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Draft regulations -

Health and accident insurance policies

Turnberry
INSURANCE GROUP

Concerns and reasons for the proposed regulations

From the information provided in Regulation Gazette no. 9706, volume 561, number 35114, 2 March 2012 (hereafter referred to as "draft regulation") and supporting documentation, it would appear that National Treasury has the following concerns in relation to health and accident insurance policies:

- Insurance premiums are based on age, health status and income – the assumption being that insurance products do not have community based rating and price according to age, health status and income.
- The Medical Aid industry is based on the pooling of risk and may not discriminate on age and health status. Equal premiums are charged for high and low risk members. Insurance products are perceived as defeating this objective.
- Insurance policies apply specific exclusions, thereby not providing cover to higher risk clients.
- Insurance products would attract younger and healthier risks, leaving the Medical Aids to cover older sicker lives.
- Insurance policies encourage "buy down" / "downgrading" of Medical Aid options.
- The effective of the above concerns would be an increase in Medical Aid contributions, which would threaten the viability of the Medical Aid industry.
- The protection of the Medical Aid industry is necessary for the successful implementation of a National Health Insurance (NHI) system.
- It is necessary to protect the public from being deceived and not having sufficient cover.

In the paragraphs that follow, we have addressed each of these concerns in relation to the products we offer. It is our view that the draft regulation has viewed health and accident insurance in a generalised form and made the assumption that all such policies are harmful. It is our intention to illustrate that our products and similar products offered in our sector of the industry are not harmful and provide a valuable contribution to the South African economy. Further, we will detail the value these products provide to policyholders and promote the need for effective Medical Aid cover.

Background to Turnberry

Turnberry Management Risk Solutions (FSP No. 36571) T/A Turnberry Insurance Group is a Short-term Financial Service Provider operating almost exclusively in the Hospital Gap/Top-up cover market. We have been operating in the market for a number of years and have built up the business from the acquisition of an existing book, as well as marketing our products through the broker market. Our oldest active policy commenced on 1 September 1997. We have approximately 20,000 policyholders and 50,000 persons on risk (including dependents) for whom we provide an administration service for their Gap Cover policy(s).

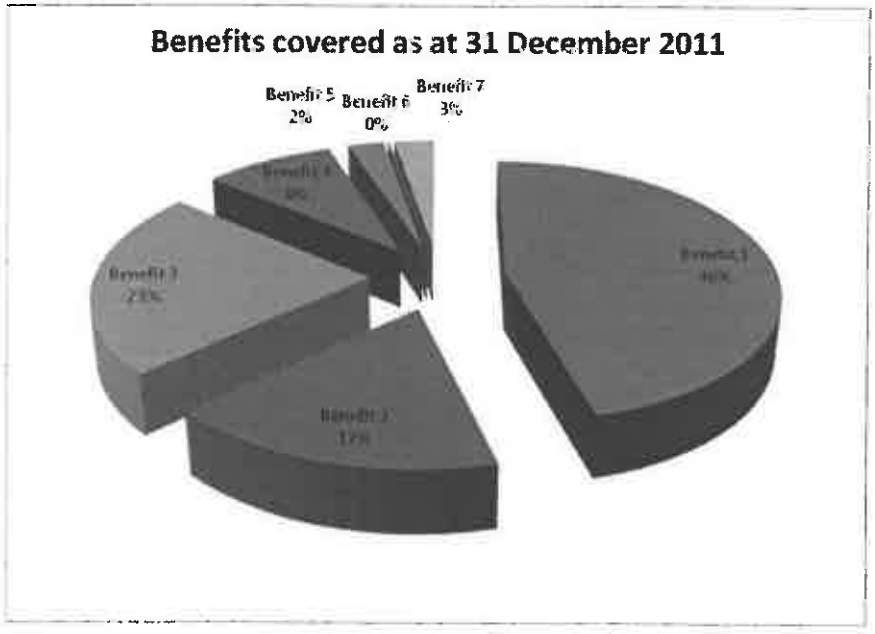
The products that Turnberry offer, which would be directly affected by the proposed regulations, have been detailed below. Hereafter referred to as "Gap Cover".

