AG

bestMed

Draft Regulations on Demarcation between Health Insurances Policies and Medical Schemes

We thank you for this opportunity to respond to the proposed Demarcation Regulations and trust that you and your colleagues will accept the comments that follow in the spirit in which they are offered:

- Concerns rather than criticisms;
- Where we believe this to be necessary, recommendations that seek to add value.

This is a matter of critical importance to Bestmed and other Medical Schemes and, as such, we trust that our position contained herein will be taken seriously. We are more than willing to engage in discussions with the authors of the Draft Regulations, and any other parties, to clarify any questions that might arise from our comments.

It is important to state upfront what the principles are that represent our point of departure:

- These recommendations seek to modify the existing Demarcation Agreement between Medical Schemes and Insurers. So any change being contemplated must be assessed in this context – will such change add or detract from the prevailing circumstances as these affect Medical Schemes, Bestmed and others.
- After all, this resonates with what the National Treasury indicates in its media statement: "…the draft regulations ……seek to find a better balance between medical schemes and health insurance products……The Regulations also seek to address the risk of

possible harm caused by health insurance products drawing younger and healthier members away from medical schemes ….".

It is against the backdrop of these to principles that our commentary should be viewed.

The Process

We feel obliged to first comment on the process that has led to the recommended Draft Regulations. The recommendations in the Draft Regulations are, according to the covering media statement, the product of discussions between the Department of Health (DOH), the Financial Services Board (FSB) and the Council for Medical Schemes (CMS).

We are unclear why the CMS, whose mandate it is to protect Medical Scheme members (and the wider public) by regulating Medical Schemes according to the Medical Schemes Act (MSA) and related regulations was brought into this process and, on this occasion, assumed the role of representing Medical Schemes without consultation. We find this inappropriate.

At no stage did the CMS, as far as we are aware, engage with Medical Schemes to procure a mandate to participate in these discussions on behalf of Schemes nor at any stage solicit their views (nor those of healthcare service providers, employers etc. - whose interests they also appear to have represented) on the current arrangement between Medical Schemes and Insurers. Nor, for that matter, if indeed there is any need to change the current Demarcation Regulations and, if so, where these needed attention.

We find ourselves now required to comment of a range of changes, some of which have negative implications for Medical Schemes. It would have been more appropriate to approach this matter from the practical departure point set out above but with appointed Medical Scheme representatives participating in the process.

Where Medical Schemes Currently find Themselves

If the purpose of the Draft Regulations is to protect the risk profiles of Medical Schemes by encouraging membership by younger, healthier persons, cognisance must be taken of changes to the MSA and related regulations that have, over the past decade, already had an impact on these issues:

- Community rating – this has made it difficult to attract younger, healthier members because of affordability in the early years of their careers.
- Open enrollment – clearly this has affected risk pools negatively.

If there is concern, as stated in the Draft Demarcation Regulations discussion papers, that care must be taken not to place Medical Schemes at a disadvantage relative to insurance products, these regulations (community rating and open enrollment) have already done so.

These and the mandatory inclusion of PMBs in scheme options, have also made option contributions relatively more expensive (as much 20% higher than they would otherwise have been!) than insurance products, and also impacted the perceived attractiveness of Medical Schemes to younger persons, negatively and that of insurance products positively.
In addition these have led to increased regulation by the CMS of Medical Schemes (an issue commented on later).

Yet, despite these developments, the total size of the membership/beneficiaries base of SA Schemes has remained much the same over this period (approx. 7 million members and dependents). In fact, in recent years there has been an increase (in excess of 8 million), despite these regulations. This is clearly the result of incentives available to employees, both in the form of employer contribution subsidies as well as deductibility of out-of-pocket expenses (even although these are capped for the under 65s). The surge in GEMS numbers, where the subsidies are significant, bears testimony to this fact.

Mandatory membership of medical schemes as part of conditions of employment has also had a positive effect on numbers. But things are set to change. The move by employers to Total Cost of Employment remuneration packages is gaining momentum and sees demands by employees for greater freedom of choice in the purchase of healthcare insurance for themselves and their families – which Medical Schemes they wish to join and insurance products as alternatives.

The recent changes to the treatment of incentives pertaining to Medical Scheme contributions, with the implementation of the Tax Credit system (at this stage for the under 65s), will, in our view, exacerbate this challenge. It erodes the financial attractiveness of Medical Scheme contributions relative to insurance products. The consequence will be both "buying-down" of medical scheme options and, for the young and healthy, a perceived increase in the advantages

of insurance products – notwithstanding that they are paying for this with "after tax" money. The Tax Credit system has already significantly weakened a "competitive differentiator" of Medical Schemes.The Draft Demarcation Regulations cannot possibly reverse this, even although their implied intention is to "protect" Medical Schemes for insurers.

