FPI

Financial Planning Institute of Southern Africa

SETTING THE STANDARD

"DRAFT REGULATIONS ON THE DEMARCATION BETWEEN HEALTH INSURANCE POLICIES AND MEDICAL SCHEMES"

our view on

FPI COMMENTARY SUBMISSION TO NATIONAL TREASURY ON THE PROPOSED AMENDMENT OF THE REGULATIONS TO THE SHORT-TERM INSURANCE ACT, 1998

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The Financial Planning Institute of Southern Africa

As the premier professional body for the financial services sector in Southern Africa with over 8,000 members, the FPI is committed to protecting the public interest by guiding practitioners in the sector towards higher technical and ethical standards. We do this by offering them a broad portfolio of services and support to achieve this, including membership, designations, continuing professional development, thought-leadership and the maintenance of a benchmark Code of Ethics.

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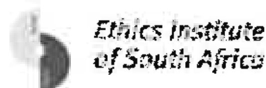

FOREWORD

The Financial Planning Institute (FPI) is the premier independent professional body in the financial services sector with over 30 years of service in being the forerunner in setting financial planning standards and representing professional Financial Planners in South Africa.

The FPI currently has approximately 7 000 members and is affiliated to the Financial Planning Standards Board (FPSB), the Ethics Institute of South Africa and to Business Unity South Africa (BUSA). The FPI is also involved in a number of work streams of the Financial Services Board (FSB).

The FPI not only focuses on our professional member's interest, but as a Professional Body, is concerned with societal issues and with a particular interest in consumer protection.

We would like to thank National Treasury for the opportunity provided to comment on the draft regulations and we trust that our comments are of value.

INTRODUCTION

Draft regulations on the demarcation between health insurance products and medical schemes were released on Friday 2 March 2012.

The purpose of the Regulations is to find a balance between medical schemes and health insurance products. They also seek to address the risk of possible harm caused by health insurance drawing younger healthier members away from medical schemes to health insurance products.

The Regulations are also required to strengthen the principal that underpins medical schemes of community rating. This is the principal whereby no person is charged premiums depending on their state of health, nor is any person declined cover due to age, race, health etc. Health insurance products on the other hand, operate on the basis that premium is charged depending on age, health status or income. These policies also contain clauses which can limit who the policy is sold to, e.g. it can limit the sale of policies to persons over a certain age.

These regulations are the outcome of a joint process between the National Treasury, Department of Health, Financial Services Board and Council for Medical Schemes. The Regulations provide for the types of policies that will be allowed to be sold by the long-term and short-term companies. In determining whether a product can be sold, special consideration is given to whether the product impacts medical schemes or not. These products will also fall outside of the scope of the Medical Schemes Act and will be subject to regulatory over sight by the Financial Services Board.

COMMENTARY

Current Medical Scheme Environment and GAP Cover Insurance Market

GAP cover insurance has evolved from an environment of an ongoing disparity between what is covered by medical scheme for major medical expenses and what is charged by the healthcare providers. GAP cover insurance exists therefore because there is a **demand** from medical scheme members for a solution to increase major medical costs (catastrophic costs) not covered by medical scheme benefits. This disparity in what healthcare providers charge and what medical schemes pay is created by the following market conditions:

- Medical inflation cost can't be controlled by a simple cap on medical scheme contribution increases (CPI + 3%), as healthcare costs increase at a higher rate than medical scheme contribution increases.
- In the face of rising healthcare costs from medical professionals the imported cap on medical scheme contributions (CPI + 3%) is only achieved by reducing benefits. Members of medical schemes have to absorb the cost shifting by having to make co-payments.
- The shortage of specialists creates an environment that healthcare cost are charged at inflated levels, due to the demand that exceeds the supply.
- The Consumer Protection Act prevents medical schemes from joining together and using argumented bargaining muscle to set industry tariffs. The balance of pricing power has been tipped to the side of the healthcare providers.
- According to the annual report of the CMS, 2010 -2011, 23% (1 090 423) of members on open medical schemes belong to a medical scheme that only reimburse medical expenses at 100% of the medical scheme rate, should a member of these medical schemes want to have additional cover in the absence of GAP insurance products they will need to change medical schemes.
- According to the annual report of the CMS, 2010 -2011, 66,5% (3 174 194) members on open medical schemes belong to a medical scheme option that only reimburse medical expenses at 100% of the medical scheme rate. Should a member of these options want to have additional cover in the absence of GAP insurance products, they will need to change their medical scheme option. However, only 1% (45 848) members on open medical schemes can afford the higher contribute at a reimbursement rate of 300%. This 1% of medical scheme members paying the highest contributions are still exposed to healthcare providers charging more than the medical scheme rate.
- **No** medical scheme provides benefits that fully reimburse or defray all medical expenses.