- Private rate cover (Benefit 1) – cover provided to clients when health service providers charge in excess of the Medical Aid tariff for in-hospital treatment (including limited and specified procedures performed at an out-patient facility).
- Co-payment cover (Benefit 2) – cover to finance co-payments levied by Medical Schemes for specific in-hospital procedures.
- Sub-limit cover (Benefit 3) – top-up cover paid at Medical Aid rates once the limit for specific in-hospital treatment / procedures has been exceeded.

- Excess of in-hospital limit cover (Benefit 4) – Cover is provided for clients who have limited in-hospital cover under their Medical Scheme. Additional cover is provided under these products paid at Medical Aid tariff once the Medical Aid's overall annual limit has been exceeded.
- Biological cancer drug cover (Benefit 5) – Cover is provided to clients for specified biological cancer drugs, which are not covered by the Medical Aid.
- Defined benefit cover (Benefit 6) – A defined benefit is paid according to the in-hospital treatment / procedure.
- Hospital cash back benefit (Benefit 7) – A defined daily benefit is paid to the insured person for periods of confinement in hospital from day 3 to day 45.

It is important to note, it is a prerequisite of all the products mentioned above, with the exception of the hospital cash back benefit, that the policyholder is a member of a registered Medical Scheme.

The distribution of our client base among the different benefits listed above is reflected in the graph below.



Insurance premiums are based on age, health status and income

Gap Cover policies, by design, have always been priced on a community based rating. There is no differentiation in the premium rate based on health status and income. There is also no significant difference based on age. That is, there are two levels of pricing based on age as determined at the age of application for cover, namely R99 for family units were the insured persons are under the age of 65 years and R125 for a family unit were the principal insured person is older than 65 years. Once a person has been accepted on a policy there are no changes in premium according to their age. Any person whose application for cover is accepted will pay the same premium regardless of their age (with the exception of the example given above), health status and income.

The Medical Aid industry may not discriminate on age and health status

The statement "Medical Schemes operate through the collective pooling of good and bad risks, and may not discriminate between individuals based on age or health status." made in National Treasury's document labelled "Demarcation FAQ" does not appear to be entirely correct in respect of both age and health status.

Medical Schemes are entitled to impose a "late joining" or "broken membership" penalty. This penalty is based on the age of the incumbent (applies to persons 35 years or older) and the number of years of non-membership. In addition, a Medical Scheme is equally entitled to impose a maximum of 12 months waiting period on specific health conditions for incumbents who have not previously been a member of a Medical Scheme or have had "broken membership" of 90 days or more. In the same way, the majority of Gap Cover companies include an initial 12 month pre-existing condition exclusion in their policy terms and conditions.

Turnberry operate on a slightly different basis with respect to the risk management of pre-existing health conditions. It is our practice to underwrite pre-existing conditions and determine prior to acceptance whether the risk is acceptable or whether to apply a waiting period or an exclusion. The benefits of this practice are that the applicant has the opportunity to make an informed decision on whether to accept the terms offered or not. By applying the waiting period / exclusion also highlights the need for the applicant to consider upgrading their Medical Aid option, thus addressing National Treasury / Registrar of Medical Schemes' objective of encourage members upgrading their Medical Aid membership.

It is worth pointing out again, that these Gap Cover products charge the same premium regardless of whether the insured persons are high or low risk in terms of their health status.

Insurance policies apply specific exclusions

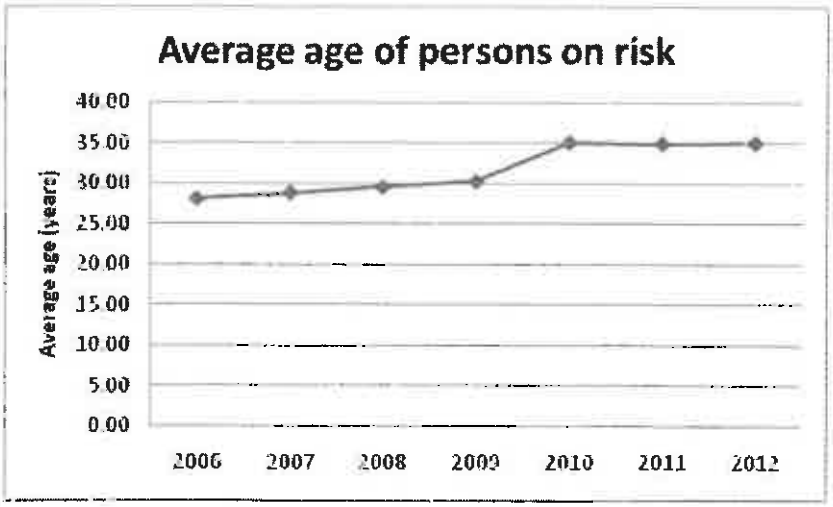
This point has been covered in the section above, which clearly indicates that a Medical Scheme may also apply an exclusion. The difference, however, is that an insurance company may apply a permanent exclusion, while a Medical Scheme is limited to a 12 month exclusion. As mentioned above, these more stringent exclusions work in favour of the Medical Scheme, as these clients are more likely to upgrade their Medical Aid option and thereby, pay a higher Medical Aid contribution and improving the Medical Scheme's risk pool.

