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NHLUVUKO
RISK ADMINISTRATION

7 May 2012

Via electronic mail
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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:	7 May 2012
Entity Submitting:	Nhluvuko Risk Administration An authorised representative under PSG Konsult Corporate Limited FSP# 33657
Type of stakeholder:	Health Insurance Administrator

After careful contemplation of the proposed draft Demarcation Regulations published by the Minister of Finance, Pravin Gordhan, on 2 March 2012 we hereby submit our comments for consideration.

In preparing this submission cognisance was taken of the following legislation, statements, publications and judgments:

- the Short-term Insurance Act, 1998 ("STIA") including the regulations promulgated thereunder;
- the Long-term Insurance Act, 1998 ("LTIA") including the regulations promulgated thereunder;

- the Medical Schemes Act, 2008 ("MSA") including the regulation promulgated thereunder;
- the Constitution of the Republic of South Africa 1996;
- the media statement by the Minister of Health entitled "Release of Green Paper on National Health Insurance", dated 11 August 2011;
- the green paper on National Health Insurance published 12 August 2011;
- the media statement entitled "Minister of Finance releases draft regulations on the demarcation between health insurance policies and medical schemes", dated 2 March 2012;
- the document entitled "Frequently Asked Questions: Demarcation between Health Insurance Policies and Medical Schemes";
- Notice 195 of 2012 entitled "Invitation for Public Comment on the Draft Financial Services Laws General Amendment Bill, 2012" ("the Bill"), published in Government Gazette 35132, dated 9 March 2012 ("the Notice"), more particularly, the amendments to the definition of "business of a medical scheme" in section 1(1) of the MSA;
- the Joint Explanatory Press Statement by the National Treasury and the Department of Health on Draft Health Insurance Products and Medical Scheme Demarcation Regulations, dated 16 April 2012.
- the Treating Customers Fairly (TCF) Roadmap published by the Financial Services Board in 2011;
- Guardrisk Insurance Company Limited v Registrar of Medical Schemes and Another 2008 (4) SA 620 (Supreme Court of Appeal);
- The Human Resources for Health South Africa – HRH Strategy for the Health Sector 2012/2013 – 2016/2016;
- Red Cross War Memorial Children's Hospital Trauma Unit Statistics 2011; and
- Council for Medical Schemes Annual Report 2010 – 2011

1. ***NHLUVUKO RISK ADMINISTRATION***

Nhluvuko Risk Administration is an established insurance administrator representing approximately 40 000 principal members and 160 000 beneficiaries, and specialises in the administration of health insurance products, namely:

- Gap cover policies,
- Hospital cash plans, and
- Accidental injury policies.

All policies are underwritten by Hollard Insurance Company and Ambledown Risk and Underwriting Managers act as the underwriting agency. The policies are marketed by authorised financial planners who comply with the required Fit and Proper requirements and whom have extensive experience in the medical scheme-, as well as, insurance industry.

In 2011, the above policy holders claimed and received in excess of R16 million in benefits with the average contribution for gap cover policies being R86 per family per month, hospital cash plans being R54 per family per month and accidental injury policies being R70 per member per month.

Nhluvuko Risk Administration is an AAA+ broad based black economic empowerment company employing 27 staff, and our client base comprises of a cross section of members, including blue chip employer groups, employer (closed) medical schemes, bargaining councils and unions.

Our underwriting philosophy closely follows that which can be found in the medical scheme industry, being a 3 month general waiting period and 12 month condition specific waiting period on individual membership, whilst group membership (members joining as part of an employer group arrangement) enjoy full cover from day 1 (one), ie no underwriting is imposed. Where the product compliments a medical scheme, as is the case with gap cover policies, the policy holder will not enjoy any benefits if they have not complied with the rules of their medical scheme in so far as they relate to the use of designated service provider networks and/or pre-authorisation procedures.

Our pricing methodology is one of community rating with the only distinction being between members joining in their private capacity and those joining as part of an employer arrangement. Members are not rated nor accepted, or declined based on their individual health status or income. Members older than 60 joining for the first time in their private capacity do pay a higher contribution.

This submission is based on Nhluvuko Risk Administration's extensive experience and understanding of both the insurance-, as well as, the medical scheme environment in which we operate.

2. Grounds for the Draft Regulations

Schedule B – the Explanatory Memorandum to the Draft Regulations at page 9, section 3, Policy Principles that Informed the Draft Regulations state that:

"A clear demarcation between accident and health policies and medical schemes is necessary to support and enhance the objectives and purpose of the Medical Schemes Act No. 131 of 1998, which entrenches the principles of community rating, open enrolment and cross-subsidisation within medical schemes.

