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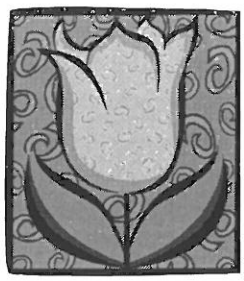

Healthcare Associates

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Attention: Dr Reshma Sheoraj (National Treasury)

Re: Draft regulations on the demarcation between health insurance policies and medical schemes

My background:
I am an independent medical aid and medical insurance specialist operating in the Durban area. I have been in the medical aid industry for almost twenty years. My experience includes initially working as a broker- consultant for a company that operated as a marketing arm for a large medical aid scheme, a manager of the healthcare division of a large corporate brokerage, a director of the healthcare division of a medium size brokerage and for the last eleven years being self-employed and operating as an independent healthcare broker marketing a range of medical aid schemes. I was involved with one of the first in-hospital gap cover products when I commenced in the business twenty years ago.

My business consists of a few hundred medical aid members. My clients range from corporate right down to the individual member. I am licensed to market medical aid and operate as a representative for a company that markets short-term healthcare products.

My concerns regarding the draft regulations:

In-hospital Gap Cover

- I personally have never encouraged a member to buy down on their medical aid and take out gap cover. Many of my clients really battle to afford their medical aid premiums. Most of them settle on a middle of the road option or reasonable hospital cover with very limited day-to-day cover. There are fewer people who are on the top-of-the-range options. The bottom line is that the cost differential between the lower to middle-of-the-road cover and top-of-the-range is so great, there is absolutely no way these members can upgrade. Remember - most of my clients are in the Durban area and salaries are far lower than in Gauteng.
- The most important point here is that the vast majority of medical aid members in this country are subjected to provider networks in hospital no matter what option they are on. Look at Discovery and Momentum for example. I am sure we agree that most people cannot afford to upgrade to the top option. However, if they do, they can upgrade as high as they like and THEY

STILL HAVE A PROBLEM. Your top options are subjected to provider networks too. It is all good and well when you have a planned procedure. In an emergency, there is no way the member or their family is going to have time to worry about finding the required network specialist. You are virtually guaranteed to have a shortfall. I have seen it time and time again. Most schemes only pay out at 200% of the scheme rate on their top options when a non-network provider is used. Most specialists charge at least 300% of the scheme rate (some a lot more – particularly after hours). Removing the right for the member to take gap cover would be a mistake. The shortfalls are not small either. Members really struggle to pay these amounts. Some have to take out a loan to pay the specialist and then pay the debt off (which ends up costing them so much more with interest).

- You have to be on medical aid in order to take out gap cover. Gap cover is only looking at provider fees and shortfalls. It does not pay for anything that your medical aid does not pay for so therein lies the incentive for the member to be on the best medical aid cover they can afford.
- The gap cover product I market is not based on age or income. There is a set rate for a single member and a set rate for a family. So far, I have never seen anyone excluded from taking the policy based on their health. There is no maximum entry age. Everyone does get a general three month waiting period and a 12 month waiting period is only applied for pre-existing conditions. That in itself should also discourage anyone from taking out a gap cover policy and buying down on their medical aid policy.

In summary, in a perfect South Africa, medical aid would cover the member in full for everything. As we well know, the reality is far from the case. I survive on medical aid business and am fully aware of how important it is. It needs to be sustainable and medical schemes are really battling in the current environment to keep their costs down and benefits at an acceptable level. There are cracks in the system and members are really battling to pay the ever-increasing premiums. The sad reality is that medical aids will not be able to always cover the member in full and shortfalls will occur. If the draft regulations go through, members will have to pay the shortfalls from their own pockets. Many will be unable to do so and will run into financial difficulties. People always think hospitalisation is unlikely and do not set aside funds for possible shortfalls. It always seems to happen when you can afford it least. I have seen shortfalls of between R2000 and R15 000 for procedures that were not even 'major'. They were emergencies in the sense that treatment had to occur immediately, but they were not for a heart bypass or anything of that nature. Those more expensive types of procedures could have a horrendous shortfall if a non-network provider is used in an emergency.

Medical Insurance

I personally NEVER EVER sell a medical insurance policy in place of a Medical Aid. I accept that there are brokers who do. For this reason, I think you should have to prove cover with a medical aid scheme before taking out a medical insurance policy. The possibility of age/premium penalties alone is enough of a reason why a member should as a first step have medical aid in place.

This being said, I absolutely disagree that these types of policies should be eradicated. Not every member can afford to have medical aid and medical insurance. There are two types of members we can look at here.

