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an authorised financial services provider

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Dear Dr. Sheoraj

COMMENTS ON PROPOSED AMENDMENT OF PART 7 IN THE REGULATIONS UNDER THE SHORT-TERM INSURANCE ACT, 1998, AS AMENDED

Please find attached comments on the proposed Amendment of Part 7 in the Regulations under the Short-Term insurance Act, 1998 as requested in the Media Release issued by National Treasury on 2 March 2012.

Yours faithfully

COMMENTS ON PROPOSED AMENDMENT OF PART 7 IN THE REGULATIONS UNDER THE SHORT-TERM INSURANCE ACT, 1998, AS AMENDED

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1. OVERVIEW

The Minister of Finance, Pravin Gordhan, gazetted on 2 March 2012, draft Demarcation Regulations (Regulations) which seek to find a better balance between medical schemes and health insurance products for public comment. The Regulations also seek to address the risk of possible harm caused by health insurance products drawing younger and healthier members away from medical schemes to health insurance products.

According to the Media Statement issued by National Treasury, the Regulations are required to strengthen and preserve the social solidarity principle that underpins medical schemes. By pooling healthier and sicker individuals, cross-subsidization is made possible through medical schemes. Those with poor health do not pay contributions according to their health status, a factor which makes medical scheme contributions affordable to a lot more people that would have otherwise been the case.

The Media Statement also indicated that health insurance products, on the other hand, operate on the basis that a policy holder pays a premium that is determined by the policy holder's age, health status or income. Health insurance policies also have exclusionary clauses, which can limit to whom the policy can be sold.

It is also alleged in the Regulations that people are using these policies as alternatives to medical scheme cover instead of buying a proper medical scheme option according to the person's health needs.

The Regulations also provide for types of policies that will be allowed 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 be given to its impact on medical schemes.

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 scheme environment.

Health insurance products which will be allowed to be sold to the public in terms of the Regulations will fall outside the scope of the MS Act and will be subject to regulatory oversight by the FSB.

According to the Media Statement, the Regulations will represent an important step in ensuring that health and financial sector policy objectives are aligned, which is critical to prevent regulatory arbitrage between health insurance and medical scheme products in South Africa.

Similar actions as mentioned above were previously taken by the Council for Medical Schemes (CMS) and judgment was first delivered in favour of the CMS on 20 December 2006 and the Supreme Court of Appeal ruled in favour of the Appellant, Guardrisk Insurance Company Limited on 28 March 2008.

2. DEFINITIONS

Gap Cover: a policy that pays the difference between medical scheme tariff- and private rates charged by healthcare providers, for example, surgeons, anaesthetists, physicians, pathologists, radiologists, pulmonologists, physiotherapists, etc, for services and procedures normally provided in-hospital.

Co-payment waiver: a policy that pays costs incurred to a patient as a result of co-payments or deductibles from the savings' account but not for penalties imposed by a medical scheme.

Top-up: a policy that pays out when the annual limit provided by a medical scheme for hospitalization or other stated benefits is depleted as a result of a long period of hospital confinement.

Hospital cash plan: a policy that pays out a cash amount according to the number of days spent in hospital.

3. CURA ADMINISTRATORS CURRENT POSITION

Cura Administrators (Cura) distribute its products, obtained from contracted product providers, via Brokers to clients. Clients have to belong to a medical scheme in order to purchase a Cura product. Should a medical scheme not offer a particular benefit, such benefit is not available from Cura's Gap Cover and Co-payment products and will therefore not be paid.

The Media Statement indicated that health insurance products are based on the policyholder's age, health status and income and that they have exclusionary clauses which may limit to whom the policy is sold. On the contrary, Cura policies have no age restriction or income bands. Cura's policy premiums are family based premiums which include the principal member, spouse and up to 8 children. Cura's underwriting is done on the same basis as medical schemes where general waiting periods and 12 month's exclusions may be imposed. Exclusions imposed are similar to those of medical schemes and enhance the underwriting of a medical scheme as opposed to jeopardising it. The products offered by Cura do, therefore, not substitute a medical scheme's products in any way, but protect the client from unforeseen expenditure not covered by his medical scheme.

Cura was previously approached by product providers selling health insurance products, to market "hospital plans" which offer similar benefits to medical schemes, but declined to distribute such products as it could jeopardize medical schemes.

When a Broker provides a client with a Cura product, it is made clear on the "Disclosure to Clients" that two separate deductions will be taken off the client's bank account, namely, for his medical scheme and his health insurance product/s. At no stage is it indicated that

the same company will be deducting for both the medical scheme and the health insurance. The client also receives a copy of the Disclosure document as proof of the products chosen by him.

Claims made against Cura's Gap Cover or the Co-payment waiver will always be paid to the client and not to the service provider.

