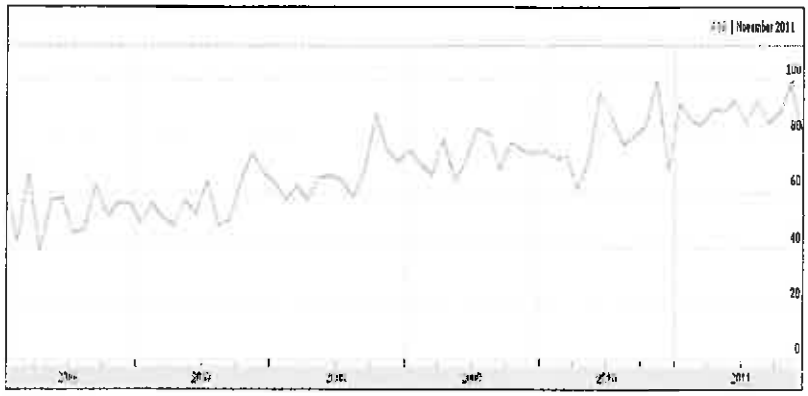
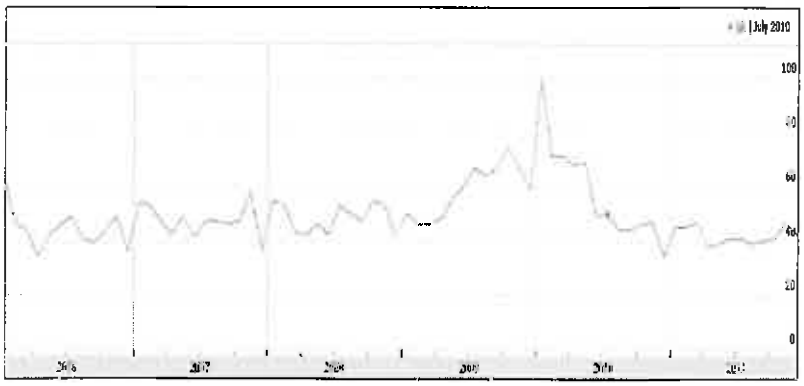


Chart 11: Indexed trend in Google searches for 'medical scheme'

No growth between 2006 and 2011.



These trends are supported by anecdotal comments from Discovery interactions with brokers and clients. Given these apparent increases, it is important to identify what negative features they may contain in themselves, and to what extent they may influence the broader private healthcare environment. This is done in section 5.

5. Negative features of insurance products offering health coverage

In this section we present arguments and evidence that short term health insurance cover in general offers poor value to policyholders relative to medical scheme coverage, and that many practices in this market are discriminatory.

5.1 Misrepresentation of cover

As described in section 2, there is an underlying set of principles governing the regulations around medical schemes. One of the cornerstones is the concept of the PMBs, which are intended to ensure that all purchasers of a medical scheme are guaranteed cover against a fairly comprehensive range of potentially catastrophic healthcare costs.

Many of the insurance products available in the market today give the false impression that the products provide adequate cover against healthcare costs.

Even relatively educated people can easily be misled into believing they are well protected for their health needs with the various health insurance products currently in the market, yet they have none of the protection afforded by the Medical Schemes Act, 1998. This particularly applies to the products represented as being adequate substitutes for medical scheme cover.

In some instances, the marketing material of hospital cash plans which form part of these products claim to offer "complete peace of mind" despite the limited nature of their claims payments. For instance, a policy that pays out hospitalisation costs at an average of only R120 to R350 per day, is marketed as "providing worldwide protection" which in itself is overstated as actual hospital costs per day are at usually many multiples of this level of payout. The 2011 DHMS experience shows an average all-inclusive hospital cost of approximately R25 900 per day. Furthermore, the small print then excludes common conditions like diabetes (which affects nearly 3.8% of scheme admissions), pregnancy and childbirth (affecting 9.4% of scheme admissions per annum). In addition, the naming of these plans creates the impression that they provide cover for hospital care, where in fact they pay out a fixed amount directly to policy holder, who must still pay a substantial deposit (often tens of thousands of Rands) to be admitted to the hospital.

