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Submission by FinMark Trust on the draft Demarcation Regulations released for public comment on 2 March 2012

1. Introduction

This submission by FinMark Trust[1] is addressed to National Treasury and focuses on the impact of the proposed revised Demarcation Agreement (as contained in the proposed draft amendments to the Long-term and Short-term Insurance Acts) on market development more generally and the impact on access by lower income households to affected products more specifically. We argue in favour of certain changes to the proposed regulations that will assist in limiting any negative impact of the proposed changes to the Demarcation Agreement on access to and affordability of health products.

While the revised Demarcation Agreement and its implementing regulations cover a wide range of accident and health insurance products, this submissions focuses on hospital cash plan insurance products, with some reference to gap cover products where relevant to our consideration of access to health insurance products. We also briefly consider some other accident or health insurance policies.

2. Background

This submission on the proposed revised Demarcation Agreement ("Demarcation") and it implementing regulations ("the Regulations") is largely informed by a study of the hospital cash plan market in South Africa which was commissioned by the FinMark Trust and conducted by Lighthouse Actuarial Consulting. The preliminary study findings provided valuable market knowledge and insights into hospital cash plans and other health insurance product lines. The draft study has not been attached as an appendix to the submission but can be made available on request.

The following background information from the study provides useful insights regarding the market for hospital cash plan products:

- The market for hospital cash plan insurance product has been rapidly expanding. The products are often sold directly to the public and the market is reliant on take-up by individuals with only a few insurers specialising in group product offerings. Profitability levels are high, as are policy lapse rates and fraud levels. The benefits of these products are offered as fixed amounts per day in hospital, with varying levels of cover. Increasingly products are being offered with higher cover levels, but the majority of products provide low cover levels.
- The market for gap cover has also grown recently, although not as rapidly as hospital cash plans. These products are predominantly sold through brokers to employer groups. Eligibility is contingent on medical scheme membership. Gap cover products provide cover for the shortfall between the amount charged by the healthcare provider and the amount paid by the policyholder's medical scheme or benefits relate to a fixed multiple of the scheme rate (usually linked to the historic national reference price list). These products provide cover mainly for specialist fees for in-hospital procedures. Profitability levels have declined recently and are under increasing pressure as policyholders and providers learn how to maximise benefits from these products.

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[1] Created with initial funding from the UK's Department for International Development, FinMark Trust is an independent trust whose business is controlled by seven trustees from countries in Southern Africa. FinMark Trust's purpose is 'Making financial markets work for the poor, by promoting financial inclusion and regional financial integration'. It does this by conducting research to identify the systemic constraints that prevent financial markets from reaching out to these consumers and by advocating for change on the basis of research findings. Thus, FinMark Trust has a catalytic role, driven by its purpose to start processes of change that ultimately lead to the development of inclusive financial systems that can benefit all consumers.

Both products will be heavily affected by the proposed demarcation agreement and regulations. The sections that follow outline some concerns and recommendations for refinement of the draft Demarcation Regulations.

3. Expected market impact

3.1 Gap cover

If the proposed revised Demarcation Regulations are implemented it will most probably result in gap cover products being left non-compliant with the Regulations. These products are intended to meet the direct cost of medical expenses, even if only in part, and as such they do not fall within any category of insurance products classified in the proposed regulations that allow indemnity based cover outside of the Medical Scheme Act, these being:

- **Under the Short-term Insurance Act**: Motor third party liability insurance, property third party liability insurance, HIV and Aids insurance, international travel insurance, domestic travel insurance and emergency evacuation or transport insurance; and
- **Under the Long-term Insurance Act:** Frail care insurance, HIV and Aids insurance and emergency evacuation or transport insurance.

Gap cover products are not typically offered in the low-income market, as medical scheme membership is a product requirement. This conditional membership will be prohibited under the ther proposed revised Demarcation Agreement and Regulations. While gap cover products do meet a very specific need, they do so outside of the medical schemes environment and supporting regulations and principles. Medical schemes are based on the principles of community-rating, open enrolment and cross-subsidisation. Members cannot be excluded due to age or health status. This ensures greater protection for older and sicker individuals but relies on cross subsidisation from younger healthier members. These principles are not currently applied to gap cover products, and so they do so reliant on the principles of underwriting, risk rating and restricted eligibility not in keeping with the spirit of the Medical Scheme Act.

While gap cover products are unlikely to provide cover to low-income individuals and are likely to be in contravention of the key principles of the Medical Schemes Act, they do assist in funding healthcare expenditure which their policyholders may be unable to afford in the absence of this risk transfer product. The proposed Demarcation Regulations will leave these products non-compliant or outside the regulatory space, thereby effectively shutting down this market. It is possible that some type of top-up, similar to gap cover, products may be allowed under the proposed National Health Insurance Scheme. Significant transaction costs are likely to be incurred in the unwinding of this market and the then later re-opening of the market for these products once the National Health Insurance Scheme has been implemented. It is questionable whether these transaction costs are in the long-term development interest of the South African health insurance market.