1) One type cannot afford even the most basic medical aid. There is a need for an even cheaper bottom-of-the-range medical aid option than is currently available. I recently had a case where both the husband and wife had lost their jobs. They just could not afford the most basic network, salary-based medical aid hospital plan. The premium was about R900 for both of them. National health would hopefully be able to help them one day, but at the moment they are having to look after themselves. They are able to take out some hospital cover through a medical insurance plan for about R360 per month for both of them. This is nowhere near as comprehensive as a medical aid, but enables them to take some cover as opposed to none at all. One of the comments that came up in the 'frequently asked questions' document from the National Treasury was that the public was often unaware of the subtle differences between health insurance and a medical schemes product. That is exactly why the members need an accredited healthcare broker who would be covering that exact subject in the advice record as required by the FAIS act. What is the point of all the FAIS regulations, compliance reports, exams etc etc, if the insinuation is that the broker is not explaining the difference to the member?
2) The second type of member can afford a reasonable to much more comprehensive medical aid. The problem here is that the member is NEVER sure as to whether or not they are covered for everything. The medical industry is extremely complex and herein lies the problem. The medical aid benefit schedule says for example – cancer cover is unlimited, or after R400 000 a 20% co-payment applies or after R200 000 a 20% co-payment applies. That is such a vague statement. What I have discovered over the years is how often the member is NOT covered. Cancer is a good example so let's start there. The member is totally reliant on the treating specialist, so is in no position to argue against procedures and tests that the specialist wants to do. In the past week alone I had a case where the member (on a top-of-the-range comprehensive option) was told she needed a PET scan. The medical aid repeatedly rejected it. The member has cancer. Eventually her daughter had to pay for the scan. I phoned the medical aid oncology dept. The response was that the requested PET scan did not meet the clinical entry criteria. In so many cases, this is the answer I get. When I ask 'what are the clinical entry criteria', I almost always get 'Oh it is very complicated'. After digging, I established that the organ to be scanned was not on the list of organs allowed for the PET scan on the clinical entry criteria. It is difficult to argue whether PMB claims should be paid in every case as that is also an extremely complex issue. This member would have benefited from having a cancer insurance policy which would pay a lump sum amount on diagnosis of cancer. That would go a long way towards paying all the items rejected by the medical aid while being treated. An income protection policy is useless to the member unless they have lost their income. Many of these cancer sufferers continue to work. They need something to help them with the costs they cannot predict they will have. The type of short-term cancer policy I am talking about is R90 per member per month. There is a maximum entry age of 65 but these are the types of policies members should be able to take if they want to. Once again, perhaps the minimum entry requirement for the insurance policy should be that you are on a medical aid.
3) I have another example of a member who has cancer and was told by his urologist that he had to have a scan. The medical aid rejected it as it was not part of his treatment plan. He has had to pay the bill himself. He also had two hospital claims (relating to diagnostic tests to establish the presence of the cancer) that have remained unpaid for the past year. The medical aid indicated that it was not part of the treatment plan. I am busy fighting this now as it probably

boils down to treatment coding and am trying to get it paid as a hospital claim. No matter who is right or wrong here (the doctor or the medical aid), the member gets lumped with huge payments at a time when they are really ill. The provider will sue the member if they are not paid and nobody can guarantee that the member will be covered for every eventuality. It would be shocking to say the least, to remove the right of the member to take out insurance for this type of shortfall.

4) The regulations refer to the concern that members are buying down or opting out of the medical aid environment in favour of medical insurance products. I would like to see unbiased professional and independent research which proves that members are buying down or opting out of the system. It is a really a vague and unverified statement that is being bandied about and I can't see how it is acceptable to base such a major change in regulations on 'opinion' which may well be incorrect.

In summary, National Health is being touted as the saviour for all our South African healthcare problems. I have seen the proposals. I have seen the facts. As much as it would be wonderful to cover everyone in this country in full we all know the size of our tax base, the size of the unemployed population, the number of hospitals, infrastructure, nursing staff, doctors/specialists, administrative infrastructure etc required to achieve this. It is HUGE. While I can see a form of National Health Insurance being set up in the next few years, I can see the employed population being taxed, I can see the unemployed getting better cover than before – I cannot see how the entire population will be covered in a way that is acceptable to them. We have to face facts. You cannot take away the rights of the tax-paying population to purchase additional medical insurance over and above their medical aid. The effect of the draft regulations will have an extremely negative effect on a large number of people in this country.