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Sirs/Mesdames

Comments on draft demarcation Regulations – Health Policies and Medical Schemes

I write to express concerns that the draft Regulations fail to meet their stated objective of reducing "the risk of possible harm caused by health insurance products drawing younger and healthier members away from medical aid schemes", while entrenching the vested interests in specific products and groups.

1) <u>Gap cover is not the problem</u>
"Gap" health insurances are only sold as a top up to medical scheme benefits, meeting consumer need for affordable ways of insuring the price difference between cost and "medical scheme tariffs" & benefit limits.

Groups and individuals purchase cover voluntarily, knowing full well that they are unable to finance shortfalls and co-payments on non-PMB's such as hip replacements, out of their pockets – this insurance fulfils a legitimate purpose and it is <u>not in the public interest</u> to outlaw it. For example, groups can provide their pensioners, disabilities and employees with safety nets of extended care much more affordably through Gap policies costed on a year-to-year basis, than buying up to the highest available medical scheme option.

The argument as to stated benefits being a "more legitimate" method of defining insurance benefits than 'balance of cost not paid by medical scheme' is spurious, as the next point clearly shows.

2) <u>Hospital Cash Plans</u>
Taking full advantage in the delay of the draft Regulations, every South African with an email address has been bombarded with "stated benefits" Hospital Plans sold **directly in competition to medical schemes**, in the form of emails such as those from <u>www.sahospitalcover.co.za</u> , as well as TV, Radio advertisements from *Clientele* and others. Invariably, these products provide 'stated benefits' that only apply after an 'excess' equivalent to the average hospital stay – in short, paying nothing in most cases while happily defrauding the public. Even the briefest search of the SA internet will find countless examples sold under both long term (Old Mutual: <u>www.mslife.co.za</u>) and short term insurance licenses (Hollard) with impunity – **this is the area which your draft regulations *should* be targeting.**

3) **Other competitors to Medical Schemes threaten universal coverage**
The proposed regulations fail to honestly and openly address the much larger loopholes in the regulatory environment that undermine the social solidary pooling principles of open enrolment – in other words, questioning *why* Treasury is focussing on health insurance rather than the elephants in the room such as:

- Bargaining council "occupational medical and sick benefit funds", which increasingly are marketed in direct competition to medical schemes, despite being exempt from the Medical Schemes Act and PMB regulations – ***GetMed*** is a visible, recent example
- Occupational health schemes – providing benefits to employees are now being sold as an alternative to medical scheme membership, specifically for lower earners
- NHI's "single payer" proposals are themselves a far bigger challenge to the survival of medical schemes than any of the factors above.

4) **Arbitrary split between "long" and "short term" demarcations, regulations**
The regulations fail to differentiate between the different types of risks which are better suited to "short term " and "life" reserving requirements, and serve mainly to protect vested interests for specific policy vendors of "frail care", "emergency evacuation" and "HIV-Aids" insurers which cover a multitude of sins under those broad umbrellas. They are vague and overlapping, failing to recognize that:

a) Long term risks (*specifically* morbidity, disability loss of income; death; HIV-Aids) can only be funded through 'long term' insurance principles, within a framework and reserving appropriate to such contingent liabilities;

b) Shorter term risks (such as 'Gap cover' balance of limits/tariff not met by medical scheme) vary from year-to-year in parallel with the "Gaps" they insure between scheme benefits, limits, tariffs, networks and the actual cost of private healthcare – these can neither be predicted nor costed over the long term and axiomatically can only safely be insured on a short-term basis;

c) The regulations elevate the purpose of "Emergency evacuation" insurances due to undue significance – what noble social purpose justifies their exemption? Where exactly are the beneficiaries of this cover transported to, if they are not members of a medical scheme?

d) The provision of "accident only" cover for health insurance is a travesty which the regulations promote, rather than curb – allowing insurers to continue to exploit the ignorance of the poor and under educated, who are unaware that the probability of *accidental* hospitalisation is far lower than the inevitability of a health event arising from 'natural causes' such as ageing.

5) **Reviewing the legitimate role of health insurance**
Most developed countries recognize the right of the individual to top up (***not replace***) NHI or medical scheme benefits through insurance – co-payments and deductibles, benefit limits and DSP networks are amongst the many reasons why an 'universal' set of affordable PMB cannot meet the needs of every citizen, at different ages, incomes and heath needs.

Adding to the dilemma for South African medical scheme members, is the regulatory impediment that precludes them from saving for planned procedures – the limitation of 25% of scheme contributions to Medical Savings Accounts, precludes medical aid from addressing this part of the problem. (Originally, the restriction was intended at preventing schemes from paying PMB's from savings, and artificially inflated solvency ratio's in their financial statements. Discovery proves on a daily basis that these *good intentions* have failed miserably, and regulation has instead become a perverse incentive that drives up scheme contributions).

it is premature to mistakenly single out "Gap cover" for regulation: honest, sober re-evaluation of the cost of "full NHI" and "NSSF" social pensions should precede piecemeal attacks on health insurance, as longer term modelling confirm that some form of private hospital top ups to NHI are both inevitable and necessary – the draft regulations should be *providing regulation for that likelihood*, not banning it.

ALTERNATIVES

Our clients and we feel that the proposed regulations hurt rather than protect the public & medical scheme members, and request serious consideration instead be given in the proposed Regulations for:

- **Short Term Insurance**– regulations should strictly regulate and allow but limit cover to
  a) "balance of costs" not paid medical scheme/NHI membership, where no claim may be paid in the absence of either medical scheme or NHI membership at the date of the claim, in respect of the difference between cost and the limits or tariffs of any registered medical scheme option;
  b) Occupational health benefits provided to employees only as provided for by current regulations;

- **Long Term Insurance** – regulations should define the life contingencies which should only be covered under life licenses (ie disability, HIV-Aids, death) and make provision for the likely future "balance of private hospital" costs that will come along with NHI, but exclude short-term risks that change from year-to-year such as tariff Gaps, benefit limits.

- **Dual prohibition** of the following, by giving reasonable notice to policyholders (until year end at least) and allowing a once off window for policyholders to enrol onto medical schemes free of Late Joiner Premium Penalties with effect from 1st January 2013:
  - All "hospital cash", "hospital plan" insurance products that are sold as *alternatives* to medical scheme membership – whether on a stated benefits, tariff or full cost basis
  - The sale and marketing of "bargaining council" sickness and accident funds beyond the intended scope of the industry for whom they were intended by sectoral determination

We urge the CMS to take steps to bring "occupational medical and sick benefit funds" under the same legal umbrella of PMB's and minimum solvency as medical schemes, requiring from them an actuarial plan to fund these requirements over the next 5 years in the run up to NHI – this is the only legitimate means of preventing a repeat of *GetMed*. Secondly, GEMS should be guided to fund for regulatory solvency requirements applicable to all other schemes over the next 5 years, to create sustainable level playing fields in which NHI can operate. Thirdly, the exemptions for employer sponsored "occupational health" (fully tax deductible, whereas medical scheme contributions are not) need to be re-examined far more carefully than has hitherto been the case.