Discovery Health

6 August 2013

Mr Ismail Momoniat
Deputy Director General
Tax and Financial Sector Policy
National Treasury

Per email : Ismail.Momoniat@treasury.gov.za

Dear Mr Momoniat

RE: FINANCIAL SERVICES LAWS GENERAL AMENDMENT BILL, 2012 –
DEFINITION OF "BUSINESS OF A MEDICAL SCHEME"

1. Thank you for meeting with us on Friday, 2 August 2013 to discuss the above matter. As per your invitation we set out below our submission on this matter for consideration during the upcoming Parliamentary amendment process.

2. The Financial Services Laws General Amendment Bill, 2012 amends the definition of the "business of a medical scheme" ('the definition') as follows:

Undertaking liability in return for a premium or contribution –

(a) to make provision for the obtaining of any relevant health service;

(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service;

(c) where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme; or

(d) to undertake two or more of the activities referred to under paragraphs (a) to (c).

3. This amendment has been proposed in the Bill in direct response to the judgment by the Supreme Court of Appeal in the Guardrisk Insurance Co Ltd vs Registrar of Medical Schemes & Another 2008(4) SA 620 (SCA) ("the *Guardrisk* matter").

4. In the *Guardrisk* matter, the Court *inter alia* ruled that the definition as it currently stands in the Medical Schemes Act, 131 of 1998 ("the Act") requires that all three elements as contemplated in paragraphs (a) to (c) of the definition have to be met conjunctively in order for a business to be conducting the business of a medical scheme.

5. It bears noting that the *Guardrisk* matter centred on whether businesses offering gap or supplementary health insurance products (ie products that indemnified persons in respect of medical care not paid for or paid for partially by a medical scheme) are doing the business of a medical scheme. The amendments in the Bill purport to prohibit gap and supplementary health insurance products.

6. Whilst having previously been agreeable to the amendment in the Bill in its current form, on recent reflection, a concise interpretation of the amended definition is not apparent to us by reason of the following –

   6.1. The amendment in the Bill could be read to mean that paragraphs a) - c) of the definition must be read disjunctively and that paragraph d) allows for the activities in paragraph a) – c) to be undertaken in any combination thereof. Thus a medical scheme business is being carried on if a business does either activity a) or b) or c) or any combination of paragraphs a) – c);

   6.2. The amendment could also be read to mean that paragraphs a) – c) of the definition must be read conjunctively and that paragraph d) be read disjunctively as a proviso or qualification. Thus a medical scheme business is being carried on if a business does at least two of more of the activities in paragraph a) – c); and

   6.3. The definition is cumbersome, ambiguous and arguably contains superfluous wording.

7. If the interpretation in paragraph 6.1 above prevails, then gap and supplementary health insurance products fall within the ambit of the definition. This would cast the net too wide and traps businesses ordinarily not deemed to be doing the business of a medical scheme into the definition. In this regard we point to a few examples, viz:

   7.1. Employer on-site medical facilities outsourced to providers of health services who receive payment for services rendered based on the size of the workplace;

   7.2. Employer based sick/illness funds capitalised on a per employee basis and created to provide financial assistance to employees to meet the cost of medical treatment;

7.3. Provider networks engaged by medical schemes that receive payments on a per member/per month basis and where the providers in such a network are remunerated by the network in accordance with its own scale of tariffs.

8. If the interpretation in paragraph 6.2 above prevails, then gap and supplementary health insurance product would fall outside the scope of the definition but then wide scope will be created for new business or new-generation insurance product to spring up that would be carrying on businesses similar to that of medical schemes without being subject to community rating, providing Prescribed Minimum Benefits or meeting statutory solvency requirements.

9. It is therefore respectfully submitted that the proposed amendment to the definition fails to attain its intended purpose and moreover compounds the problem by giving rise to anomalous outcomes.

10. Furthermore, it is important to note that the *Guardrisk* judgment also held that gap and supplementary health insurance products could lawfully be marketed and sold by virtue of the fact that these products met the requirements of the Short-term Insurance Act, 53 of 1998 ("the STIA") – ie they fall within the definition of an "accident and health" policy.

11. Hence the mere amending of the definition of the Bill is not sufficient to achieve the purpose of resolving demarcation issues in respect of gap and supplementary cover. The STIA and the Long-term Insurance Act, 52 of 1998 ("the LTIA") also require revision. We are aware that the STIA has been amended by the Insurance Laws Amendment Act 27 of 2008 ("ILAA") to exclude the business of a medical scheme from the definition of an "accident or health policy". However, the ILAA also provides notwithstanding this exclusion, for an "accident or health policy" to include any other policy deemed by the Minister of Finance (albeit through a consultative process with the Minister of Health and the Registrars for short-term insurance and the Council for Medical Schemes) to be an "accident or health policy".

12. It is evident from the above, that these twin amendments do not resolve with certainty and finality the status of gap and supplementary cover. It simply compounds complexity and effectively postpones and "processes-out" a solution regarding such complexity to a later date.

13. In our view, the abovementioned anomalies stem from the amended definition perpetuating the problem of incorporating into the definition aspects, (particularly paragraph (a) and features of paragraph (c)) which do not *per se* constitute doing the business of a medical scheme. Making provision for and rendering health services are simply measures that have been introduced by medical schemes, whether at inception or subsequently, to contain costs, acquire (medical) professional capacity and improve the service offering to members of a scheme. The fact that many medical schemes perform activity (a) and features of (c) of the definition is not sufficient reason to include (without qualification) these elements into the notion of what constitutes a medical scheme. To do so is to conflate essence with reality.