Accident and health policies (providing similar benefits as medical schemes) **may** result in –

- Younger and healthier persons terminating, limiting or reducing their medical scheme cover;
- A negative impact on the life-cycle protection offered by medical schemes; and
- Medical schemes reducing benefits."

Further to this, the Minister of Finance, Pravin Gordhan, in his media statement stated that, "...the regulations also 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."

It is our contention that the above highlighted sections along with the absence of any data, research material and/or study provided in the explanatory notes or any other

statement and/or report by the National Treasury, Department of Health or Council for Medical Schemes, indicate that no substantiated reason for the draft regulations have been established.

Furthermore Nhluvuko Risk Administration is not aware of the existence of any study examining the impact of health insurance products on medical schemes. Any inference as to the impact on medical schemes' risk profiles and costing must thus be regarded with a level of scepticism.

The explanatory memorandum at page 10 continues stating that:

"A clear demarcation between accident and health policies (providing benefits that appear similar to that of medical schemes) and medical schemes is further necessary to protect consumers/policyholder. The absence of a clear demarcation **may** result in consumers believing –

- that accident and health policies offer the same protection as a medical scheme, when in fact the protection is partial and conditional; and/or
- that accident and health policies are medical schemes."

Once again, no evidence has been provided to substantiate that the above two bullet points is currently the prevailing belief in the industry, or that this situation may ensue at some point in the future. In addition, it is Nhluvuko Risk Administration's understanding that the Treating Customers Fairly (TCF) initiative published on 31 March 2011 by the Financial Services Board, will address any potential cause for concern with particular reference to Fairness Outcomes 2, 3 and 5 being:

- **"Outcome 2:** Products and services marketed and sold in the retail market are designed to meet the needs of identified customer groups and are targeted accordingly.
- **Outcome 3:** Customers are given clear information and are kept appropriately informed before, during and after the time of contracting.
- **Outcome 5:** Customers are provided with products that perform as firms have led them to expect, and the associated service is both of an acceptable standard and what they have been led to expect."

Given that no evidence has been offered to establish a risk to medical schemes, and that the TCF initiative will provide consumers with additional protection in terms of the marketing of health insurance products, Nhluvuko Risk Administration does not see the need, or any basis, for the introduction of additional regulations in the form suggested.

3. Consultation Process

The Explanatory Memorandum contends that the Draft Demarcation Regulations had been drafted based on "robust and inclusive consultation with interested and affected stakeholders." The parties involved in this process who served on the National Treasury Demarcation Work Group however, were subject to confidentiality agreements thus

rendering them unable to consult with parties outside of the work group which comprised of;

- National Treasury,
- Department of Health,
- Financial Services Board,
- Council for Medical Schemes,
- Association of Savings and Investments South Africa, and
- South African Insurance Association.

It is our contention that the requirement for confidentiality agreements severely compromised the consultation process in that it did not allow for the representative bodies to deliberate with major industry players and other interested parties such as underwriting managers, administrators and financial advisors.

4. Definition of "Business of a Medical Scheme"

It is Nhluvuko Risk Administration's understanding that if it is the intention of the legislature to amend the definition of "business of a medical scheme" then such amendment should be proposed through an amendment in terms of the Medical Schemes Act and in accordance with the powers afforded the Minister of Health who is responsible for overseeing the implementation of the Medical Schemes Act. It is thus not clear why this proposed change has been introduced via the Financial Services Laws General Amendment Bill.

It is also not clear why a change to the definition of "business of a medical scheme" is required as this is not explained in the Financial Services Laws General Amendment Bill. If the intention of the legislature is to address the legal status of the definition, then this has already been dealt with by the Supreme Court of Appeal in the decision of Guardrisk Insurance Company Limited v Registrar of Medical Schemes and Another 2008 (4) SA 620 (SCA), with particular reference to paragraph 16 and 18 of the judgment, where the Supreme Court of Appeal acknowledged that the definition had been drafted deliberately to take into account the definition of "accident and health policy" in the Short Term Insurance Act and to allow both definitions to co-exist amicably.

In so far as the ramifications of the proposed amendment to the definition of "business of a medical scheme" is concerned, it is Nhluvuko Risk Administration's opinion that this matter must be finalised first in order for the Draft Demarcation Regulations to be read in its entirety. The ramifications of the proposed change in the definition is far reaching and has a fundamental impact on the reader's understanding and interpretation of the Draft Demarcation Regulations.

5. Effect of the Draft Demarcation Regulations on Consumers

It is Nhluvuko Risk Administration's submission that the introduction of the proposed 7 (seven) categories of health and accident policies will severely limit the consumers' choice and freedom to transact, in particular infringing on the consumers' rights in respect of access to healthcare services, in terms of Section 27 (1) of the Constitution.