4. BACKGROUND TO HEALTH INSURANCE PRODUCTS

Health Insurance products such as Gap Cover became a necessity when the High Court ruling in 2010, declared the NHRPL invalid. In a judgment handed down in the North Gauteng Division of the High Court on 28 July 2010, the NHRPL, as published by the Department of Health, was declared null and void.

The NHRPL was the benchmark of the cost of medical services that the medical scheme industry used to define its tariffs for each year. It represented the base cost for each medical procedure or service against which South Africa's various medical schemes set their tariffs.

The NHRPL was published by the Council for Medical Schemes, but it came under fire from the Competition Commission as it was considered to be anti-competitive. The Department of Health took on the task of researching and defining the NHRPL. Unfortunately, the High court found that the appropriate levels of consultation and research were not carried out by the Department of Health and subsequently the NHRPL was declared invalid. The last valid tariff of the NHRPL was published by the Council for Medical Schemes in 2006.

The High Court ruling as mentioned above caused uncontrolled pricing by healthcare providers, which left most medical scheme members out-of-pocket. Health Insurance, such as Gap Cover, has assisted members greatly.

Medical scheme tariffs range from 100% to 200% and with a few exceptions, 300% of scheme tariffs. Scheme tariffs differ from scheme to scheme and a service provider can charge a member any amount for services rendered.

Various medical schemes promote Gap and Co-payment cover as additional benefits above 100% of scheme tariffs which can be offered by Health Insurance providers at a lower premium. No medical scheme can afford to give unlimited benefits due to the possible abuse by service providers.

Gap Cover and Co-payment products enhance a member's medical scheme option and don't replace or substitute the member's medical scheme. These products result in a healthier medical scheme member as the member doesn't need to fear shortfalls and can feel free to see a doctor / specialist. Without Health Insurance products, members tend to wait until they are critically ill before seeking medical care.

Proof of scientific research cannot be found to confirm the Treasury's statement that: the cost of medical scheme cover may increase for older/sicker individuals, as a result of younger/healthier individuals either leaving medical schemes while they are good risks and that anti-selective behaviour may be encouraged by incentivizing good risks to remain on insurance products until they need better health cover, at which point they seek to join a medical scheme.

5. PROBLEMS WITH CURRENT HEALTH INSURANCE PRODUCTS

Clear confusion exists around what benefits each health insurance product provides. Each product should be clearly defined.

Products in the market which are a substitute for medical scheme membership are products offered by Oneplan Insurance. Underwriting is done by Onecard Management Services (Pty) Ltd and the Insurer is ABSA Insurance Risk Management T/A AIRMS. According to the marketing material, the product is a Short-term Insurance product – not a Medical Aid Scheme. Although the product is a Short-term product, its cover is equivalent to that of a medical scheme with different options / plans, family size premiums and the majority of benefits are offered by medical schemes.

Products in the market which pay for "penalties" where medical schemes have negotiated fixed tariffs with service providers e.g. Discovery's Delta and KeyCare Plus products should not be allowed as it jeopardizes the medical schemes initiative to provide members with cheaper options.

Although fees for services and procedures are fixed according to a Designated Service Provider fee, some service providers continue to charge more than the negotiated fixed fee.

It is clear from the media statement that conflict between the Medical Schemes Act and the Regulations exists. Schedule B of the Regulations, Explanatory Memorandum, point 3 and the media statement indicates 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-subsidization** within medical schemes. The Regulations are required to strengthen and preserve the social solidarity principle that underpins medical schemes. By pooling healthier and sicker individuals, cross-subsidization is made possible through medical schemes. Those of poor health do not pay contributions according to their health status, a factor which makes medical scheme contributions affordable to a lot more people that would have been the case otherwise".
On other hand, The Medical Schemes Act, Act No 131 of 1998, as amended, Chapter 6, Section 33(2) stipulates that:
"(2) The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option-

(a) includes the prescribed benefits;

(b) shall be self-supporting in terms of membership and financial performance;
(c) is financially sound; and
(d) will not jeopardize the financial soundness of any existing benefit option within the medical scheme".

Should the contributions of medical schemes become Community rated as in the "Explanatory Memorandum – Box 1", which stipulates that Community rating refers to the practice of charging a contribution to all members on a specific benefit options within a medical scheme that does not discriminate against them unfairly. In other words, all members on a particular option pay the same contributions, regardless of their age or health status or any other arbitrary ground. Community rating is the opposite of individual risk-rating, where the latter describes the practice of distinguishing between "high risk" individuals and charging an individual more if he/she is more likely to claim a benefit and therefore poses a high insurance risk.