Rationale for the inclusion of GAP cover insurance products in the regulations

The FPI suggests that the following five points be considered to include GAP cover insurance products in the regulations:

1. Negative impact on members if withdrawn

   In their current form, the draft regulations do not make appropriate provision for GAP cover insurance products. GAP cover insurance would require substantial restructuring to exist as lump sum or income replacement policies. This restructuring of GAP cover insurance products will tend to increase since a value would need to be assigned to each procedure or event and a benefit would be paid irrespective of whether a shortfall in reimbursement tariff occurs. Under an income replacement structure the policy benefit would be limited to 70% of the member's net income which could result in insufficient benefits for lower income earners.

   The withdrawal or fundamental restructuring of GAP cover insurance products would have a significant impact on members, especially members who cannot afford to purchase a more comprehensive benefit option. It is estimated that there are 300 000 gap cover policy holders in a population of 3,6 million medical scheme principal members. This represents a coverage rate of approximately 8,5% therefore the impact of GAP cover insurance products on medical schemes is very small. However the impact on the average GAP cover insurance policy holder is significant if these products are withdrawn from the market.

2. Short-comings in medical scheme benefit design:

   In the 2008 Supreme Court Ruling in the matter between Guardrisk Insurance Company Limited and the Registrar of Medical Schemes, the judgement included the following statement "***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*"**.
   The reality is that in a perfect medical scheme environment there would be no need for gap cover insurance products. These products exist in direct response to systemic shortcomings in the medical schemes regulatory environment. It is our view that issues such as mandatory membership and risk equalisation (proven mechanisms for risk pool stabilisation) together with regulated provider tariffs need to be addressed before gap cover insurance products are removed. This will limit the negative impact on members.

3. Addresses the problem of member affordability:

   It is our experience that medical scheme members make decisions on benefit option choice based largely on affordability constraints. An analysis of how medical scheme members chose to select benefit options will show that the vast majority of medical scheme members chose to remain on their current benefit option.
   This view that members choose benefit options based largely on affordability is further supported by the CMS, who in their Annual Report 2010-2011 are quoted as saying ***"An online survey was conducted to understand how members of medical schemes choose or change a benefit option. The study revealed that the most common reason why members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options."***

The reality is that members will generally continue with the benefit option that is the most affordable to them and have to absorb the costs of any shortfalls in cover as and when they occur.

For the vast majority of medical scheme members cover for in-hospital professional services and medical procedures is limited to 100% of the medical schemes' reimbursement tariff. Although a level of protection against out-of-pocket shortfalls is afforded under regulation 8 of the Medical Schemes Act, which requires PMB claims to be paid at full invoiced cost, the average member still faces the very real possibility of large unexpected shortfalls in the cover of in-hospital expenses caused by the ever widening gap between the scheme reimbursement level (generally 100%) and the cost of professional fees (up to 500% and more).

4. Financial Risk Protection:

The Greenpaper National Health Insurance in South Africa published on 12 August 2011 cited the three dimensional approach towards universal coverage. The extent of cover provided by medical schemes refers to the **Financial Risk Protection** division of universal coverage. This dimension refers to the extent to which the population is protected from catastrophic health expenditure particularly for households. The purpose of focusing on this dimension is according to the World Health Organisation's 2012 report to prevent households to be driven into poverty due to financial risk as a result of illness. The department of Health in on Greenpaper and National Health Insurance made the following observations:

- ***"Out of pocket payment accounts for a significant part of total health expenditure and this could be in the form of co-payments, or direct payment to private providers particularly by those who are not covered by medical schemes. Even for those who are covered by medical schemes, the extent of co-payment confirms that the current system does not provide full cover. However, for those who are not on medical aid this could have catastrophic effects."***
- ***"Payment for health care, particularly for those who cannot afford and who pay out of pocket cannot be planned in advance and this lack of predictability is what exposes households to financial hardships."***

The removal of GAP cover insurance products will have the result that medical scheme members cannot protect themselves sufficiently against medical expenses and are therefore legislated into poverty. Property rights are protected by our Constitution. Financial security is considered as property and as a result legislative poverty should be avoided.

5. GAP Cover Insurance supports rather than competes with medical schemes:

The argument put forward by National Treasury and the Department of Health that health insurance products cause hardship to the medical schemes environment by attracting younger and healthier members out of medical schemes and undermine the principal of cross-subsidisation, does not hold true for GAP cover insurance products. Membership of a medical scheme is a pre-requisite for gap cover insurance, thus gap cover insurance is a supportive product and not a replacement product for medical schemes.

The role of Health Insurance Products within a NHI environment

South Africa started its journey to quality and affordable universal healthcare for all. Embarking on this transformation of our healthcare system we are cognisant that not even the wealthiest society can provide every possible medical treatment that may be required by their citizens. It is therefore an acceptable practice that rationing of healthcare is used within a National Health Insurance system. This principle of rationing was also suggested in the green paper on National Health Insurance in South Africa as published by the Department of Health on 12 August 2011.