South Africa has a working population of more than 37 million people and less than 22% of citizens belong to a medical scheme. Many policy holders, who are not able to afford traditional medical scheme cover, will be severely jeopardized by the cancellation of policies such as hospital cash plans and accidental injury cover, and will place an even greater burden on the state to obtain the services which they currently have access to via their health and accident policy.

The Minister of Health, Aaron Motsoaledi's, has by his own admission stated that the "quality of care in public health institutions is often totally unacceptable" and the Human Resources for Health Strategy document for the Health Sector reflected a severe shortage of health care professionals in the South African Public Sector compared to similar countries (see the table below), with unacceptably high infant and maternal mortality rates (IMR and MMR respectively).

Comparative benchmarks for staffing per 10,000 population and health outcomes:

Indicator	International benchmarks												SA current	
	Brazil		Chile		Costa Rica		Colombia		Thailand		Argentina			
Population	195,737,795		16,970,265		4,578,965		45,659,709		67,764,033		40,276,575		49,320,150	
GDP per capita (USD)	4,399		6,063		5,043		3,102		2,567		9,986		3,608	
%GDP health	9.05		8.18		10.47		6.42		4.31		9.53		8.51	
GDP growth (annual %)	-0.64		-1.53		-1.50		0.99		-2.25		0.85		-1.76	
GINI index	53.9		52.08		50.31		59.49		53.57		45.77		57.77	
DOCTORS	17.31	17%	15.71	42%	20.42	39%	10.43	35%	8.72	19%	31.83	62%	3.43	12%
NURSES	45.59	64%	10.45	28%	22.19	42%	5.85	17%	33.21	71%	4.57	10%	26.1	80%
PHARMACY	6.81	6%	3.72	10%	5.34	10%	0	0.0	2.92	6%	5.08	10%	2.29	7%
ORAL HEALTH	12.69	13%	7.44	20%	4.65	9%	9.26	25%	1.73	4%	9.28	18%	1.2	3%
Total	102.39		37.32		52.6		30.52		46.58		50.19		46.02	
IMR (per 1,000 live births)	17.3		7.0		9.9		19.2		12.0		13.6		43.1	
MMR (per 100,000 live births)	75		18.2		26.7		75.6		12.2		40		165.5	

In the absence of a workable and affordable alternative, the abolishment of policies that provide cover for those socio-economic groups who cannot afford anything else, infringes on the consumers right that "the State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of each of these rights (with reference to Section 27(1) of the Constitution)."

We further contend that the inclusion of products which allow for HIV/AIDS at the exclusion of other chronic diseases contravenes Section 9 of the Constitution with particular reference to Section 9.4, "...National legislation must be enacted to prevent or prohibit unfair discrimination."

6. Effect of Draft Demarcation Regulations on the Industry

It is Nhluvuko Risk Administration's belief that various requirements proposed in the Draft Demarcation Regulations will have an unnecessary upward impact on the costs associated with the administration of accident and health policies. These include but are not limited:

- Additional reporting requirements in respect of Section 7.4 and 7.5 requiring the insurer to submit a summary of the benefits, terms and conditions, as well as marketing material of the accident and health policy to the Registrar **and** the Registrar of Medical Schemes.

- Linking the policy benefits in respect of lump sum policy benefits payable on a health event to 70% of the policy holder's net income per day as per Section 7.2.1 will require the administrator to house and maintain income information and amend claims processing procedures. This will in most instances require IT and administration platforms to be reformatted at great expense to the administrator and will also frustrate the claims procedure for the consumer given the additional data required.

- The introduction of Section 7.2.2 will force the insurer to underwrite each application, (the norm currently is to apply group/standard underwriting) thus increasing the cost of administering the policy and increasing the complexity of the policy for the consumer.

7. Product specific comment

7.1 Gap cover

In the absence of empirical data on the entire population (as this does not exist), Nhluvuko Risk Administration has obtained authorisation from one of its employer groups to demonstrate the financial impact of the proposed Regulations. The parameters of which has been set out in the table below:

Total Number of Members	**384**
Medical Scheme of Choice	**Discovery Health**
Benefit Description	**Number of policies**
Classic Comprehensive	39
Classic Core	12
Classic Delta Comprehensive	1
Classic Delta Core	1
Classic Delta Saver	24
Classic Priority	43
Classic Saver	29
Coastal Core	36
Coastal Saver	98
Essential Comprehensive	3
Essential Core	7
Essential Delta Core	3
Essential Delta Saver	9
Essential Priority	2
Essential Saver	14
Executive Plan	4
Keycare Core	12
Keycare Plus	47
Grand Total	**384**
Monthly Risk Contribution	**R750 832**
Monthly Savings Contribution	**R194 090**
Total Contribution	**R944 922**

The Executive plan covers specialist services in-hospital at 300% of the Discovery Health tariff, the Classic plans at 200%, while the Coastal and Essential plans cover specialists services rendered in-hospital at 100% of the Discovery Health tariff. The Keycare options are network options and will as such be ignored for the purposes of this exercise.