Medical Scheme member and beneficiary numbers are, we believe, set to decline. And this ahead of the proposed Draft Demarcation Regulation changes. These comments are meant to sensitise the reader that as a Medical Scheme, we find ourselves in a parlous situation. Any further disruption to the status quo or increase in the regulatory regime cannot be expected to be in our interest.

Medical Schemes and Insurance Products – Current Position

Following the 2007 Supreme Court of Appeal ruling in favour of Guardrisk Insurance Company Ltd, in relation to its continued ability to market and sell AdmedGap and AdmedPulse, both so-called Gap Cover products, Medical Schemes and Insurers have lived harmoniously alongside one another. In fact products like these are complementary to Medical Scheme options – were MedicalSschemes to offer higher tariffs in order to decrease the need for gap cover, Medical Schemes would become even less affordable for younger members and, in any event, short and long term insurers are able to offer gap cover at far more affordable rates.This state of harmony between the two sets of players in the healthcare arena can be attributed to key dimensions of the "business of a medical scheme" (ito the MSA) and that of an "insurer" – in the case of the Guardrisk ruling, a short-term insurer (ito the STI Act).

Of critical importance here is that:

- In the case of Medical Schemes, the current definition (which the Draft Demarcation Regulations seek to change – see our later objections):
    - **Allows contributions to enjoy tax benefits** (although as indicated and as is well-known this advantage is being eroded by Tax Credit regulations);
    - Offers the **option to pay the healthcare service provider or member** for a healthcare service rendered according to the conditions in the benefit option in question.

- In the case of an Insurer, the current definition (also included in the Draft Regulations):

- **Allows premiums to be paid from discretionary, after-tax money** – the use of which by a consumer must embed the principle of "freedom of choice";
- Although possible to be triggered by a specified healthcare event a **policy pays the owner of the policy a predetermined "...stated sum of money..."** after the policy conditions have been met (e.g. Rx after y days in hospital for as long as the affected person is unable to earn his income):
- So these **cannot " ...defray, expenditure in respect of any health service obtained" (i.e. cannot be linked to the cost of such service)**
- Nor can these benefits "..... be provided to any provider of a health service in return for the provision of such service".
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We regard the current demarcation of the "playing-fields" as clear in general terms. The Draft Regulations seek to tamper with these and increase the extent which the Regulator (CMS) has cause to distort the marketplace in which Schemes operate. In our view this space is already over-regulated – as indicated.

Some Comments on Marketing by Insurers

We have some sympathy with the concern expressed in 7.3 of the Draft Regulations (Marketing and Disclosures). It is probable that STI advertising of healthcare products creates the impression that they are cheaper substitutes for Medical Scheme options since, as one might expect from electronic and print advertising campaigns, they build on the positives ("low cost options paying out Rx/day while in hospital") and downplay the negatives (the daily payout only "kicks in after z number of days").

We find it difficult, however, to understand how the CMS would be able to justify "controlling" the content of these campaigns to the extent envisaged in the Draft Regulations – prohibiting the use of words such as "medical" or "hospital" when, in reality, the "healthcare events" that trigger a claim against an STI derive exactly from these sources! Once again this seems over-regulation, this time by an inappropriate body (Registrar of Medical Schemes), when recourse to an appropriate body, the Advertising Standards Authority, has always been available to any party who finds an advertisement misleading or inaccurate.

The Business of Medical Schemes

Both the gazette STI and LTI Draft Regulations include amendments to the "business of medical aids". Those that refer to the Guardrisk judgment (the "and/or" confusion) are considered by us as appropriate. However we find the addition of:

"d) to undertake two or more of the activities referred to under paragraphs (a), (b) or (c)" as being unnecessary with the potential of being onerous on Schemes and request that this be deleted from these Draft Regulations and the draft Financial Services Laws General Amendment Bill.

The Motive for the Changes to the Current Demarcation Regulations

Having not been party, in any way, to the process that led to the publication of these Draft Demarcation Regulations it is not clear to us why the National Treasury, FSB and CMS regard it necessary to change the status quo.

We refer to the Green Paper on NHI, specifically to the expressed need to ensure that Medical Schemes remain strong and able to continue to provide the service to the Healthcare Sector they currently do while the powers that be (DOH and others) design an appropriate NHI model for South Africa. Yet the authorities concerned, while articulating this as a National Healthcare Goal, on the one hand (in the Green Paper), Medical Schemes immediately faced the reality of having a key instrument that made membership more attractive, the tax benefits (replaced by Tax Credits), eroded.