Unlike medical schemes, where regulation stipulates a wide range of PMB conditions and treatments that have to be covered in full, short term policies are able to use opaque terms and conditions to reduce their liability, in a way that is frequently unclear to clients who do not have a medical or insurance background. Many clients may thus find that they do not have the cover that they believe that they have purchased, and may be exposed to financially catastrophic medical payments if they do not have adequate medical scheme cover in place.

Below we set out some other commonly occurring features in these plans, and compare them with the the minimum which is required by law to be offered under a medical scheme option.

Table 5: Benefit comparison between insurance products and medical schemes

	Examples of cover provided by insurance products	Required under a medical scheme plan	Comment
Insurance category	Short term insurance product	Medical Scheme	The rules governing a medical scheme do not apply to the short term industry. Hence, the short term product will apply waiting periods, premium loadings, exclusions that apply depending on the age and health status of the client. In addition, the short term product offers life product benefits (ie. dreaded disease, disability etc). The combination of life and health type of benefits is misleading to clients as it may appear that clients will be receiving value for money.
Hospital benefits	Waiting periods can be applied to every client. Restrictive cover for specified benefits in hospital - subject to exclusions and premium loadings. For example - 6 out of the 9 options offer cover for "illness in hospital" with overall annual limits ranging between R30 000 to R200 000 per family. This falls far short of amounts to cover high cost hospital admissions (for example, R300 000 for a coronary bypass, or R990 000 for a lung transplant)	On any medical scheme option members are guaranteed cover in full for any admission related to the PMBs. The majority of medical scheme plans also offer unlimited cover for hospital events.	The richer benefits offered on DHMS plan options therefore negates the need for additional, albeit extremely limited insurance cover. In an "emergency", the short term product provides limited benefits. DHMS products provide cover when members need it most - ie. Those high cost, life threatening events that members are not able to afford. For instance, the highest cost hospital admissions in DHMS in 2011 included long term ventilation cases costing R2.2m and R4.6m.
Chronic benefits (including cover for acute medication)	Restrictive and limited cover for medication. plans offer these limited benefits.	All medical scheme members have comprehensive chronic cover. For diseases like hypertension this is critical (affecting 8.7% of members).	Providing rand limits for medication does not lend itself to the ongoing effective management of the clients condition as their benefits will run out within the year.
Cost	Premiums can vary by age, health status (ie. premium loadings can apply).	All members on the same plan pay the same (although the Medical Schemes Act does permit premiums to vary by income)	Medical scheme members do not face the risk that their own premiums will increase rapidly once they start claiming
	Typical plan represented as constituting adequate replacement for medical scheme	**DHMS KeyCare**	The real cost to the short term insurance product is much more than what appears on the marketing material. In comparison - the medical scheme contribution is determined by a
Activation fee	R 100	R 0	
Reactivation fee	R 100	R 0	

	Examples of cover provided by insurance products	Required under a medical scheme plan	Comment
Transactional card fees (ie membership card)	R50 per card	R 0	member's plan choice and income band
Cancellation fee	R 100	R 0	
Excessive claims	Premium increase	No premium increase	
Health history	Health loading	No loading	

5.2 Poor value and underpricing due to very low claims payout ratios

For these types of products, claims processes are frequently paper-based and cumbersome, rather than being predominantly electronic, as most medical schemes are. In the case of Discovery, close to 100% of hospital claims, and close to 90% of all claims, are submitted and processed electronically, with payment usually occurring within 3-4 days. By contrast, the cumbersome paper based and complex claiming process for most health insurance products creates administrative hurdles against claiming, resulting in reportedly very low loss ratios for these products, and ultimately relatively poor client value. Based on anecdotal evidence, we believe that average payout ratios for health insurance products are around 30% or less. This compares with medical schemes where the payout ratio is typically above 85% or higher. This clearly demonstrates very poor value of most health insurance products for most members. This also suggests that as and when payout ratios do increase, the premiums for these products will increase rapidly as well, thus undermining their ostensible benefit and value for money for consumers

5.3 Discriminatory aspects of health insurance policies

Many of these products exclude from coverage those who are older or not part of a nuclear family. Generally, the maximum age of inception is 65 years, and the policy will cease at age 70. In this way the insurers can leave the most vulnerable elderly members exposed, and effectively 'dump' these members on medical schemes, which are obliged by law to accept and continue to cover such members. Needless to say, it is precisely these members who tend to have the highest health risks and need the most protection from their health insurance cover.

