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South African Dental Association

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0201/2012/NT/pg
19 April 2012

National Treasury
Cape Town
Per e-mail – STDemarcation@treasury.gov.za

Dear **Sir / Madam**

SADA COMMENTS ON:

1. **LONG-TERM INSURANCE ACT, 1998: PUBLICATION OF PROPOSED AMENDMENT OF REGULATIONS UNDER SECTION 72 FOR PUBLIC COMMENT**
2. **SHORT-TERM INSURANCE ACT, 1998: PUBLICATION OF PROPOSED AMENDMENT OF REGULATIONS MADE UNDER SECTION 70 FOR PUBLIC COMMENT**

Preamble

1. The South African Dental Association (SADA) is a non profit company with general and specialist dentist members working in both the private and public sectors. The Association has a paid up membership in excess of 3000 general and specialist dentists representing all disciplines.
2. We refer to the above regulations ("the demarcation regulations") both published on 2 March 2012 in Government Gazette R192/2012 and R193/2012 respectively, and take this opportunity of submitting our views and comments on the regulations.
3. Our consolidated comments contained in this submission should be read as a response to both of the demarcation regulations unless specific reference is made to any one regulation.
4. SADA supports a pragmatic approach to health care reform, and believes any proposal seeking a radical overhaul of the medical scheme or insurance system should be carefully considered and be supported by empirically researched prior to being implemented. Furthermore, such proposal should also be subject to a comprehensive

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SADA

consultative process of engagement with all affected and key stakeholders of which SADA is one.

5. We do not believe that the demarcation regulations are necessarily a reflection of the view of all participants in the healthcare sector and they are certainly not the result of a consensus view of all stakeholders.
6. In order to understand the supposed necessity for the demarcation regulations, a view of the state of the private healthcare sector is not only essential but is required to highlight how disconcertingly out-of-touch these demarcation regulations are with reality.
7. The demarcation regulations show that the private health care industry is poorly understood, there is a lack of appreciation of the impact of the demarcation regulations on medical aid members who are already hard pressed in meeting their healthcare costs and have not taken into account the sustainability issues facing dental service providers and practices in the present funding environment.
8. The Council for Medical Schemes and its Registrar failed in their first attempt to close down the "gap" product through the courts, later failed to amend the definition of "business of a medical scheme" in the Medical Schemes Act ("the MSA") when the amendment was withdrawn in 2008 to allow government and the Department of Health to focus on National Health Insurance, and are instead attempting through the demarcation regulations to achieve previously failed efforts.

Commentary

1. We reject the policy principles that informed the demarcation regulations and their basis for only allowing for certain types of policies to be sold by long-term and short-term insurance companies based on their impact on medical schemes.
2. We believe that the MSA promulgated in 1998 exacerbated cost problems and brought about unintended consequences of law change in relation to the cost of medical scheme cover:-

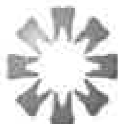
2.1. Firstly, entrenched within the MSA, is open-enrolment and community rating but without the concomitant balancing of mandatory membership to offset the risk of anti-selection. Open enrolment meant guaranteed acceptance by a medical scheme of an applicant regardless of age, health status or historical cover and community rating is the practice of charging everyone the same contribution regardless of claims or health status. In an open-enrolment environment without mandatory membership, the young and healthy will not join until they are older and sick, since they are guaranteed acceptance at any stage in the future – this well-known human behaviour is called 'anti-selection'.

2.2. It is with no small sense of irony that the demarcation regulations place the blame for anti-selection upon insurance products in "keeping the young and healthy out of the medical scheme system" yet by combining open enrolment with non-mandatory membership, the medical scheme regulators provided an unbalanced frame work that has singlehandedly achieved exactly this undesirable practice for more than the past decade.

2.3. The second key regulatory change came in 2005 from the Competition Commission, which ruled against collective negotiation of reimbursement tariffs by medical schemes with providers. This drove a wedge between the medical schemes and service providers.

2.4. As a result of an outcry from medical schemes, the collective establishment of an industry tariff was undertaken by the Department of Health resulting in the National Health Reference Price List (NHRPL). Its primary shortcoming was that it remained a voluntary reference. To add insult to injury, a further Government attempt to establish a more industry representative tariff was declared irregular by the courts in 2010 and the entire process was set aside.