Insurance products would attract younger and healthier risks

National Treasury's concern that insurance products would attract younger and healthier risks and leaving the Medical Aids to cover older sicker lives, is a real concern and should be addressed if this is indeed the case. We are not aware of any data the Registrar of Medical Schemes has provided to support this statement and if there is evidence of such a trend, which insurance products are responsible. An analysis of Turnberry's sales over the past five years does not support this theory. Over this period the average age of the principal insured person taking out a policy has increased from 40 years 10 months to 42 years 5 months. These figures would suggest that we are attracting an older client base, who see the importance of protecting themselves against medical expenses not covered by their Medical Scheme. In the Council for Medical Schemes press release on 6 September 2011, with respect to their Annual report for 2010 – 2011, they state the following "The average age of beneficiaries in restricted schemes was 32.0 years in 2006; this reduced to 29.3 years in 2010. The average age of beneficiaries in open schemes increased from 31.9 years in 2006

to 32.9 years in 2010.". These figures clearly show that there has been no significant change in age profile of Medical Scheme age profiles over the past five years.

When comparing Turnberry's average age of beneficiaries it is higher than that of the Medical Schemes and we are reflecting an upward trend. Our current average age is 35 years. This is contrary to the Registrar of Medical Scheme's claim that Gap Cover products attract a younger healthier client. The graph below reflects the increase in the average age of beneficiaries on Turnberry policies.



Insurance policies encourage "buy down"

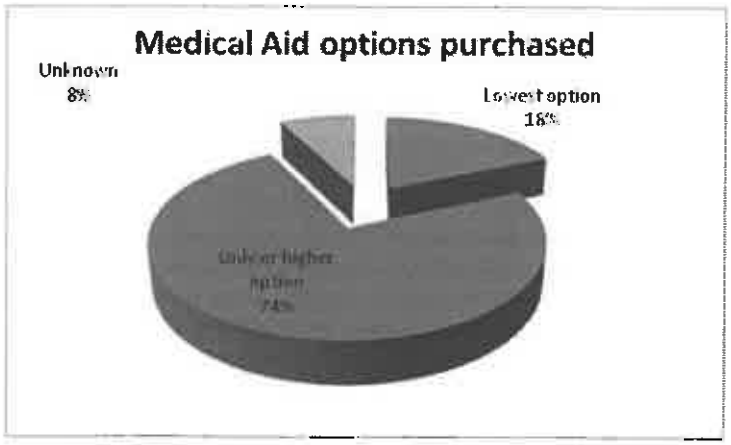
In order to better understand the impact of our products on Medical Schemes, we have analysed the benefits that the majority of our clients have purchased. These products focus on different areas that Medical Schemes do not necessary cover.

In addition, we have also reflected below the reasons for policies being cancelled, which allows us to draw inferences with regards to consumer spending on medical cover / Medical Aids. The sales process has also been considered in this regard.

Private rate cover (Benefit 1)

This particular product / benefit is probably the most important as the likelihood of a person being hospitalised and the health service provider charging above the Medical Aid tariff is high. With a number of Medical Schemes offering various cover limits, ranging from 100% to 300% cover of Medical Aid tariff, the concern would be raised and whether Gap Cover products would encourage "buy down" of the Medical Aid option.

An analysis of our client base, which is reflected in the graphic below, indicates that only 18% of the clients who have Gap Cover have selected the lowest Medical Aid option. Seventy four percent (74%) of the clients either did not have an option what level of cover the Scheme offered (ie. Scheme only offered 100% cover) or they chose to select a higher option. This high percentage indicates that the Gap Cover is not a contributing factor in the decision of the Medical Aid option selected.