This proposal is therefore in conflict with the Medical Schemes Act, Act No. 131 of 1998, as amended, Regulation 13(1) and (2) stipulating "(1)A medical scheme may apply premium penalties to a late joiner and such penalties must be applied only to the portion of the contribution related to the member or any adult dependant WHO qualifies for late joiner penalties.

(2) The premium penalties referred to in sub-regulation (1) shall not exceed the following bands.....".

6. PROBLEMS ANTICIPATED SHOULD DRAFT REGULATIONS BE IMPLEMENTED

Should regulations be implemented, it will have a negative outcome due to:

- Members of medical schemes will prolong seeing a doctor due to a lack of extra funds to pay for the difference between the tariff paid by the medical scheme and the tariff charged by the service provider;
- Limitations on benefits such as prostheses, pathology and radiology will contribute to a sicker society, because members cannot afford these benefits once their medical scheme benefits are depleted;
- Medical schemes' contribution increases are exorbitant on options which pay more than the previous NHRPL e.g. 200 to 300% versus the premium increase of health insurance to fill the gap;
- Members will become sicker with more complications before considering consulting a doctor and this will cost the medical scheme considerably more to treat the member, or it may become a PMB condition for which service providers charge uncontrolled fees which the medical schemes must pay at cost according to the CMS circular 66 of 2010 dated 15 December 2010. This will put the reserves of medical schemes under pressure;
- Members will be blacklisted due to unpaid accounts and it will have a negative effect on the economy, because blacklisted persons cannot get credit;
- Companies will feel the economic pinch as employees will be affected and become negative;
- Members will feel negativity towards their medical schemes which will result in members moving from one scheme to another for better benefits;

- Should members not pay service providers, more service providers will leave the country and a further "brain drain" will be the end result;
- With a "brain drain" and a shortage of service providers, the health standards will drop even more;
- Medical schemes do not disclose what "Scheme Tariffs / Rates" are and members only realize this when accounts are not paid in full which put the member under extreme financial pressure;
- It is a transgression in terms of the consumer's constitutional right to insure himself against unforeseen expenditure should he/she be a member of a medical scheme as he/she cannot insure him/herself against unexpected expenditure – members are unaware of what service providers charge;
- Low income members will feel it the most, because service providers don't charge according to income;
- Members will be out-of-pocket, because employers often pay the medical scheme contribution, but not the shortfall between the medical scheme tariff and the private rates charges or the co-payment for admission to hospital.
- Fewer members will join medical schemes due to the contribution increases, because medical schemes will be exposed to higher tariffs caused by service providers who need to be paid at cost.

7. PREVIOUS JUDGEMENTS

1. CMS vs. Guardrisk judgment (Attached)
2. Guardrisk vs. CMS Appeal judgment (Attached)

8. PROPOSAL

- Medical schemes should offer the same set of benefits without additional "wellness" products which a member doesn't necessarily need or use;
- CMS's model Scheme Rules should make provision for ALL benefits which should be offered by a scheme;
- Medical scheme benefit options should be written in the same format which is in simple language with no "fine" print;
- Health Insurance policies must be approved by the Registrars under the Short-term Insurance Act and the Medical Schemes Act, the same as medical scheme options being approved by the CMS;
- All current Health Insurance products should be approved as proposed above within 12 months from the Regulations being approved and not within 3 months as prescribed by the draft Regulations;
- Knowledgeable persons from the industry who are familiar with the medical scheme industry as well as Health Insurance industry should constitute the Council for Health Insurance;
- Health Insurance policies should be clear on what will be paid and what is excluded;

- Scheme tariffs should be approved for each ICD 10 code according to a scheme or a Regulatory body such as BHF or CMS who should compile such a proposed tariff list;
- All schemes should disclose what tariff they pay after the implementation of a Scheme Tariff list or Proposed Tariff List;
- Late joiner penalties (LJP's) should be revised to allow more members to join medical schemes who cannot do so due to high LJPs;
- Late joiner penalties should have more age bands with smaller percentages and should start as early as 25 instead of 35 years of age;
- Schemes should be differentiated by service and price and not by benefit options;
- REF - which the CMS has been busy with for several years should be made a priority to prevent anti-selection.

9. SUMMARY

A definite need exists for Health Insurance products to protect the consumer against unexpected expenditure where medical schemes don't pay the entire Health Provider's bill.

Research should be done and guidelines should be drawn up by a regulatory body to exercise more control over these products. The regulatory body should consist of representatives from the Short term Insurance-, Long term Insurance- and Health Industry regulatory bodies as well as product providers, administrators and distribution channels.

The proposed Regulations should be withdrawn and a pilot committee existing of above mentioned bodies should be formed to do the necessary ground work for the implementation of a Regulatory body, writing of regulations and compiling of product guidelines.