3. Since the 2005 ruling by the Competition Commission, the disparity between the rate of reimbursement of providers, offered by medical schemes and the actual charges by dental service providers, especially dental specialists, started to accelerate due to cessation of negotiations between Board of healthcare Funders representing medical schemes and provider Associations. This meant dental benefits determined by medical schemes were out of touch with the average costs of providing dental services. In addition, the dental inflation outstripped the increases in benefits determined by medical schemes.
4. Members of medical schemes were being exposed to growing out-of-pocket healthcare costs due to decrease in benefits. These were no longer confined to smaller manageable amounts involving day-to-day healthcare consumption but also large amounts for tertiary healthcare expenses such as surgery.
5. Medical schemes therefore attempted to contract dental service providers into networks at pre-negotiated rates in return for greater volumes of patients. There was no compulsion for any dental provider to contract so the success of these networks relied heavily on prevailing market forces. Not surprisingly, these were largely unsuccessful at tertiary health care levels which are also where mandatory PMB services are focused such as surgery and other specialist services.
6. But the private healthcare sector, especially at a tertiary care level, is anything but a perfect market. Specialist services remained in high-demand and the extent of the services they deliver (i.e. the utilisation component of costs) are largely self-determined.
7. What followed this can only be described as disregard for the most basic principles of risk management in that the Council for Medical Schemes (CMS) insisted that medical schemes pay for the PMB mandatory treatment at actual cost and not scheme tariff. Although the MSA was promulgated in 1998 with Section 8 intact as it is now, a decision that the definition "payment in full" means at cost and not at medical scheme tariff was only enforced some 12 years later which means increased costs to medical schemes.
8. *This means that the CMS is actually determining health policy as opposed to enforcing an existing regulatory framework. The CMS should have referred this matter to the Department of Health for consultation and engagement with stakeholders rather than taking this matter to court and claiming victory for the consumer.*
9. In the face of what is stated above, the CMS has compelled all medical schemes to comply with "at cost" payment for PMB services threatening schemes with deregulation should they not comply.
10. Providing for PMBs as a "at cost" benefit alongside high demand for these services nullifies a critical aspect of potential risk management otherwise available to medical schemes being able to provide PMBs at a benefit level that an individual scheme can afford. It leaves no room for the medical scheme to negotiate with the provider in respect of PMBs since providers are happy to be paid at cost for PMB services.



11. Under current medical scheme regulations a medical scheme is only compelled to pay at cost for a PMB service if the member involuntarily acquired the services from a 'non-contracted' service provider under certain circumstances such as a medical emergency. If a member receives PMB services from a 'contracted' network provider then the provider is paid in full in terms of the contract between the scheme and the provider and no shortfall will transpire.
12. However, in the event that the medical scheme is unable to contract certain service providers then the relevant PMB services must be paid at cost regardless of who delivers them.
13. In addition, the CMS published a circular late in 2011 castigating medical schemes for implementing such high contribution increases whilst acknowledging the following regarding increases for medical specialists and hospitals - "[the increases] *cannot be rationally explained but might be attributed to market failures inherent within the private healthcare market*".
14. In the 1980's most medical scheme members enjoyed comprehensive benefit plans covering almost everything from unlimited medicines to specialised dentistry to comprehensive hospital care.
15. As cost pressures grew, more benefit options came about with limited benefits – medical schemes also made use of savings accounts to fund day-to-day benefits, thereby shifting these costs onto the members.
16. That trend continued strongly over the past 2 decades with only the bare minority of members now able to afford comprehensive plans. These benefit downgrades are so obviously a factor of affordability and have very little if anything to do with available health insurance policies available as stated as one of the primary reasons for the demarcation regulations.
17. The CMS undertook its own survey regarding downgrades and concluded in their 2010 annual report that the majority of the reasons for downgrades revolved around affordability.
18. Patients are then forced to pay out of pocket in respect of short payment or make a co-payment or plans where limits are imposed.
19. Given all of the above it is clear why medical schemes are grappling to controlling high tertiary costs. But the medical scheme market remains competitive, so instead of giving consumers an increase of CPI plus 5 to 6%, each year medical schemes instead create options with less cover and which members can have at CPI plus 2 to 3%. Medical scheme contribution increases for 2012 averaged around 9 to 12% with CPI for 2012 at about 6%.
20. The disparity between the numbers is glaringly obvious. To illustrate the long-term impact of forcing member to stay with their medical scheme cover, if a family is currently spending 13% of their net income on medical aid contributions, quite a feasible percentage, and the differential between CPI and scheme increases is 4% per annum, within 10 years that family's medical aid spend will have grown to almost 20% of net salary in order to maintain the same benefits.
21. Over the past few years the health insurance industry found a growing demand from consumers for supplementary insurance to cover costs of tertiary hospital events not covered by their medical schemes. This accelerated the rise of the appropriately named 'gap cover' industry, none of which was by consumer choice.

