PSG KONSULT CORPORATE

23 April 2012

Via electronic mail
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Dear Dr Sheoraj,

RE: THE DRAFT REGULATIONS PUBLISHED FOR PUBLIC COMMENT IN TERMS OF THE SHORT-TERM INSURANCE ACT NO. 53 OF 1998 (GOVERNMENT GAZETTE 35114), DATED 2 MARCH 2012 (COLLECTIVELY REFERRED TO AS THE "DRAFT DEMARCATION REGULATIONS")

Submitted:	23 April 2012
Entity Submitting:	PSG Konsult Corporate Limited An authorised financial services provider FSP# 33657
Type of stakeholder:	Intermediary

As a healthcare advisory company with in the region of 90,000 families under advisement, spread over various medical schemes (via mainly corporate appointments), we feel it necessary to comment on the above matter.

The media statement by the Department of Treasury at the release of the draft Regulations positioned them by stating that the Regulations:

- Seek to address the risk of possible harm caused by health insurance products drawing younger and healthier members away from medical aid schemes to health insurance products.
- Furthermore, they serve to strengthen and preserve the social solidarity principle that underpins medical schemes.

- And that, in determining whether health insurance products will or will not be allowed to be sold to the public, regard was given to the objectives of the MS Act and the current or potential harm that a health insurance policy may cause to the medical schemes environment.

Although we are in agreement with the broad positioning of the draft regulations as they pertain to certain health insurance products, we feel that bundling gap cover insurance with other health insurance products is fundamentally flawed. In addition, we feel strongly that gap cover insurance does not have the negative impact described, and will provide reasons for this below:

1. Gap products can only be sold to medical scheme members, and can't be sold as stand-alone cover (while other health insurance products can be). Gap products are therefore sold purely to complement medical scheme cover, and never to replace it.

2. Gap products are not priced on pure insurance principals at individual level – but across a risk pool at either employer or product specific level (although it is accepted that in some cases there is premium differentiation based on age). It can therefore be argued that gap products also uphold the social solidarity principles (of cross subsidisation).

3. It is mentioned that downgrades apparently impact the cross-subsidy principle underpinning medical schemes. Why then are schemes allowed to have options? In our view this is perhaps forgetting the fact that cross subsidisation is protected by the PMB's – as stated by the editorial committee of the "CMS news" dealing with the topic "How guaranteed benefits protect members of medical schemes" – Issue 1 of 2011 – 2012.

4. In our experience, very few medical scheme members select cover based purely on need, and often the most important consideration is affordability (as stated by the CMS themselves in their annual report of 2010-2011).
   - The medical needs analysis form completed by all our consultants, when providing assistance to members with the selection of medical scheme options, has been altered to ask what the available budget is for scheme contributions, as one of the opening questions, as our experience was that this is often the material factor behind option choice.
   - It is also our experience that members rank day-to-day benefits and chronic illness benefits ahead of hospital benefits when it comes to selecting options, as these are the high volume items covered by schemes (and therefore top of mind).
   - Members often select the option that comes closest to suiting their budget. Gap products are more often than not only considered after the option choice has already been made. The reason for this is that across all medical schemes there are very few (if any) options that can guarantee member/s no shortfalls in respect of in-hospital cover.

5. Our experience over the past few year ends is that a similar number of members have in fact upgraded their medical scheme cover, to those who downgraded. Moreover, the upgrades are usually due to younger members who originally joined entry level options (due mainly to affordability constraints), moving up to richer options as their incomes increase. As a generalisation, the downgrades are often due to pensioners being forced to seek more affordable options. The reasons for this are that;
   - most pensioners have lost post retirement subsidies (due to buy-outs),

- medical scheme inflation (and hence the medical scheme increases) has comfortably outstripped inflation, and
- in many cases pensioners' incomes have not kept pace with inflation.

Pensioner members are also more likely to be hospitalised for elective procedures like joint replacements, and simply can't afford the shortfalls – or the deductibles / co-payments which have been introduced by the schemes over the recent past.

It is our understanding that the Gap cover insurers can in fact validate this statement (i.e. the age profile of their members reflects that they are not predominantly younger).

6. Downgrades within a medical scheme generally impact the day-to-day benefits and chronic illness benefits to a greater degree than hospital benefits. Prescribed Minimum Benefits have to be covered in full by all options on all medical schemes, of which there in excess of 270 relating to the in-hospital treatment of life threatening / emergency conditions. The difference in these benefits usually relates to the imposition of DSP Hospital groups, and in some cases, reimbursement rates. However, there is a significant difference on all schemes in the day-to-day benefits and chronic illness benefits. By way of example, the richer options in almost all medical schemes cover members for a number of non-PMB chronic illnesses. In addition, members usually also have access to broader medication formularies. Due to this, it would therefore make little sense to downgrade one's option in order to replace the lost cover with Gap insurance, as the Gap insurance only covers in-hospital shortfalls.

7. Many schemes don't offer cover for in-hospital service providers at anything above 100% of the "scheme rate" – so in the absence of gap cover members will always be faced with shortfalls. So, even if every member on the scheme was on the top of the range option, they would still have shortfalls. Similarly, with very few schemes now offering more than 200% of the medical scheme rate on their top-of-the-range options, even if every member was on the most comprehensive option, they would still be faced with shortfalls in respect of non-PMB hospital admissions. Removing the Gap products would therefore mean that medical scheme members would lose the ability to cover themselves for these shortfalls – and face potential financial hardship in order to meet the same.

8. An important concluding point on Gap cover, is that it's in the absence of some kind of tariff setting agreement/s that medical schemes have introduced a variety of benefit changes / reductions to remain viable (e.g. reimbursement rates have decreased, deductibles & co-payments introduced for elective procedures). This has severely compromised members' abilities to provide (affordable) comprehensive cover for themselves, which in turn created the need for the Gap cover products. Overall, the insurance products are by nature reactionary – surely the solution lies in addressing the underlying problem the schemes are faced with? The proposals in their current form leave medical scheme members extremely vulnerable to financial loss.

Regarding the hospital cash plans, we are concerned about the imposition of a daily limit of 70% of one's daily income, as this is clearly discriminatory against low income employees, because the expenses this type of policy is meant to defray are in no way linked to one's income.

The exemption of cover in respect of HIV/Aids and Frail Care is perplexing and potentially discriminates against those suffering from, for example, TB and cancer – and one wonders if this would pass the test of being in the public interest.

To conclude, although we are in agreement that there are health insurance products that may be considered as substitutes for medical scheme cover (and have no problem with these being addressed via the draft Regulations), we are not in agreement with the reasons provided to henceforth exclude gap cover products.

In addition, the intended exclusion of gap cover insurance will result in medical scheme members losing their ability to insure themselves against (what may be financially crippling) shortfalls after non-PMB hospital admissions. In the absence of any irrefutable evidence as to necessity for the withdrawal of these products, as argued above, one wonders whether doing so would be in the public interest.

Yours truly,