5.4 Risk of exposure when cover is most needed

The structure so many of these products is that the benefit is pre-defined in monetary terms, making it quite limited. The nature of health events is that they are largely unexpected and of varying severity, hence it is almost impossible for the client to predict the actual extent of expenses that will be incurred. Again, this leaves the more vulnerable person of lower financial means exposed to potentially catastrophic medical expenses. This problem is becoming more serious as healthcare inflation increases, and with it, the number of high cost medical cases occurring each year. In the case of DHMS, the ratio of high cost cases (defined as cases with claims cost of R500,000 or more in 2010 terms) has increased over 3 fold between 2000 and 2010, from 1.5% of all scheme members to just below 5%.

5.5 Misalignment of broker incentives

Certainly in parts of the market, broker behaviour in terms of advising clients can be heavily influenced by the commission they may receive from choosing one course of action compared to another. The sale of gap cover with a poorer scheme plan can yield a higher net commission for brokers than selling the richer scheme plan without gap cover and generate savings for the client.

For instance, as described above, a large employer referred to in section 3.2 benefited from an overall premium saving of 16% and the broker earned an additional 13% in commission. The overall impact to the scheme was negative, but the existence of the insurance product provides a strong incentive for both the employer and the broker to act against the interests of the community rated medical scheme.

At an individual level, one sees a similar pattern as can be shown below where a broker could be advising a family on the choice between a Comprehensive plan or a Priority Plan plus a gap cover product.

Table 6: Monthly premium comparison for member

Member premium comparison	PACC**
OPTION 1:	
Classic Comprehensive	5,941
OPTION 2:	
Classic Priority	4,395
Gap cover	100
TOTAL: DHMS + Gap Cover	4,495

PACC** is Principal member, adult dependent and two children

Table 7: Monthly commission comparison for broker

Monthly commission comparison	PACC**
OPTION 1:	
Classic Comprehensive	74.84
OPTION 2:	
Classic Priority	74.84
Gap cover	12.50
TOTAL: DHMS + Gap Cover	87.34

In the above scenario, the broker was able to earn a higher income for giving this advice. Typically, a broker earns a maximum of R74.84 per policy (the regulated level of 3% of gross contributions) through selling medical scheme cover. By selling it in conjunction with gap cover as happened in the above case, the broker could potentially boost his income by a further 16.7%, through simultaneously selling gap cover, where commissions range between 10% and 15% of premiums.

This additional commission can be sizeable when considering a large group of members. For instance, Employer B, when seeking to find medical scheme cover for 1701 lives in January 2011, moved its employees from the medical scheme equivalent of DHMS Classic Comprehensive to DHMS. 48% of Employer B's employees chose the Classic Priority plan and were required to supplement the less comprehensive plan choice with gap policies.

In this particular example, the broker stood to gain an additional commission of over R100 000 per annum for selling gap products in conjunction with medical scheme cover.

In our view, this is clearly a case where the incentives are misaligned with the policy objectives of community rating and social solidarity. Both the intermediary and the majority of clients have a clear financial incentive to act against the cross-subsidy requirements.

6. International experience

There is some international experience to support a policy position of protecting access to medical care through private health insurance, as opposed to permitting commercial imperatives to override the public benefit of risk pooling.

In the OECD[10] , different regulatory instruments are applied to not-for-profit health insurers (equivalent to South African medical schemes), as compared to commercial insurers (equivalent in function to South African health insurance policies). In general, not-for-profit insurers apply community-rated premiums and open enrolment; whereas commercial insurers apply market segmentation and risk assessment.

The following are examples that illustrate that the presence of both types in one market may have detrimental effects.

In France, the entry of commercial insurers into the complementary PHI market in the 1980s prompted many mutual associations ("mutuelles") to adopt similar practices to those of commercial insurers in order to minimise the risk of being adversely selected against. Both now vary premium prices according to subscriber age, to the detriment of older and on average sicker people.

