Regulations giving effect to demarcation between health insurance and medical schemes

Presentation to the Select Committee on Finance

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Department:
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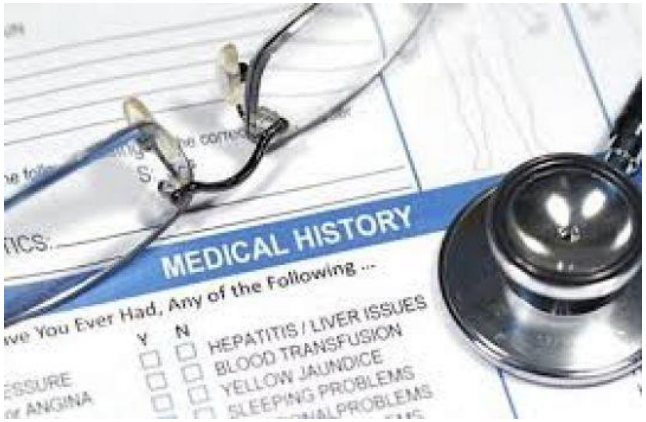
Structure of presentation

1. Difference between medical schemes & health insurance
2. Scope of demarcation regulations
3. Background to drafting of demarcation regulations



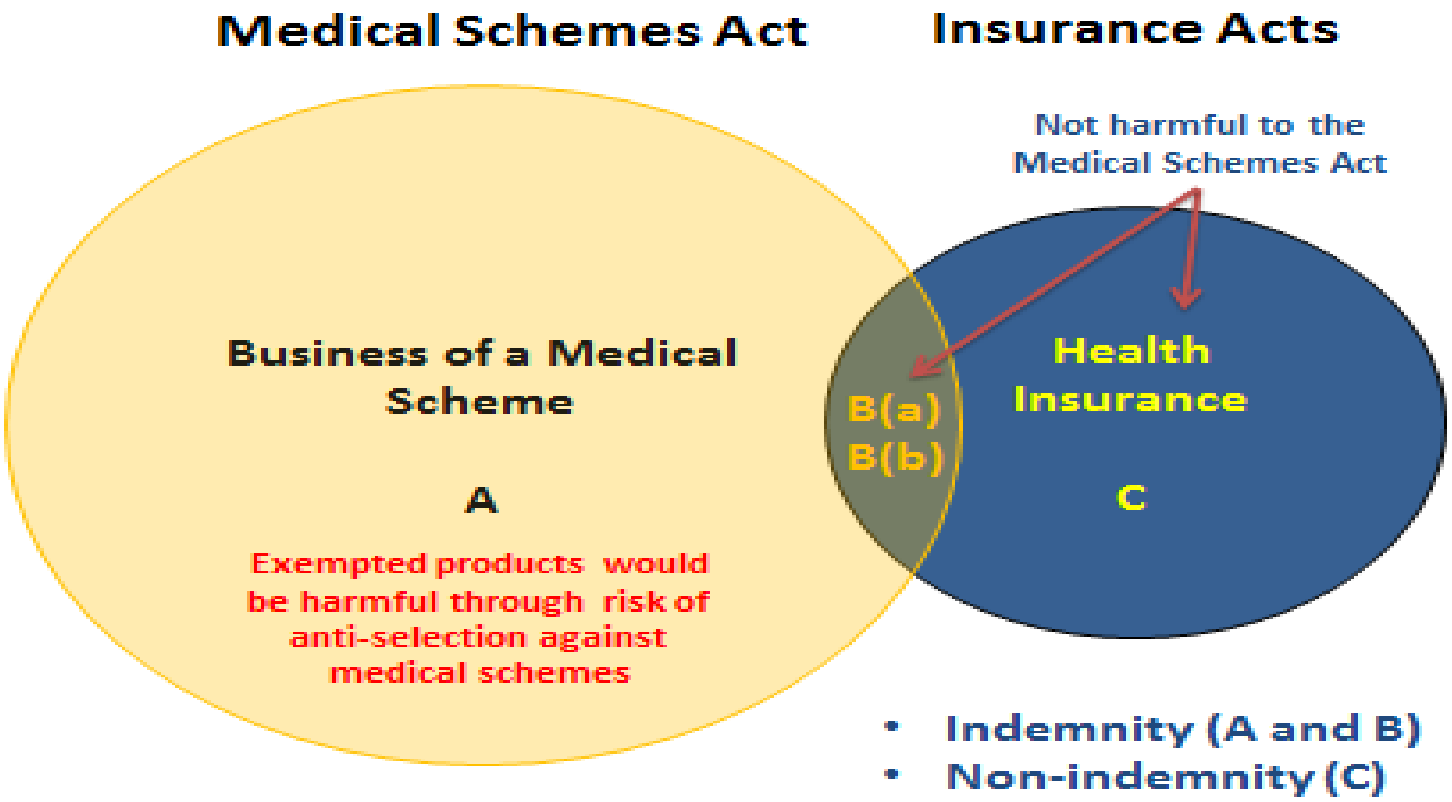
Difference between medical scheme and health insurance