When surveying our leading supporting brokers who sell both Medical Aid plans and Gap Cover, the overwhelming decision when deciding on a plan is "affordability". Their main objective was always to provide the best Medical Aid plan according to the clients financial circumstances. Only once the Medical Aid plan had been chosen was the Gap Cover policy considered; if the client was able to afford an additional R100 or R200 premium. These brokers sell Gap Cover to between 20% and 25% of the clients that take a Medical Aid plan through them. The low take-up percentage of Gap Cover indicates that there is either an affordability issue or there is a perception that the Medical Scheme option selected provides sufficient cover.

Unfortunately, the amounts that healthcare service providers charge over the Medical Scheme tariff can be significant. One particular client has received benefits totalling R107,617 for procedures / treatment, where the amount charged was in excess of the Medical Scheme tariff. We regularly have claim amounts in excess of R10,000. These are amounts that the majority of people are not able to afford. These sorts of costs not covered by Medical Schemes are significant and could result in serious financial difficulties, particularly when you consider that our products are targeted at lower / middle income groups.

The number of claims we have received which exceed 300% of tariff is growing and will continue to grow should there be no regulations placed on the pricing of health service providers. The lowest percentage of claims in excess of 300% we experienced was 9.7% in 2008. This percentage increased to 18.5% in 2011. These are costs that cannot be covered by any Medical Scheme, regardless of the option selected. One needs to bear in mind that there are very few Medical Schemes that provide a product that covers 300% of tariff and even where this an option covering 300% these options tend to be way in excess of what people are able to afford. When reviewing the number of claims above 200% in the past five years the numbers are even more alarming. The lowest percentage of claims in excess of 200% we experienced was 28.3% in 2008. This percentage grew to 61.4% in 2010 and reduced slightly in 2011 to 58.5%. This further highlights the need for our products which are designed to cover these high costs of healthcare.

Consumer purchasing trends with respect to Medical Aid cover and "affordability" is further supported in the "Council for Medical Schemes Annual Report 2010-2011". In our analysis we reviewed twelve (12) Medical Aid companies and their scheme options, which represented 91% of the main members covered by "Open" schemes. Only 1.1% of the main members had the maximum hospital cover of 300%; clearly these "top-end" options are only available to persons in the top income brackets. When reviewing those clients who had an option to select between different options, 45% selected scheme options higher than the

lowest option. Therefore, this high percentage would suggest that people are purchasing the "best" option they can afford and not using Gap cover products to "buy down".

Co-payment cover (Benefit 2) and Sub-limit cover (Benefit 3)

Co-payments and procedure sub-limits were introduced by Medical Schemes with the intention of reducing their exposure to high frequency and / or high cost in-hospital procedures. Feedback received from the Medical Aid industry appears to indicate that there has been a growing trend for doctors to refer their patients for in-hospital scopes for ailments that they are not able to diagnose, where in the past they would have tried medicating the symptoms first before considering the use of a scope. In addition, the high cost and relatively high frequency of procedures like joint replacement and spinal operations have resulted in Medical Schemes introducing co-payments and sub-limit cover. In this way they hope to discourage unnecessary procedures / treatment and improve the risk pool of their Schemes.

The argument that the Registrar of Medical Schemes and the Medical Schemes would have against these forms of products would be that these insurance policies are encouraging the very objective the schemes are trying to discourage. The Registrar for Medical Schemes argument that insurance policies discriminate in terms of health status is the reason why they are protected against any possible negative impact a benefit of this nature could have on their risk pool. A basic principle of short term insurance is that there should be an equal opportunity of an event either occurring or not (assuming a level premium). It is for this reason that we underwrite applications and apply exclusions. In this way we are managing our risk pool and not negatively impacting on the risk of the Schemes. In addition, we are providing clients with cover for an unforeseen event, that their Medical Scheme is not providing.

Any co-payments levied by a Medical Scheme as a result of a member not using a Designated Service Provider or not complying with the Scheme rules is excluded through the following clause in the policy contract "No benefits are payable in the event that an insured person did not pre-authorise, make use of a mandatory Designated Service Provider (DSP) or any other condition set by the insured's Medical Scheme;". Further indication that the policies in no way are trying to undermine the Medical Scheme.