Although the need for rationing may be clear, it is far less obvious how a society should allocate its limited healthcare budget. There is also no global consistency to what extent a country should rely on the free market to allocate healthcare, and to what extend should the government guarantee a specific level of access to healthcare for people who are too poor to afford the necessary healthcare.

The following table provided by ***"Catalyst-pulse"*** clearly indicates that private health insurance is extensively used.

Country	Dominant Health system
Argentina	Health is divided into three sectors: the public sector, financed through taxes; the private sector, financed through voluntary insurance schemes; and the social security sector, financed through obligatory insurance schemes – and **from private insurance accounts for 51.1%.**
Australia	Medicare universal healthcare system – **private insurance accounts for 23.2%.**
Botswana	National health. The government, through its Ministry of Health, is the main provider of healthcare, but private practioners and health insurance are significant players – **healthcare spend are from private insurance accounts for 5.2%**.
Brazil	Public private sectors are mutually compatible, and private insurance is actively encouraged – **private insurance accounts for 33.8% of healthcare spend.**
Chile	The system consists of a single non-profit public insurer (Fonasa) and multiple for – profit or non-profit private insurers (Isapres) – **private insurance accounts for 45.1% of healthcare spend**
Columbia	Sistema Nacional de Sequridad Social en Salud (SNSSS, or National Social Security System or Health) –**private insurance accounts for 56.1% of healthcare spend.**
France	Universal coverage through national health insurance. All NHI funds are legally private organizations responsible for providing a public service. In practice, they are quasi-public organizations supervised by the government ministry that oversees French

	social security- **private insurance accounts for 63%**
Germany	National Health Service: statutory health insurance providing universal healthcare – **private insurance accounts for 57.2%**
India	Most healthcare is paid out of pocket. For the small percentage of Inidans who have insurance, the main provider is the government-run General Insurance Company and its four subsidiaries – **private healthcare spend accounts for 1.1%**
Ireland	Voluntary private insurance is predominant, although state care is available to about 85 of the population – **Private insurance accounts for 38.6%**
Italy	National Health Service (Serviozio Sanitario Nazionale, or SSN), established in 1978 – **private insurance accounts for 4.1%**
Japan	Compulsory universal public health insurance, mainly through private providers. National health insurance is generally for self-employed people and students, while social insurance is normally for corporate employees – **private healthcare spend accounts for 13.7%**
Kenya	The National Hospital Insurance Fund covers employed individuals and their dependants – **healthcare spend from private insurance accounts for 6.9%.**
Mexico	Stae-run insurance for private sector and public sector employees, plus new cover for indigent and unemployed citizens – **private insurance accounts for 6.1% of healthcare spend**
Namibia	State Finance most health services, especially for the poor and low income earners – **private insurance accounts for 79% of healthcare spend**
Netherlands	Three-part system national health insurance for exceptional medical expenses, compulsory sickness funds for low-income individuals, and private health insurance. **Private insurance accounts for 28.7%**
Nigeria	The National Health Insurance Scheme, established in 1999, encompasses government employees, the organised private sector and the informal sector – **private insurance accounts for 6.7%.**
United Kingdom	National Health Service (NHS) – **private accounts for 7.8%**

Concluding Remarks

The FPI believes that it is necessary to protect the consumer and this is done in many ways namely:

- Regulatory oversight of financial products including medical schemes to ensure the sustainability of products.
- Markets conduct regulation under the Financial Advisory and Intermediary Services (FAIS) Act.
- Access to suitable financial products to finance the cost of health expenses and ensure that consumers are not exposed to financial ruin when medical scheme cover is insufficient.

The root cause of the problem is not the existence of Health Insurance products but the fact that provides is able to change rates substantially in excess of medical scheme rates. This practice leaves consumers or members of medical schemes vulnerable to financial ruin where providers charge these higher rates.

The enforcement of the demarcation determination and proposed amendments should be postponed until such stage as legislative interventions are promulgated that avoid exploitation of members of medical schemes by a minority of healthcare providers

The FPI believes there is a need for gap cover products and for these to be appropriately regulated. Product designs aimed at risk management and cost containment, we believe, undermine the risk management strategies of medical schemes and thus should not be allowed. Medical schemes should be able to channel members to have procedures performed in more cost effective treatment settings, without the threat of gap cover products discouraging members from using the most cost effective setting, as this has a direct impact on medical scheme costs (i.e. hospitalisation costs versus day facility costs).

The FPI respectfully urge the regulators to make appropriate, reasonable and rational space in the demarcation regulations for gap cover insurance products. The FPI believes that solutions can be found where the interests of both medical schemes and individual members, seeking to limit their out-of-pocket exposure in a cost effective manner, are recognised and protected.

Thank You!