- Medical schemes are regulated in terms of the Medical Schemes Act, No. 131 of 1998 (MSA), subject to regulatory oversight by the CMS
- **SOCIAL SOLIDARITY** principles underpinning medical schemes:
  - **Cross subsidisation** - Young and healthy subsidise the old and sick. Pooling healthier and sicker individuals improves the overall affordability of medical schemes and protects more vulnerable individuals. Any individual entitled to be a member irrespective of age or health status.
  - **Community rating-** Contributions apply universally to all enrolled members and may only vary in respect of affordability and family size. Different benefit options are priced differently depending on the level of cover afforded and are determined by the rules of the scheme.
  - **Open enrollment** – anyone can join at any stage but late joiner penalties allowed

Difference between medical scheme and health insurance contd..

- A health insurance policy is issued by an insurer to a policyholder in terms of the Long-term Insurance Act, No. 52 of 1998 (LTIA) or Short-term Insurance Act, No. 53 of 1998 (STIA), subject to regulatory oversight by the FSB
- **INDIVIDUAL RISK RATING** principles underpinning insurance
  - The policy promises to pay for certain stated benefits when the policyholder is ill, or injured, in return for a premium.
  - Premium is directly related to the age, health status or income of the individual covered by the policy
  - Specific types of exclusions and conditions may also be built into a policy, which can have the effect of limiting who the policy can be sold to, or excluding certain circumstances under which the policyholder can claim under the policy
- Referred to as health policies under the LTIA and accident and health policies under the STIA

Overlap between medical schemes and health insurance



Source: Presentation by Prof Alex van den Heever, 15th BHF Southern African Conference

Challenges in medical schemes

- Medical schemes becoming unaffordable to middle income groups and are not accessible to poor vulnerable households. NT supports the Competition Commission Enquiry into high private health care costs
  - households are buying down medical scheme coverage due to over inflationary price increases in medical schemes
  - need for low cost medical scheme options
  - medical schemes must cover the costs of Prescribed Minimum Benefits (PMBs) related to the diagnosis, treatment and care of any emergency medical condition; a limited set of ±270 medical conditions; and 25 chronic conditions
- Structural challenges - partial social solidarity, no risk equalisation fund, voluntary membership, absence of a reference pricelist – MSA has not kept pace with changing regulatory environment
- Market conduct problems - lack of standard disclosure, overly complex products with limited comparability
- Outdated solvency regime – not risk based, inefficient use of capital –impact on premiums.
- Weak / fragmented recourse mechanism

Overview of medical schemes

In 2015, 83 medical schemes in SA (23 restricted and 60 open)

	Unrestricted Schemes	Restricted Schemes	Total
Member	2 327 137	1 623 790	3 950 927
Dependants	2 611 316	2 247 280	4 858 596
Total Beneficiaries	4 938 453	3 871 070	8 809 523

Source CMS annual report 2014-2015

Overview of health insurance products

Table 1 – Product number and policies

Product Type	Number of insurers offering products	Number of products	Number of individual policies in force	Number of group policies in force	Total policies in force
Gap cover (ST)	9	100	349,404	121,217	470,621
Hospital Cash Plans (ST)	21	56	594,327	38,648	632,975
Hospital Cash Plans (LT)	17	65	686,576	690,565	1,377,141
International travel (ST)	11	59	1,601,228	8,752	1,609,980
Emergency evacuation and transport (ST)	4	6	11	83	94
Primary Health Care (ST)	3	15	2,905	952	3,857
Primary Health Care (LT)	2	5	4,286	-	4286

Overview of health insurance products contd..

Table 2 – Policies entered into, Gross Written Premium (GWP) and premium ranges

Product Type	Policies entered into – Year preceding last financial year	Policies entered into – Last financial year	GWP (R'000) year preceding last financial year	GWP (R'000) last financial year	Premium Ranges
Gap cover (ST)	32,786	39,240	R97,799,307	R77,274,075	R20 - R170 / R40 – R271 Group & Individual
Hospital Cash Plans (ST)	247,748	344,379	R69,470,824	R66,459,313	R25 – R242
Hospital Cash Plans (LT)	609,075	672,994	R3,365,895	R3,601,832	R45 – R6,232
International travel (ST)	283,006	1,924,361	R3,074,613	R6,179,818	Significant variations
Emergency evacuation and transport (ST)	184	78	R2,528,728	R4,691,721	Not sufficient data
Primary Health Care (ST)	3,040	3,107	R1,727,109	R4,714,187	R40 – R257
Primary Health Care (LT)	4,019	7,136	R4,546	R10,961	Not sufficient data

Overview of health insurance products contd..

- Table 1 and 2 are based on unaudited information submitted to the FSB by insurers operating in the health insurance market.
- The data provides a rough snapshot of the extent and footprint of health insurance/demarcation regulation products currently offered in the South African Market.
- The quality of the information submitted was not adequate in all instances to allow for an aggregated view on certain types of policies.
- Provision of the information was complicated by the fact that the insurers' statutory returns do not require policy level detail and therefore the insurers' systems are not designed to record this level of data.
- Note: Number of group policies reflected denote the number of lives insured under the group policies.