Most Medical Aid options impose co-payments and / or sub-limits, therefore there would be no reason to 'buy down" on the Medical Aid options in favour of these benefits.

Excess of in-hospital limit cover (Benefit 4)

There are a few Medical Aid options which limit the amount that the Medical Scheme will pay for in-hospital costs. We have researched the benefits of 14 major "Open" Medical Schemes, who offer in total 101 different Medical Aid options, and there are only 14 options which limit their in-hospital cover. These Medical Aid options tend to be entry level options and generally purchased by consumers that are not able to afford more comprehensive Medical Aid options. If the view of the Registrar of Medical Schemes that the insurance policies would encourage "buy down" of the Medical Aid option, then the average age of policyholders taking this form of cover would be significantly less than the average age of our other policyholders. The average age of the principal insured person taking out this type of policy is 42 years, as opposed to our current average age for all policies being 43 years. This would imply that age is not a factor in purchasing this level of cover for both the Medical Aid option and the Gap Cover policy.

In addition, the number of policies for this product has steadily declined over the past few years. The total decline for this form of cover has been 58.4% for the period 1 January 2006 to 31 December 2011.

The reason for this decline is the following –

- Clients have upgraded their Medical Aid option to an option with unlimited cover and therefore, no longer need the policy.
- Medical Schemes have increased their cover and some options have been changed to unlimited cover.
- Clients being unable to afford our policy, and possibly also their Medical Aid.

From the above, it is evident that this type of policy provides valuable cover to people that are not able to afford a higher level Medical Aid option. The fact that people are cancelling these policies and upgrading to Medical Aid options with higher benefits clearly indicates that the decision to purchase a particular Medical Aid option is not based on the Gap Cover policy. If the Gap Cover policy was the key reason for the choice of Medical Aid option then people wouldn't upgrade their Medical Aid option. Therefore, this product is a necessary affordable addition for Medical Aid members that are forced to purchase an entry level Medical Aid.

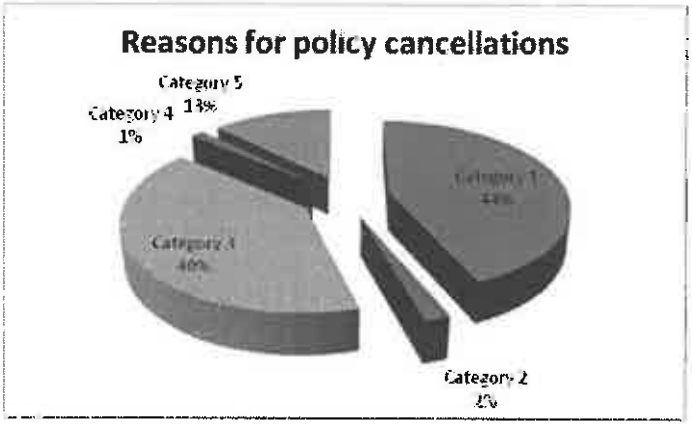
Biological cancer drug cover (Benefit 5)

This is a newly introduced benefit that allows policyholders to get treatment for specific cancer drugs that their Medical Aid plans do not cover. This benefit provides cancer sufferers with an alternative if conventional treatment is not able to assist the patient.

Analysis of policy cancellations

By analysing the cancellation of Turnberry policies we can get an idea of the potential impact on Medical Schemes. The various reasons for policies being cancelled have been listed below and presented in the graph below.

Category 1 – These policies have been cancelled due the non-payment of premiums and returned debit orders.
Category 2 – Deceased principal member.
Category 3 – Insured persons have cancelled for various reasons. The major reasons include affordability or the insured has upgraded their Medical Aid and feel they no longer need the Gap Cover.
Category 4 – Upgrading their Medical Aid, which provides the cover they previously enjoined on their Gap Cover policy.
Category 5 – Switching to a competitor's product or stop paying their premiums (reasons not known)



These figures clearly indicate that the overriding reason why our policies are being cancelled is related to affordability. This implies that if a person is not able to afford a premium of approximately R100 per month for their family for Gap Cover, they would be unlikely to afford a monthly contribution of a few thousand Rands for a Medical Aid. It is for this reason members are cancelling or "downgrading" their Medical Aid options.