22. The demarcation regulations appear to deploy a blunt and simplistic approach to the demarcating of health insurance products from medical schemes that in no way assists the consumer or medical schemes.
23. Should Government proceed with demarcation regulations in their current form one can only imagine they will face a huge public backlash or even a legal challenge to the constitutional right of consumers to insure themselves against such intrinsically entrenched financial risks.
24. *On the basis there is simply no evidence to prove the position: we reject the contention that the demarcation regulations are necessary to separate clearly certain health insurance products (which provide similar benefits to medical schemes) in the long-term and short-term insurance market which cause harm to the medical schemes environment by attracting young and healthy members, out of medical schemes by purchasing more cost effective insurance cover to finance their health care.*

Consumers and Medical Aid Cover

1. Most people view medical scheme membership as a grudge purchase; it is something they do not willingly prioritise over other household needs. A choice must be made between health care and other uses of money, and in our view products and systems that allow individuals to make these choices and thus achieve better results.
2. Medical scheme membership is predominantly income-related: only high income groups effectively access reasonable cover. This lack of affordability is a severe constraint that prevents low income groups from joining medical schemes.
3. In the past low income groups had medical scheme cover usually through their employers. However, many employer groups have relinquished in house or restricted medical scheme in recent years and subsidies that accompany monthly medical aid contributions. Employees are now faced with total cost to company remuneration packages and are forced to make trade-offs between health cover and other consumption priorities.
4. Medical schemes have thus struggled to formulate benefit packages that would accommodate low income individuals whilst at the same time affording them reasonable cover.
5. For the consumer, private medical insurance can be a bewildering terrain of co-payments, shortfalls, limitations, self-payment gaps and so-called 'savings' accounts, to name only a few but there is no such thing as 100% cover. There are always shortfalls and inevitably these are an onerous burden when one is recovering from illness.
6. That is the reason why gap cover is growing as fast as it does in South Africa. Completely independent from mainstream medical aid policies, with affordable monthly payments, it can give consumers peace of mind: it pays for shortfalls that may be incurred for expenses like dental and dental specialists' treatment, hospital cover, assist with co-payments or pre-admission payments required in some case and shortfalls due to difference between medical aid benefits and dentists' rates which the patient has to pay for, are covered.
7. We would argue that the National Treasury and the Council for Medical Schemes envisage that by removing gap cover, members of medical schemes are likely to take out more expensive medical scheme cover. Yet this is completely out of line with reality. The real situation is that there is a groundswell of frustration mounting against medical aids after another round of reduction in benefits in 2012, hand in hand with an

increase in premiums. People are thus tending to "buy down" and in effect making themselves more vulnerable to the gap between a fee and a benefit. The demarcation regulations are further incorrect in stating that members will be allowed to upgrade at the end of the year

8. If insurance options are removed, rather than buying more expensive cover, people will be forced to opt for even less cover. In the 1980s medical aid costs were in the region of 3% of a person's salary. Today, for some consumers it can be as high as 20%.
9. The demarcation regulations will take away the right of consumers (patients) to access affordable products to insure themselves against the financial risks of more expensive medical expenses and will compel them to buy more and unaffordable medical cover.
10. Currently, consumers are able to purchase a baseline product such as a hospital plan offered by medical schemes and to add day-to-day benefits and hospital gap cover offered by short-term insurers, allowing them to structure a plan that may be tailored to their specific requirements.
11. In addition, it has become more difficult for medical schemes to provide products that are attractive to the young and healthy, who therefore opt out of the system making it more expensive for those that remain. This is proven by the lack of growth in medical scheme industry.
12. Young people should be able to take individual responsibility for their own and their families' health care, utilising all the skills of competitive private insurance market and having at their disposal world class health care providers competing to offer excellent health care to them and their families.
13 Gap cover presents a means of accessing relatively low cost provision for unplanned medical expenses. It can provide a means for employers to assist vulnerable employees with some form of protection against a major medical expense when a full medical aid package might not be affordable for either the company or the employee. Removal of this means will seriously disadvantage many workers.
14. It is our considered opinion that the provisions of the demarcation regulations would be negatively viewed by the Consumer Commissioner, in terms of the Consumer Protection Act, because they would deprive the consumer of the right to seek quality treatment at a fair price. The regulation of medical insurance products would surely abrogate the consumer's right to finance a product or service that he or she wishes to acquire.
15. There were expectations that the Risk Equalisation Fund (REF) could have been introduced during 2012/2013. This would have benefitted medical schemes with high demographic and geographic healthcare risks amongst its members. This project is now on hold as the Department of Health focuses on National Health Insurance. The Council for Medical Schemes (CMS) also believes that it was 'highly unlikely that a risk equalisation system would be implemented in the near future'.
16. Even the proposed National Health Insurance will not provide full cover in respect of healthcare costs and it should be the person's constitutional right to purchase gap cover and/or hospital policies to defray costs incurred without being forced to purchase more expensive full medical scheme cover. Mandatory NHI will probably force existing medical scheme member to opt out of their preferred health care option in which case they will have to investigate other forms of gap insurance.
17. There is no factual evidence to support the contention that gap cover policies undermine or would undermine the Medical Schemes Act, or would in any way affect the viability of medical schemes in general. Therefore basing existence of the