In the United States, some not-for-profit plans experienced financial difficulty following the emergence of commercial insurers who were able to risk rate. The regulatory response has been to increasingly treat both types of insurance in the same way.

In the Netherlands and other EU states, there has been a similar tendency for convergence between not-for-profit and commercial insurers. In fact, EU law now generally requires all health insurers to be subject to uniform treatment unless the differences are expressly justifiable in the public interest.

The inference from the above examples is that South Africa has made the appropriate choice in choosing to protect access through regulation by the Medical Schemes Act, and to limit the ability of other insurance products to undermine medicals schemes.

7. Anticipated impact of proposed regulations

We firmly believe that the amendments as gazetted will substantively address the problems identified above. They will reduce and/or eliminate the proliferation of health insurance

[10] Private Health Insurance in OECD Countries; OECD 2004

products, and will thus reduce scheme member incentives to downgrade, thus upholding scheme finances and cross-subsidies. They also ensure that schemes' efforts to control costs through intelligent plan design are not undermined, and they will sustain the ability of schemes to negotiate fair and affordable contracts with all health service providers on behalf of their members.

Overall, these amendments to the regulations are likely to have the ultimate effects of encouraging more lower-risk members to join plans with greater benefits, strengthening scheme operating results, therefore permitting richer benefits, lower premium contributions and higher solvency. Over time, there is no doubt that this will improve the long term affordability and sustainability of the medical schemes environment.

Where insurance products are permitted, the key criteria for review should be an assessment of whether these products have the potential to encourage either scheme downgrading or opting out from scheme cover. Any products that have this potential should not be allowed.

In our view, there are specific product types which may be offered by commercial insurers in a way that does not adversely compromise access to health care. The summary below lists these product types.

Insurance product	Policy benefit
Disease-specific or critical illness policy	Lump sum on diagnosis
Income replacement	Replaces all or part of income on event of temporary or permanent disability
Cash plan	Linked to an insured event, such as a day in hospital

A common principle is that the benefits are not linked in any way to the incurred costs of a particular episode of illness, and cannot be viewed as indemnity insurance for such costs. This principle concurs with the framework approach adopted by National Treasury in defining the products that can continue to be offered as insurance products.

Discovery strongly supports clear demarcation between products that are completely de-linked from expenditure incurred for health events, and the benefits offered by medical schemes.

Although the South African medical scheme environment does not yet have all the requisite protective regulatory mechanisms in place, namely the risk equalisation fund and mandatory enrolment, it is clearly prejudicial to members of the public to further compromise this environment.

SECTION 2: SPECIFIC COMMENTS ON THE REGULATIONS MADE UNDER SECTION 70 OF THE SHORT TERM INSURANCE ACT, 1998 and SECTION 72 OF THE LONG TERM INSURANCE ACT, 1998.

8. Definitions and Interpretation

Section 7.2 (1) of the regulations for both Acts lists the categories of accident and health policy contracts.

Discovery supports the categories identified in the regulations, and that these do not include any other type of product, specifically that the categories must not be expanded to include cover that is for out-of-hospital health expenditure, nor in-hospital health expenditure, except as occurs in terms of the categories below.

a. Definitions common to both Short Term and Long Term Acts

<u>Lump sum or income replacement policy benefits payable on a health event.</u>

- There are two different types of policy in this category, and it is strongly recommended that they are listed as two separate categories, ie. Lump sum policy; and an Income replacement policy. This will allow the lump sum policy to offer benefits only for a defined health event; and the income replacement policy will be targeted specifically at those who are employed or receive an income.
- Agree with the policy benefits
- Agree that the benefits are stated in monetary terms or on a pre-determined basis as set out in the contract.
- Recommend that the limitation of 70% of the policyholder's net income per day be amended to state "a pre-determined percentage of the policy holder's income"
  This will retain flexibility in the market and allow the policy holder to choose the level of cover required.
- Agree that policy benefits may be differentiated for different health events; and in accordance with severity of the health event, up to a maximum of 10 severity levels.
- Agree that an elimination or deferred period may be applied.