The Green Paper also envisaged (even went so far as to articulate) a role for Medical Schemes after the NHI is fully established. This will require a major repositioning of Medical Schemes (in parallel with the gradual shift to an NHI) in terms of its healthcare offerings, and relationships with members, employer groups, service providers and the NHI itself. Current over-regulation of Medical Schemes will already inhibit this and will need "relaxing" even "removal" if Schemes are to find their new space in healthcare. Yet, in the Draft Demarcation Regulations we find not less but more (another layer) of regulation affecting our ability to adjust to changing market circumstances.

We believe, instead of securing Medical Schemes and protecting them from Insurers the additional regulations will disturb a "settled" and "harmonious" relationship amongst us, where the greater co-operation that will be needed amongst us, will be more difficult.

We sincereiy request that these intended changes to demarcation be set aside. We see little or no value in them.

Concluding Remarks

These remarks are generic to our commentary on both the proposed Draft Demarcation Regulations as these pertain to both STIs and LTIs. Specific commentary on STIs is set out in the Appendix.

Appendix: Specific Comments on STI Act, 1998: Proposed Amendment of Regulations made under Section 70

1. **Schedule A Part 7**

   7.1 Definitions: No Comments

   7.2 (1) Categories of contracts identified as accident and health policies under para (b)

   of the definition of accident and health policy:

   Here we offer the following commentary.

On page 4 of 17, in relation to :

4	HIV and Aids	Covers expenses for HIV-related testing and HIV and Aids treatment on an employee group basis.	• Cover offered to employers in respect of employees. • Policy benefits may be paid in kind or to a provider of a relevant health service. • Policy benefits may be linked to actual costs or expenses of a relevant health service. • Cover may be offered on a pre-funded or immediate needs basis.

We do not understand nor agree with the Criterium "Cover offered to **employers in respect of employees."** Surely this is in conflict with the "business of an STI" and is discriminatory. The employee, we believe, must be the beneficiary. This will require the rephrasing of the Policy benefits.

On page 5 of 17, we refer to:

7	Emergency Evacuation or Transport	Covers guaranteed access to and utilisation of specialised medical transportation and / or guaranteed hospital admission to ensure that the policyholder or insured persons are admitted to an emergency treatment facility and stabilised.	▪ Policy benefits are ancillary to the main policy benefits provided under the policy. ▪ Policy benefits may be payable in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service.

Again we have difficulties with the wording of the Criteria:

- Firstly: "Policy benefits may be **payable in kind(?) or to a provider of a relevant health service**".

  We draw the reader's attention to the definition of the "business of an STI", specifically the principle:

  "Although possible to be triggered by a specified healthcare event a **policy pays the owner of the policy a predetermined "...stated sum of money..."** after the policy conditions have been met (e.g. Rx after y days in hospital for as long as the affected person is unable to earn his income)".

  We contend that the Criteria is in conflict with this principle.
- Similarly, with regards to "Policy benefits **may be linked to actual costs or expenses of a relevant health service**", we find this in conflict with the "business of and STI".

Marketing and Disclosure (7.3 - page 6 of 17)

We refer the reader to our comments in this regard in the body of the covering letter dealing with this issue.

Reporting of product information (7.4 – pages 6 and 7 of 17)

The underlying intention of this section is highly questionable:

- The need for this cumbersome regulatory regime is directly related to the move to tamper with the current Demarcation Regulations and introduce the over-complicated set of regulations contemplated in the Draft in question and to which our commentary relates;

- Consequently, it defines the need for the Registrar of Medical Schemes to perform a regulatory role **in an industry (STI) outside his mandate.**

Both point to the Draft being fundamentally flawed, complex and unnecessary.

Transitional arrangements

We expect the STIs to have quite a bit to say on the contents of this section.

Our view is that this could well be in conflict with the Consumer Protection Act and probably other legislation as well.

Again the Registrar of Medical Schemes is expected to play a substantial roll outside of his mandate.

2. **Schedule B: Explanatory Memorandum**

This Schedule, in the main, summarises the previous components of the Draft Demarcation Regulations. Consequently the reader is requested to refer to our comments above as these pertain to the various sections.

The exception being that we feel obliged to re-iterate our strong objection to the proposed changes to the **'business of a medical scheme'**.

Annexure 1 to Schedule B refers (Page 17 of 17):

"EXTRACT FROM THE MEDICAL SCHEMES ACT
SECTION1: PROPOSED AMMENDMENT

'business of medical scheme……'

Where this is amended to deal with the rulings in the so-called Guardrisk Appeal and relating to the words "and", "or" and "and/or" we accept the changes.

However we request that the following additional clause be scrapped.

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