demarcation regulation on such statements renders the demarcation regulations susceptible to attack in terms of the requirement that all laws must meet the legality principles states in the Constitution of the Republic of South Africa, 1996 and the pronouncements in this regard of the Constitutional Court.

18. To have HIV/AIDS as exceptions is discriminatory against the likes of cancer, strokes, heart disease, diabetes and other life threatening diseases.
19. There are various forms of health products available which bring value to consumers and that are not harmful to medical schemes but the regulators have sought to paint all health insurance products with the same brush, sweeping out the good with the bad.
20. *Lack of affordable medical scheme cover is the single barrier constraint that forces many to abandon medical scheme membership or look for alternative but additional but adequate cover.*
21. *Clearly efforts by the medical scheme industry to introduce products for the low-income earners have been met with very little success. Existing products are still priced at unaffordable levels. Purchasing these products often implies that low-income earners have to spend 30%-40% of their income on cover compared to less than 10% spent by middle to high income earners. They thus have to look at insurance gap cover which is more affordable.*

DENTISTRY SPECIFIC CONCERNS

1. The medical schemes environment has evolved into an environment where a dentist's income relies not only in satisfying his or her patient, but rather satisfying a third party funder. Dentists are forced to accede to patient requests to treat them based on the coverage they have rather than their actual healthcare needs.
2. Gap cover plays a significant part in the overall dental healthcare funding environment over the past couple of years as a consequence of systematic reduction in dental benefits by medical schemes. Gap cover provides a mechanism by which patients are able to access needed dental care that is otherwise not covered by their medical schemes.
3. Medical scheme plans often exclude or limit dental coverage, and even those that include a dental benefit often require high levels of cost-sharing, making dental care unaffordable for many low- and middle-income families.
4. The combination of dental benefits and gap cover insurance is probably the only reason many dentists and dental specialists can still keep their doors open in the country, because cost studies conducted between 2006 and 2009 have shown that dental benefits offered by medical schemes are reimbursed far below the average costs of providing dental and dental specialist services.
5. SADA has always advocated its support for a dental service provider to charge a fee that he or she regards as sustainable to operate a successful practice and provide high quality care. The difference between medical scheme benefits which are determined by individual medical schemes without regard to actual costs of providing a dental service and the dentist's fees is normally for the patient's account, and it is here where additional insurance, like gap cover products, play a major role.
6. The eradication of gap insurance by legislation would remove the financial bridge many patients need to access the services provided by dentists and specialists. This will, in turn, lead to the demise of many practices and we may very well face another dental expertise drain from this country.

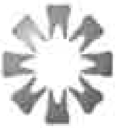
7. In our submission on the NHI Green Paper we made reference to the globally accepted view on the essential role of oral health as part of general health and well-documented clinical links between oral conditions and other systemic conditions.
8. Worldwide, insuring dental treatment is a complex and somewhat enigmatic issue. Like medical science, dental science has also grown far more rapidly than the economies of the world. The return on investment on new dental products, new equipment and new treatment techniques has to be sought from the ultimate end user, the patient insured.
9. A review of benefits in South Africa reveals that over the years there has been a consistent reduction in payments by medical aid schemes. Many ingenious benefit mechanisms have been concocted by medical schemes with the sole purpose of transferring risk of oral care back to the patient. The much promoted medical savings account is one such example, but the reality is that savings accounts offer no insurance benefit to the medical scheme member.
10. Medical schemes also consider dentistry as part of day-to-day benefits; members themselves must allocate a portion of their available funds to dentistry but also other healthcare services they may require. Medicines took up the largest share of medical savings accounts expenditure in 2010 at 34.2% and medical specialists accounted for 19.3% and medical general practitioners for 16.1%.
11. Dental insurance is therefore one solution that goes to the heart of the issue of accessing healthcare as it provides clearly stated benefits for dental treatment. The insurance is sustainable and inexpensive because it is not based on treatment costs, but rather on clinical conditions. As the affordability of 'full cover' medical schemes recedes, many South Africans will be looking to cover their health risks in a more affordable way.
12. In the late 1990s dentistry pay-outs accounted for 8.4 percent of healthcare expenditure by medical schemes. According to the Council for Medical Schemes (CMS) Annual Report for 2010-2011, pay-outs to dentists accounted for only 2.3%t of total healthcare benefits paid from schemes' risk pools in 2010. Pay-outs to dental specialists amounted to 0.6%. The two categories received the smallest share of healthcare expenditures by the medical schemes.
13. Most medical schemes implement benefit design programmes for dentistry which place such services in a 'savings' component. This means that there is no risk pooling in respect of dental benefits. As a result members delay accessing appropriate early interventions or preventive care based on cost concerns. This in turn leads to serious conditions that are easily avoided. Belated dental treatment is more costly.
14. The recent practice costs studies forming part of the submission for the determination of the Reference Price List showed that benefits for dental services currently bear little resemblance to the actual overhead costs to the dental service provider providing dental treatment.
15. At the same time, uncosted, untested and unilaterally imposed administrative burdens (preauthorisation, treatment plans, motivations, updates, ICD10 codes clinically verified, treatment codes, quotes, etc) have further eroded the financial viability of dental practices.
16. By denying the ability of the public to access additional cover, the end result is that dentists are expected to provide quality services at well below cost. There is a large gap between benefits deemed to be affordable to medical schemes and the actual costs to the dental profession of providing a service. Many dentists continue to bill at medical aid rates only to ensure cash flow through direct payments and patient