14. We attach what we believe are the principles that ought to inform an amendment to the relevant statutory provisions that seek to define what constitutes the business of a medical scheme.

15. In this regard we wish to point out at the outset that Discovery would, all other things being equal, strongly prefer that gap and supplementary health insurance products be included in the definition – thereby eliminating these products from the market. In our view these products have the potential to destabilise the long term sustainability of medical schemes. Notwithstanding this firm view, in proviso (b) of the attachment containing the principles, we have excluded gap and supplementary health insurance products from the definition of the business of a medical scheme by reason of the following:

15.1. The current proliferation of these types of products in the market place;

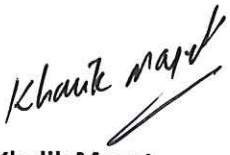
15.2. Policy and regulatory tolerance for these types of products;

15.3. The likelihood of businesses marketing and offering these products being able to successfully mount legal challenges to the validity of any attempt to prohibit such type of economic activity; and

15.4. The necessity given the above, that regulatory space be created that allows for the development and marketing of products that can be supportive of and strengthen medical schemes, rather than undermine them, as is currently the case.

16. We hope that the above is of assistance to you when finalising the Bill. Please do not hesitate to contact us if you require clarity on any of the above.

Yours faithfully



Khalik Mayet
Head: Legal Services

ATTACHMENT

PRINCIPLES TO CONSIDER FOR A COMPREHENSIVE AMENDMENT

1. 'Business of a medical scheme' in the MSA

A business which in return for a premium or contribution[1] indemnifies[2] a person in respect of expenditure incurred in connection with the rendering of a relevant health service and/or undertakes to render a relevant health service[3] : Provided that –

a) for purposes of this definition -

i) the indemnification is limited[4] to granting full or partial[5] financial assistance for defraying expenditure[6] connected with the relevant health service rendered in accordance with the rules of medical scheme or in terms of any payment or tariff agreement that the medical scheme enters into with providers of such service,

ii) rendering a relevant health service means a medical scheme rendering the service itself or procuring such service from any provider or group or providers or from any person acting in association with the medical scheme;

b) A business will be deemed not to be doing the business of a medical scheme if –

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[1] An employer sick-illness fund fully funded by the employer is neither doing the business of a medical scheme or an insurance business because it is not receiving a premium contribution.
[2] Means undertaking of liability – "indemnification" has a clearer insurance meaning.
[3] Hospital groups or corporates employing health professionals collecting premiums for product offering(s) will therefore have to register as a medical scheme. This prevents them from entering the health insurance sector without having to provide for PMB's.
[4] This proviso excludes other non-indemnity type financial assistance.
[5] This proviso contemplates co-payments and deductibles.
[6] "Defraying expenditure" means payment in respect of expenditure incurred relating to a relevant health services actually received. It does not matter whether payment is to a member or a provider. The trigger for the payment and the amount paid is associated with the out of pocket cost incurred for the service and not conventional loss/damages (eg loss of earnings, travel costs, etc) which are covered by other insurance products.

i) the financial assistance is granted in respect of an amount not paid or paid in addition to[7] the amount paid by the scheme for the relevant health service[8];

ii) The relevant health service is rendered at a health facility established or registered to the business paying the premium or contribution[9]; or

iii) it establishes a sick or illness benefit for its employees that is fully funded by the business.

c) A medical scheme shall not be precluded from making provision for the rendering of a relevant health service[10]; and

d) No person may conduct the activities contemplated in b) above or receive a premium or contribution for such activities in respect of any person or group of persons on the basis of such persons' race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability or state of health[11].

2. Addition to definition of 'health policy' in the LTIA

c) entered into between a medical scheme registered under the Medical Schemes Act and any person which relates to that person's membership to the scheme[12]

3. Addition to definition of 'accident and health policy' in the STIA

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[7] ie "over and above" the amount paid by a medical scheme.
[8] This proviso excludes Gap and Supplementary Cover in the definition of a medical scheme business.
[9] Care-Cross/OCSA Health/outsourced models will therefore not be doing the business of a medical scheme.
[10] "Make provision" means payment to a health care provider (doctor, pharmacy, managed care organisation) irrespective of whether the health service is provided or not. It contemplates access to a service albeit that such access is limited to meeting certain entry criteria or subject to utilisation caps. Payment of such service could take the form of capitation fees, retainers or even a premium/ contribution. It invariably entails the transfer of risk. "Making provision" could also refer to cushioning oneself from the consequences of a health event occurring and not just in respect of medical costs. It could therefore also refer to providing for loss of income or incidental cost associated with procuring a health service (eg. travel and accommodation cost.)
[11] The non-discrimination/open enrolment and restricted scheme provisions for medical schemes is in the main body of the Act. This proviso prevents risks selection, internal buy-down to and/or external top-ups from Core plans but would not preclude risk related Gap and Supplementary Cover products.
[12] This proviso excludes from the FSB's jurisdiction, medical scheme business thereby ensuring clear regulatory demarcation between CMS and FSB.

f) entered into between a medical scheme registered under the Medical Schemes Act and any person which relates to that person's membership to the scheme.[13.]

[13] This proviso excludes from the FSB's jurisdiction, medical scheme business thereby ensuring clear regular demarcation between CMS and FSB.