3.2 Hospital cash plan insurance

The proposed revised Demarcation Regulations seems to retain hospital cash plans-type cover under product category 1 for both Acts, with this type of cover referred to as "lump sum or income replacement policy benefits payable on a health event". From our reading, it seems these policies are allowed to cover loss of income and indirect expenses associated with a health event but are not permitted to provide cover for any direct expenses associated with healthcare services sought as a result of the health event. The draft Demarcation Regulations do allow some flexibility for differentiating cover by different types of health events and the severity of these health events.

We would like to point out a difference in the proposed tabled criteria for this category of policy between the Long-term Insurance Act and the Short-term Insurance Act. The revisions proposed for the regulations of the Long-term Act include (under the criteria column in the table categorizing

accident and health policies) the possibility that "policy benefits may be differentiated for different health events". This same criterion does not appear on the proposed revisions to the Short-term Insurance Act regulations. It is not clear if the omission is intentional and if so what the purpose of the omission is.

The first point to note in considering any potential impact on hospital cash plan insurance products is that it that it serves a sizeable percentage of South Africans. *The total number of lives covered through hospital cash plan insurance products could be up to half the number of beneficiaries of medical schemes.* The hospital cash plan insurance market has experienced a period of rapid growth in recent years with the total number of polices estimated to be between 1,000,000 and 1,500,000. This estimate is based on historical figures, relative industry growth rates in and information provided during stakeholder interviews which inform our study. There is currently no data available from any source that provides an exact number of policies in force. If it is assumed that many of the estimated number of policies do not simply cover the policyholder, but also direct family members such as a spouses and children, the number of lives covered is much larger than the number of policies, even with multiple policies purchased by the same person. If we multiply the lower bound estimate by four (thus 4m) or the upper bound estimate by three (4.5m), it is possible to arrive at a number of lives covered equal or nearly equal to half the number of beneficiaries of medical schemes. The medical schemes market currently serves 8.3 million lives.

Furthermore, analysis of the market for these products shows that a fair portion of the market is made up of low-income to low-middle income policyholders. While there is no direct match between a specified need and the policy benefits, some modelling of expenses associated with hospitalisation, such as travel, accommodation for family members, etc., shows that the benefits payable under these policies can contribute substantially to the recovery or part-recovery of these related expenses.

There are two main product design features that will be impacted by the proposed regulatory changes that are of concern. Firstly, the naming of these products often involves use of the term 'hospital'. The use of this term is specifically prohibited under the revised Demarcation Agreement and its implementing regulations, along with any derivation of the term. In a market already characterised by low consumer awareness of insurance and low levels of insurance consumer education, this approach is likely to add to consumer confusion. The prohibition on the use of the term 'medical' and the disclaimer requirements concerning declaration that these products are not medical scheme products or suitable replacements for medical scheme products would appear to be sufficient in preventing confusion on the issue. We therefore strongly argue in favour of allowing the term 'hospital' to be associated with these types of products.

Secondly, and more importantly, the limit on benefits to 70% of net income per day will have a significant impact on the commercial feasibility of these products. As mentioned before, hospital cash plan insurance products have typically been sold to low-income or low-middle income policyholders, with benefits traditionally ranging from R100 to R1,000 per day in hospital. Over the last few years maximum benefit levels have been increased to approximately R5,000 per day typically with some income vetting for benefit levels above R3,000 per day.

For someone that has purchased cover of even only R250 per day, which could be considered on the 'low' end of the benefit spectrum, with monthly premiums ranging from R50 to R100 per month, this would imply a required net monthly income of R7,750 under the revised Demarcation Agreement Regulations. The latter amount is well above the R6,000 gross monthly income requirement typically used to categorise the low-income market by the providers of hospital cash plan insurance products. Considering this from another perspective, someone earning a net income of R5,000 per month would only be able to purchase cover of about R160 per day. The financial modelling in our study demonstrates that at these levels the ability to cover related expenses as well as compensate the policyholder for foregone income decreases significantly with low-income policyholders likely only able to cover half their related expenses. *Low-income policyholders could therefore be left substantially worse off due to the indirect costs of a health-related event.*

It is worthwhile considering hospital cash plans relative to other income replacement policies in order to support an argument for a higher or no income limit. Under the revised regulations a typical income replacement policy, for example a long-term sickness policy, will pay the policyholder 70% of net daily income. It could be argued that this cover level is sufficient to cover expenses and 'get by'. If the policyholder is ill and, for instance, bed-ridden, then her daily expenses may be lower due to limited transport, entertainment and other activities. However, in the case of a hospital admission, not only is income forgone but indirect expenses are likely to increase due to travel costs which can be substantial in the case of tertiary hospital care, accommodation for family members for prolonged stays in hospital and other related expenses. This means the 70% income limit of benefit places the policyholder not only in a worse position in terms of income compared to before the event, but will likely be too low to cover the policyholder to fully cover the indirect expenses of a major medical event.