volumes. The removal of gap cover will effectively disable dental providers from applying the principles of balance billing, which enables the service provider recover their fees.

17. SADA believes that every dentist has the right to charge a fee that is fair, that enables him or her cover his or her costs, pay himself or herself an income commensurate with his or her training and experience, and earn a return on investment made in the practice.
18. Profitability in dental practice requires increasing turnover and reducing costs (management, budget, sharing, multitasking, outsourcing, referrals, recall, advertising, reporting and records, equipment, collections etc). Furthermore, the practitioner must have strategies for time management, personal health and wellness, continuing education, financial planning and yet nurture their social responsibilities.
19. For the reasons set out above the demarcation regulations that are supposedly intended to "protect" the public and members of schemes will, in fact, only serve to make their financial position more untenable.
20. The demarcation regulations allow certain types of policies to be sold by long-term and short-term insurance companies. In determining whether a health insurance product should be allowed to be sold, consideration will in future have to be given to its impact on medical schemes. In addition, companies will have to report products to the Registrar of Medical Schemes who is required to determine the objectives of the Medical Schemes Act and the current potential harm that a health insurance policy may cause to the medical schemes environment.
21. No similar obligation is imposed on the Registrar of Medical Schemes to determine similar affordability of medical schemes or even affordability of higher end medical scheme cover.
22. Short-term or long-term insurance policies are not designed to displace medical scheme benefits. This could never be the case in light of the differences between these two types of products.
23. Adam Smith wrote in *The Wealth of Nations, published in 1887,*"It is not from the benevolence of the butcher, the brewer, or the baker, that we can expect our dinner, but from their regard to their own interest." He also wrote, "Man has almost constant occasion for the help of his brethren, and it is in vain for him to expect it from their benevolence only." The discovery that self-interest and benevolence are not antithetical to each other is the source of modern economic progress and fundamentally of civilisation itself.

Conclusion

1. Access to health care is a constitutionally recognised right, under section 27 of the Constitution of the Republic of South Africa. The demarcation regulations do not comply with the constitutional principle of rationality and unjustifiably limit the fundamental rights of access to healthcare as set out in the Constitution.
2. The health right of "everyone" in section 27 (1) (a), to have "access to" healthcare services is qualified by "available resources". This means that the State has a duty to provide more and more people with better access to health care. We would argue the demarcation regulations do not comply with the constitutional principle of rationality and unjustifiably limit the fundamental rights of access to healthcare as set out in the Constitution of the Republic of South Africa.



3. The Constitution places a duty on the state and on private health care providers not to interfere with a person's access to health care services. This is also called the *duty to respect that right*. This means that any action or conduct by the State or a private company that interferes with existing access to health care services, or would make it more difficult for an individual to gain access to existing health care services, could be a violation of the right to health.
4. If the National Treasury and the Council for Medical for Medical Schemes genuinely have all south Africa's citizens' health care interests at heart, it would increase competition in the market by removing barriers currently constraining the efficient functioning of the private provision of, promoting access to and financing of healthcare services.
5. We trust that our comment will be favourably considered and that, in the interests of both the consumer and the service provider, this retrogressive legislation will not be promulgated.

Yours faithfully