Sales process

Key to determining whether there is any undue exposure to "buying down" or "downgrading" of Medical Scheme options would be to review the sales process. The sales process is largely regulated by the Financial Advisory and Intermediary Services (FAIS) Act of 2002. The principle behind this legislation is that brokers / sales consultants are required to provide "best advice". In order to accomplish this objective they are required to determine the client's needs. This analysis would include the client's requirements in terms of day-to-day health benefits and hospital cover. In addition, the client's financial status would be a major factor in determining the best cover that they can afford. The providers of Medical Schemes are also subject to this Act and it is our experience that this is well regulated through the services of Compliance Officers and the reports they are required to submit to the Financial Services Board (FSB).

It is worth pointing out that in-hospital cover is only one part of the decision on what option the client takes. Particularly, for healthier younger persons and families with young children, the day-to-day cover is often more important than the hospital cover, as they don't expect to be hospitalised in the near future and would not necessarily be concerned about in-hospital cover. As noted above, our products focus on hospital cover. In addition, as noted in sub-section "Private rate cover (Benefit 1)" above, the major factor in the decision is affordability and only 20% to 25% of Medical Schemes sold include a sale of a Gap Cover policy and these products are attracting an older client base who perceive the value of the cover.

Threat to the viability of the Medical Aid industry

We would suggest that insurance products that specifically attempt to "do the business of a Medical Aid" and encourage consumers to cancel their Medical Aid cover in favour of their products, should be investigated and regulated; although there appears to be definite need for a low cost Medical Scheme that is not currently available in the Medical Aid market and there are short term insurance products that are meeting this demand. The Registrar of Medical Schemes should be focusing on this end of the market, which would attract many more people to the Medical Scheme risk pool and thereby promote governments objective of NHI. It is worth pointing out that Medical Schemes have shown a steady growth in membership since 2006. In Statistics South Africa's survey ("General household survey, 2010" (Statistical release P0318, 3 August 2011)) they reflect an increase of membership from 6,599,000 in 2006 to 8,742,000 in 2010. These figures do not reflect a decline in membership in favour of insurance products replacing Medical Schemes.

Our products and other Gap Cover products of a similar nature in the market are in no way trying to replace the Medical Aid. On the contrary, our policies have a specific condition that requires a policyholder to be a member of a Medical Scheme, namely "Cover shall only be in force provided that the Insured person is registered with a Medical Scheme approved by Turnberry.". The policy contract further defines a Medical Scheme as "'Medical Scheme' means a registered Medical Scheme in terms of the Medical Schemes Act 131 of 1998;".

These products are specifically designed to cover a patients financial obligations in relation to medical expenses that are incurred, which are not covered under their Medical Scheme.

Further evidence of this can be found in the policy's terms and conditions which states "No benefits are payable if such costs are covered by the Insured's Medical Scheme." We also require that the policyholder follows their Medical Scheme rules by ensuring that the procedure / treatment was authorized.

These terms and conditions clearly indicate that these policy are attempting to provide cover not provided by the Medical Scheme, and in no way are they trying to replace the Medical Scheme. The objective of these forms of Gap Cover products is to enhance the consumers medical cover.

Having operated in the health insurance environment for a number of years, the Medical Aid industry and their viability is of particular interest to our business. However, at the current point in time the greater threats to the Medical Aid industry include -

- Cost of medical treatment increasing significantly above inflation without necessarily considering the Medical Scheme tariff.
- Healthcare service providers' ability to charge any fee they deem appropriate.
- Medical Aids having to restrict benefits and limit their increases for their tariffs used to calculate the amount they reimburse their members.
- Anti-selection by members within the Schemes – There are two forms of anti-selection that immediately come to mind, namely
    - Medical Scheme members are permitted to purchase a lower level option and annually upgrade to a higher option. Brokers have indicated that there are clients who experience poor health in a year or expect to have high future claims switch to a higher option at the end of the year. Clearly, such a practice is negatively impacting on the Medical Schemes risk pools.
    - Late joining members or members with broken membership who join an option on one of the lower options then upgrade to higher option once their 12 month waiting period has expired.
- Medical Aid inflation being almost twice the Consumer Price Index

The success / viability of the Medical Aid industry will depend on their ability to address these major issues. Gap Cover products such as those we offer are ensuring that consumers have a facility whereby they are able to protect themselves against undue expenses that they may not necessarily be able to afford and indeed lead to serious financial hardship in spite of being a member of a Medical Scheme.