HIV and AIDS

- Agree that the national HIV/AIDS epidemic requires a multi-pronged response, hence the principle to allow this type of product is endorsed.
- The policy benefit is limited to employee groups. We recommend that the policy intention is further clarified by defining "employee groups" preferably in alignment to the Department of Trade and Industry definitions of business enterprises. Ideally, these policies should be limited to small and micro enterprises so that larger employers are incentivised to enrol all employees on medical schemes.
- Agree with the benefit criteria.

Emergency evacuation or transport

- This is an area to be monitored with caution as medical schemes already provide this benefit.
- It is appropriate that a policy holder does not have to be a member of a medical scheme.
- It is recommended that the term "stabilised" is defined in alignment with the Prescribed Minimum Benefit definition.
- The first criterion, "policy benefits are ancillary to the main policy benefits provided under the policy" lacks clarity.

b. Definitions pertaining only to the Short Term Insurance Act

Motor: third party liability

- Agree with the policy benefits
- Agree that benefits may be linked to the actual costs or expenses of a relevant health service for the third party.
- Recommend that contracts expressly advise the policy owner of benefits available from the RAF.

Property: third party liability

- Agree with policy benefits
- Agree that benefits may be linked to actual costs or expenses of a relevant health service for the third party.

International travel insurance

- Agree with the policy benefits
- Agree with the benefit criteria

Domestic travel insurance

- Agree that there may be circumstances when this cover is desired by those who are not already members of medical schemes
- Agree with the policy benefits
- The benefit criteria link the benefits to actual costs or expenses of a relevant health service. We agree that the product itself is not harmful to the medical scheme environment; however we do recommend that this is an area that is monitored by the FSB and the CMS so that products in this category do not evolve over time into more problematic products.

c. Definitions pertaining only to the Long Term Insurance Act

Frail Care

- Agree with the policy benefits that cover custodial care (assistance with activities of daily living) for policyholders.
- Agree that policy benefits are one or more sums in Rand terms or an pre-determined basis set out in the contract
- Agree that policy benefits may be paid in kind to a provider of a relevant health service
- Agree that policy benefits may be linked to actual costs or expenses of a relevant frail care service. Noting that the words "health service" should be replaced with "frail care service"

In our view, Dread disease cover; Lump sum disability; Major health event; and Income replacement policies are generally linked directly or indirectly to a health event. Their key distinguishing feature is that they offer a pre-determined payment, which is not linked to actual expenses incurred. The payments go to the life insured, and not to the service provider; and there is no relationship, inferred or otherwise, to medical scheme cover. These products are therefore acceptable as long term insurance products.

The broad definition of Category 1 products encompasses all four types of policy referred to above, namely Dread disease cover, Lump sum disability, Major health event and Income replacement policies.

A significant point is that of terminology and scope. The draft regulations do not attempt to define existing insurance products within the scope allowed by the product framework proposed. This leaves some uncertainty about whether certain products, such as the ones mentioned above, are actually intended to be covered by these regulations, and if so, in which category they would fall. It is recommended that this lack of clarity is addressed by expressly identifying the relationship between products currently on the market, and the terms used in Section 7.2 of the draft regulations.

9. Contract restrictions

Section 7.2 (2) and section 7.2 (3) consist of restrictions that are entirely appropriate in our view, because they strengthen the clarity of demarcation between accident and health policies and medical schemes.

There have been some arguments mooted that some short-term insurance products encourage medical scheme uptake by requiring policy holders to be members of medical schemes. This is a fallacious argument which is not supported by any market analysis. In fact, the DHMS experience shows a contrary trend (as shown in the first part of this submission) whereby those who are young and healthy conspicuously avoid medical scheme membership.

Section 7.2 (2) (a) and section 7.2 (2)(d) must be retained as written in order to avoid negatively impacting on the business of medical schemes. There should be no link between actual medical expenses incurred and the policy benefits payable to the policyholder.

A final comment is that the removal of ambiguity on the product categories that may be offered by short term insurers also enables and supports more innovation by both short-term insurers and by medical schemes. The capacity for medical schemes to design and develop value-added products for their members is no longer undermined. A significant opportunity that is re-opened with such regulatory demarcation, is the opportunity to review the possibility of low-income medical schemes, thus expanding health insurance coverage to a much bigger segment of the population.