In the absence of gap cover in the example above, 'buying-up' to a higher level of in-hospital cover for those members on Coastal and Essential plans, would result in an 11% increase on the risk rate being paid. The 11% increase would only result in the employees' in-hospital cover being increased by 1 multiple, ie from 100% of scheme tariff to 200% of scheme tariff.

It should also be noted that when faced with limited financial means, members tend to put a greater emphasis on their day-to-day medical scheme needs such as chronic medication and GP/Dentistry/Optical benefits, rather than the high cost/low frequency events such as hospitalisation. Downgrading their medical scheme option will in most

instances have a greater impact on these day-to-day benefits and the purchase of gap cover will not assist them in this instance as it only supplements authorised in-hospital procedures.

In light of the financial pressures which South African citizens are exposed to, the catastrophic financial impact of removing a product such as this on the estimated 300 000+ policyholders, must be carefully considered and unrefuted evidence that speaks to the reason for cancelling the policy, **must** be provided by the Regulators.

A review of the available medical scheme options in the open medical scheme market, and particularly of 11 schemes representing 1 946 059 members or approximately 90% of the open medical scheme market, revealed the following statistics (please refer to annexure 1 for a comprehensive list of the options reviewed):

In-hospital reimbursement tariff for specialists	Number of options
100%	65
150%	2
200%	29
300%	6
Total	**102**

Only 36% of the options reviewed provide cover in excess of the base medical scheme reimbursement tariff and of the 11 schemes reviewed, 4 (four) did not provide any cover in excess of the base medical scheme reimbursement tariff. Members are thus not able to increase their level of cover on these schemes and the introduction of gap cover policies should thus not have any impact on these schemes. Once again, in the absence of specific data showing the causality of gap cover products on medical schemes, no inference can be drawn from a comparison between these schemes and those that do provide cover at a higher reimbursement tariff.

The Joint Explanatory Press Statement by the National Treasury and the Department of Health on Draft Health Insurance Products and Medical Scheme Demarcation Regulations, dated 16 April 2012 stated that, "the draft Regulations do not propose the phasing out of all health insurance products, but only those which compromise the key principles of social welfare, solidarity and cross-subsidisation found in medical aid schemes (e.g. gap and top covers). **A health insurance policy is not a substitute for being a member of a medical aid scheme**." It is important to point out that it is a condition of membership, that a policyholder belong to a registered South African medical scheme in order to benefit from a gap cover policy, and as such this is not a replacement policy but rather a complementary benefit which enhance the in-hospital benefit for specialists already enjoyed by the policyholder by virtue of his/her medical scheme membership.

7.2 Hospital Cash Plans

It is Nhluvuko Risk Administration's contention that by linking the policy benefits in respect of lump sum policies payable on a health event to 70% of the policy holder's net income per day as per Section 7.2.1 of the Draft Demarcation Regulations, the regulators are unfairly discriminating against lower-income individuals. As there is no

relationship between the income of a policyholder and the relative cost of the event or subsequent costs, this proposed amendment must be reviewed. It is also not clear, how it is proposed the benefit be calculated for those who are unemployed, such as students and house wives.

7.3 Accidental Injury Cover

According to a report released by the Red Cross War Memorial Children's Hospital Trauma Unit, 8304 children were admitted in 2011 for accident related injuries ranging from burns and falls to motor vehicle- and pedestrian accidents. Furthermore the policy paper on National Health Insurance in South Africa, specifically identifies injury and violence as one of the four main contributing factors to the burden of disease in South Africa.

It is thus Nhluvuko Risk Administration's submission that Accidental Injury policies in their current form serve a very specific purpose and reduces the burden on State facilities by providing cover for policyholders within private facilities.

Conclusion

It is Nhluvuko Risk Administration's belief that health insurance products and medical schemes can co-exist and that it would be in the best interest of the consumer and the industry to re-examine the Draft Regulations with this single goal in mind. The starting point for such an examination would be a mutually agreed upon research study of the environment and the impact of health insurance products on medical schemes, which in our opinion, is a prerequisite for robust and constructive discussion.