Approximately 40% of policies sold to clients are purchased after the policyholder has purchased their Medical Aid. Therefore, the decision to purchase the Gap Cover product has had no bearing on the Medical Aid option that was purchased.

National Health Insurance

The regulator views the protection of the Medical Scheme risk pools as being vital in ensuring the risk pool of a future NHI system and the necessity of protecting this risk pool. Based on the information provided above, it is our view that our products not only do not negatively impact or harm this risk pool, but positively contributes to improving the risk pool.

When reviewing different NHI models implemented in other countries, all these countries have both a NHI system as well as a private health insurance system. These private health insurance systems provide "Gap Cover" for procedures / treatment not covered under NHI and / or allow the person to receive treatment through private health service providers. Therefore, it would be reasonable to assume that a similar model will be followed in South

Africa and there will be a need in the future (as there is now) for cover for treatment / procedures not covered by NHI. It is our belief that Gap Cover providers are equally as important in a future NHI system as Medical Schemes would be.

Protection of the general public

The purpose of any legislation is the protection of the rights of the citizens of the country and the protection of the general public. It is clear that the intent of the regulator is to do so in drafting this regulation. However, by not differentiating between the different health and accident insurance policies and removing policy's such as those we offer to Medical Aid members is taking away the protection these members currently enjoy through these products. The draft regulation does not in any way place an obligation on the Registrar of Medical Schemes or the Medical Aid industry to provide the cover that these policyholders would now be losing, nor could they do so at the price that these products are provided currently in the market. The general public has a right to protect themselves against the financial loss of an unforeseen health event. Our products are not designed to threaten the financial viability of any Medical Scheme. This report proves that this is not the case and that our products enhances the cover of the consumer. By taking these products away from consumers would not accomplish the desired intention of protecting the general public.

In the recent Supreme Court Ruling in the matter between Guardrisk Insurance Company Limited and the Registrar of Medical Schemes, the Court chose to include in its judgment a paragraph stating that "Practical reality has shown that there exists a need for this type of insurance and there seems to be no reason why it should not be permitted" . It is clear from this judgment that the court found a need for the products offered by Guardrisk, which are similar in nature to our products.

Conclusion

The overriding purpose of the proposed regulation is to protect the risk pool of Medical Schemes and thereby protect the interests of the general public. In so doing, this will ensure a more effective and efficient transition to the government's ultimate objective of providing the public with a NHI system.

The regulation has not differentiated Gap Cover from the other forms of health and accident insurance policies. Any conclusion made by the Registrar of Medical Schemes that Gap Cover is harmful to Medical Schemes would appear to be not based on facts, but rather a perceived threat. It is our opinion, based on the information provided in this report, that National Treasury should exempt these products from the proposed regulation. The basis of this view can be summarized as follows –

- It is a requirement that a policyholder is a member of a registered Medical Scheme.
- There is no evidence to suggest that these products encourage "buying down" or "downgrading" of a Medical Scheme option.
- These Gap Cover products provide protection that would otherwise not be available. Thereby reducing the burden on the current health system, which is a concern of the regulator as indicated in Question 12 of "Demarcation FAQ".
- The restriction of cover under Gap Cover for unhealthy persons encourages "buying up" on the Medical Scheme and thereby, promotes an improvement in the risk pool.
- There is legislation (FAIS Act) in place that protects the interests of the general public and prevents "buying down" or "downgrading" of Medical Scheme option.

- Both the Supreme Court and Constitutional Court have had an opportunity to review these products and have found the products to be legal in terms of current legislation and have endorsed that there is a definite need for these types of products.
- These products are the foundation for a healthcare insurance system that would be available after the implementation of NHI.
- Gap Cover products should be allowed to continue as short-term insurance products and continue to operate on the basic principles of insurance to ensure the protection of Medical Schemes and these forms of products. Applying the principles applied by Medical Schemes will see the eventual demise of these forms of products.

No Medical Scheme pays at cost and their product designs are creating these "gaps". Our company takes pride in knowing that we are providing a valuable services to the community by giving consumers the ability to purchase a comprehensive package. The discontinuation of Gap cover products will impact most on the most vulnerable of sociality, namely the lower income groups.

I would like to thank you for taking the time to review this document and would welcome any requests for further analysis or clarification. For further information please contact