10. Marketing and disclosures

Discovery agrees that all marketing material for accident and health policies should not in any way infer that these products are either linked to, or can be used as a substitute for medical scheme cover. Although the statement in 7.3(c) is appropriate and may be prominently displayed, and use of the terms "medical " or "hospital" creates a perception that associates these products with health events or hospitalisation, thus continuing the common misperception that such products are bought in order to defray medical expenses.

A limited selection of marketing material that is completely inappropriate is quoted below:

(a) Short Term PRODUCT A:

"Are you puzzled by Medical Aid shortfalls? Tariff Gap will assist with the shortfall by providing a benefit equal to the charges levied by medical practitioners for in-hospital procedures performed on you or your dependents, to a maximum of 400% less what is covered by your Medical Aid."

(b) Short Term PRODUCT B:

FAQs: "What if my medical aid doesn't pay for a procedure or if I don't have a medical aid?"

Response: "We will then ignore the first 100% of your bill (as if it was settled by a medical aid scheme) then pay the difference up to a maximum of 300%"

(c) Short Term PRODUCT C:

"Building on our Basic Plan, the Core plan introduces benefits such as Optmometry. Radiology and Pathology."

"Our plan is an extremely flexible and accommodating policy, and allows changes to membership, i.e. new-borns, upgrades, downgrades, etc. We aim to keep our clients for a lifetime and not only for a certain period of their lives."

"The team continually updates and introduces new benefits and plans to ensure our products appeal to everyone. Have a look at the new Emergency illness benefit"

The above examples are a small selection of marketing material, that uses concepts and language similar to that used by medical schemes, so as to create the impression that the policy holder has a policy that is similar to medical scheme cover and will be able to claim benefits similar to those available with medical scheme cover.

While the provisions of section 7.3 are supported, it is further recommended that a monitoring mechanism be established so as to ensure that the provisions of this section are not flouted. Section 7.4 requires the submission of marketing material to the Registrar and Registrar of Medical Schemes only at the launch of the product. Since marketing material is regularly updated, a more constant monitoring mechanism is recommended.

11. Reporting of product information

Discovery agrees with the provisions of section 7.4(1).

Section 7.4(2) relies on the subjective discretion of the Registrar or the Registrar of Medical Schemes, at any time after the product has been launched, to take any of the three courses of action set out in section 7.4 (3) (a), (b) or (c). This discretion may be applied immediately after launch, or years of after product launch.

Such an arrangement is contrary to the fundamental principle of regulatory clarity, and obscures the accountability for monitoring compliance with an important piece of legislation. It is recommended that the Registrar reviews all new health products within 90 days of initial launch, in consultation with the Registrar of Medical Schemes, in order to instruct the insurer of full approval or recommended action as set out in section 7.4 (3) (a), (b) or (c).

Discovery agrees with the provisions of section 7.4(3).

A key principle for regulatory clarity is that no products should be allowed to undermine the Medical Schemes Act. The Council for Medical Schemes retains the legal responsibility of determining whether or not an insurance product is undermining the Medical Schemes Act. The regulations as written do not provide sufficient clarity about how two regulators will decide on a matter concurrently.

We propose an additional section, as paragraph 7.4(4), which reads as follows, or is a close paraphrase of the following paragraph:

"Any insurance product that is determined by the Council of Medical Schemes to undermine the objectives of the Medical Schemes Act will be regarded as being in contravention of both the Medical Schemes Act and the Long/ Short Term Insurance Act"

12. Transitional arrangements

Although the gist of the transitional arrangements is supported by Discovery, we do differ with the implications of sections 7.5(2) and 7.3(3) for the same reasons stated in the preceding paragraphs of our comments.

There is no clarity about what will happen to health insurance products that were launched before 15 December 2008; nor is it clear why this particular date was selected. Discovery recommends that this date is removed from the regulations, and that all health insurance products must be subject to these regulations.

It is recommended that the phrase "or at any time thereafter" in section 7.5(2) and section 7.5 (3) be removed.