The imposition of an income threshold will also lead to an increase in the administration costs associated with the provision of these products which will eventually be passed on to the client. The stakeholder interviews which informed the market study on hospital cash plan insurance revealed that it is general practice for insurers to not require proof of income for polices with benefits below R3,000 per day cover. In order to comply with the revised regulations insurers will have to collect income in some verifiable way.

While the rationale for medical scheme principles and regulation are clear and indeed strongly supported, there is an economic reality that access to medical scheme cover is limited to the high-income market by the cost of cover. The lowest cost of access to open medical scheme cover, based on the lowest income bands of so called lower income options, ranges on average from R490 to R600 per month for principal members, or between R1,280 and R1,570 per month for a family of four. This means that for the vast majority of South Africans, medical scheme membership is unaffordable without significant employer subsidies. People with lower incomes that cannot afford medical scheme cover typically use public sector hospitals. If they earn a regular income the public sector means test applies and they may be expected to pay significant out-of-pocket amounts for their hospital stay. Under the proposed revised Demarcation Regulations employed low-income individuals who are excluded from medical schemes due to affordability constraints and who are left to use the public sector will have no way to fund public sector costs except fund costs on an out-of-pocket basis. Hospital cash plans, even at moderate benefit levels per day, can be used to assist in defraying loss of income and indirect expenses without having to be linked to the direct expenses associated with a health event. Limiting the benefits to 70% of income would significantly restrict this ability.

Given the above arguments, we would strongly encourage the working group tasked with drafting the revised regulations to reconsider the imposition of any type of limit for policies under category 1 such as hospital cash plans.

4. <u>Reporting of information and continuity</u>

The revised regulations require all new and existing products to be vetted and approved by the Registrars of Short-term and Long-term insurance and the Registrar of the Council for Medical Schemes. We raise two points of concern with the proposed process below.

Firstly, from the revised regulations it is clear that should the respective Registrars deem an existing product to fall foul of the revised Demarcation Agreement and the Regulations, instruction can be given to the insurer to cancel existing policyholder contracts. While there are provisions to allow insurers to amend policy details to make products compliant this is likely to be difficult in practice. It has generally not been the standard approach under such changes in regulations to cancel existing policy portfolios, but rather to let them run off. Cancelling the whole portfolio of policies risks exposing policyholders to significant risk and members that do not/cannot buy-up to a more comprehensive medical scheme option will likely be left under-insured.

Secondly, the proposed revised Demarcation Regulations do not seem to provide for any dispute resolution process. This may be a minor point and dealt with in other regulations or industry guidelines, but we expect there to be much contention regarding many of these products and provision for a formal process for dispute resolution outside of the courts would be beneficial. There also does not appear to be any guidance provided on the process to be followed should, for example, the Registrar of Short-Term Insurance and the Registrar of the CMS do not agree on which policies fall foul of the Demarcation.

5. Other concerns and further suggestions

The revised regulations and Demarcation Agreement also place certain restrictions on policies that are expected to affect the logistics and certain operational aspects of these policies. In particular, the prohibition on underwriting at claims stage means that insurers will have to underwrite at policy inception. Underwriting at policy inception is more expensive and will substantially increase the cost of these policies to policyholders, thereby making any type of cover for the impact of health-related events even more unaffordable to South Africans.

There is general recognition in the industry that fraud is a significant problem, driven by both policyholder and in some cases healthcare provider behaviour. We would encourage industry stakeholders and regulators to set up industry data sharing mechanisms to help combat this problem. By sharing data across the industry, an appropriate supervisory body could investigate policyholders that may have multiple policies and are abusing benefits, as well as identify particularly fraudulent providers and syndicates. By reducing the cost of fraud, cover can be delivered more cost effectively which will eventually be passed on to policyholders through reduced contributions.

6. Conclusion

We have argued in favour of certain changes to the proposed revised Demarcation Regulations. Without revision of the proposed Regulations, the ability of insurers to meaningfully offer these products will be severely negatively impacted, leaving policyholders exposed to costs they currently could cover, in part or in full, from the benefits of these policies.

FinMark Trust would like to thank National Treasury for the opportunity to comment on the proposed revised Demarcation Regulations. We are able to make in-person presentations on this submission and our research if so required.