13. Recommendations on the wording of the draft regulations

a. Expand the explanatory framework to expressly identify the category that applies to products that are currently on the market so as to achieve regulatory clarity about the categories under which these products would be defined.
   This should include an explanatory statement about products that are generally sold only as riders to disability or life policies.

b. Ensure that gap products, products that mimic the business of a medical scheme, and hospital cash plans are not permitted, on the basis of their high risk of compromising the medical schemes environment.

c. Review the wording that limits policy benefits of income replacement or lump sum policies, so that there are two separate categories of policies, namely a lump sum policy and an income replacement policy. For the latter, it should not be restricted to a maximum of 70% of net income per day, in order to allow flexibility of policy benefits up to a maximum of 100% of income per day.

d. Revise paragraph 7.4 to include a clause that requires the Council for Medical Schemes to submit a written recommendation to the Registrar within one month.

e. Establish a monitoring mechanism that will ensure that regulators are able to monitor marketing material on an ongoing basis, not just at launch.

f. Revise the section 7.5 on "Transitional arrangements" to make it clear what the status of health products introduced before 15 December 2008 will be. Discovery recommends that this date is removed from the regulations, so that all health insurance products are governed by these regulations, regardless of their date of issue.

g. Revise the wording of the section on "Reporting of Product Information" to create clarity about when new products will be reviewed.

14. Concluding remarks

It is essential that regulatory clarity is established about the business of a medical scheme, and that the public is protected from products that are misleading in the nature of the protection offered, that are fundamentally discriminatory against those with high health risks, and that pose material risks to the medical schemes environment.
This submission has shown that current health insurance products pose material risks of seriously undermining and eroding the social solidarity regulatory framework that has been painstakingly built up through the Medical Schemes Act, and that some of this damage is already taking place and that the pace of this damage is escalating.

The submission has also argued that the specific damage that these products will cause to the medical schemes environment will be to escalate premium inflation, and to undermine the ability of schemes to maintain their current levels of cover in a sustainable and affordable manner, and that the mechanisms by which health insurance cause these effects are by:

- Undermining the cross subsidies between the healthy and the sick through encouraging healthy scheme members to buy down to lower plans, thus reducing scheme premiums without reducing scheme costs;

- Undermining the positive impact of scheme benefit design elements such as the copayments and deductibles used in affordable network plans;

- Undermining the ability of schemes to negotiate contracted arrangements with healthcare providers and hence compromising the ability of schemes to comply with PMB requirements of the Medical Schemes Act.

When considered collectively, these impacts result in weakening medical scheme finances, by reducing premiums and increasing claims costs. This in turn increases premium inflation in a context where premium inflation pressures are already significant. Given that the nature and range of these products is proliferating and that their market penetration is increasing, this negative impact on schemes is actually growing.

In addition to these negative impacts on social solidarity and medical schemes, these products offer poor value for money to consumers, due to:

- The short-term nature of the cover, with a high risk of re-pricing or even exclusion once risk events occur;
- Very low claims ratios, and artificially low pricing, with the high likelihood that the costs of these products in the market will begin to rise rapidly once claims ratios begin to increase.

For these reasons, Discovery firmly supports the principles, objectives and detailed content of the proposed regulatory amendments. These amendments, with a few modifications, will effectively prevent all of the problems caused by these products. The amendments will also lead to a more effective and pragmatic regulatory framework, which will enable both long and short term insurers to develop, market and sell health insurance products that are compatible with, and do not undermine the social solidarity framework of the Medical Schemes Act.

Short-term health insurance cover currently meets market needs that can, to a large extent, be addressed by other interventions that are consistent with the medical schemes framework. These include:

- Working towards appropriate and compliant mechanisms to establish mutually agreed and reasonable provider costs, which will alleviate tariff gaps
- Establishment of a low-income medical schemes framework to provide current users of short-term health insurance products with access to affordable, reliable and appropriately regulated coverage.
- Completing the regulatory framework that governs medical schemes, including the implementation of mandatory cover for all earning above a defined threshold in formal employment, and the Risk Equalisation Fund.

Discovery strongly recommends that the principles and intentions of the regulations are upheld and implemented, with the changes recommended above.