Objective of demarcation regulations

- The Demarcation Regulations balance policy objectives across the medical schemes and the insurance sector and seek to prevent regulatory arbitrage.
  - The Regulations specify which types of contracts are regulated under the LTIA and STIA as health policies and accident and health policies, respectively, and accordingly are excluded from the MSA, despite such contracts meeting the definition of the business of a medical scheme.
  - The Regulations seek to clearly demarcate the responsibility for supervision of medical schemes and health insurance products, and ensure that health insurance products do not undermine the social solidarity principles inherent in medical schemes.
- Address market conduct abuses to better protect customers.

Health insurance policies affected by demarcation regs

- Three categories of health insurance products are of particular relevance to the demarcation regs , namely:
  - **Medical Expense Shortfall policies (Gap cover plans):** These policies cover the shortfall between medical scheme benefits and the rates that private medical service providers may charge.
  - **Non-medical expense cover as a result of hospitalisation policies (Hospital cash plans):** These policies pay out a stated benefit upon hospitalisation, usually per day spent in hospital. The stated benefit is unrelated to the actual cost of any medical service as it is aimed at covering incidental costs, such as loss of income.
  - **Primary healthcare insurance policies:** These policies provide limited medical service benefits (often to employee groups or bargaining councils) including services such as general practitioner visits, acute and chronic medication, emergency medical care, dentistry and optometry.
- Other types of health insurance products included: lump sum/income replacement policy; cover for frail care; HIV/AIDS; emergency evacuation or transport, motor car third party liability cover and property third party liability cover; international travel insurance

Overview of health insurance products contd..

COVER TYPE	Not deemed to be business of medical scheme (written under LTIA/STIA; MSA does not apply)	Deemed to be business of medical scheme, but exempted from MSA through the regulations		Deemed to be business of medical scheme, not exempted from MSA through regulations
		Can be written under LTIA	Can be written under STIA	
Non-impacted products, e.g. dread disease	X			
Medical expense shortfall (Gap Cover)			X	
Non-medical expense cover as a result of hospitalisation (Hospital Cash Plans)		X	X	
HIV, Aids, tuberculosis and malaria testing & treatment		X	X	
Medical emergency evacuation or transport		X	X	
Frail care		X		
International travel insurance			X	
Primary health insurance				X

Scope of demarcation regulations

Medical expense shortfall (Gap Cover)

- Covers the difference or a part of the difference between the cost of a health service and the amount the person's medical scheme paid towards such costs
    - Biggest problem is that it drives up the cost of medical services and incentives doctors to charge more - undermining medical scheme bargaining arrangements intended to contain medical costs
    - Encourages young and healthy members to buy down medical scheme coverage undermining social solidarity principles
- Benefit limit may not exceed R150,000 per insured person per annum
- Strict underwriting, marketing, reporting and broker commission limitation introduced

Scope of demarcation regulations contd ..

Non-medical expense cover as a result of hospitalisation (Hospital Cash Plans)

- Policyholders mislead into believing that these policies are equivalent to medical schemes and offer comprehensive protection when hospitalise
  - Recent advertising standards authority forced insurer to pull “wallet doctor” advert which was misleading to public
  - Collusion and fraud between medical providers and policyholders – impacts on medical schemes
- Covers non-medical expenses associated with hospitalisation
- Benefits must be a fixed sum of money per insured per day not exceeding R3,000 or a lump sum amount of R20,000
- Policy may not require hospitalisation of longer than 3 days before policy benefits become payable
  - Current policies don’t offer value as in some cases people are in hospital for less than 3 days so by implication these policies never pay out.
- When paying policy benefits the benefit amount must always be calculated from day 1 of hospitalisation
- Benefits may not be paid or ceded to a provider of a health service
- Strict underwriting, marketing, reporting and broker commission limitation

Scope of demarcation regulations contd …

HIV, Aids, tuberculosis or malaria testing and treatment

- Covers expenses for testing and treatment of HIV, Aids, tuberculosis or malaria testing and treatment
- No restrictions on policy benefits
- Strict underwriting, marketing, reporting and broker commission limitation

Medical emergency evacuation or transportation

- Covers costs of or provide emergency evacuation or transport to a medical treatment facility; or covers the cost of emergency medical treatment
- No restrictions on policy benefits

Frail care

- Covers costs or expenses of assistance for activities of daily living
- No restrictions on policy benefits

International travel insurance

- Covers costs associated with a health service obtained while travelling in a country in which the insured persons are not ordinarily resident
- No restrictions on policy benefits

Scope of demarcation regulations contd…

Gap cover, hospital cash plans and cover for HIV/Aids, TB, malaria testing & treatment subject to prescribed requirements which seek to level to level the playing field between medical schemes and health insurance:

- prohibition on health insurance policies from discriminating against any person on the grounds of age, gender and other criteria (policies must be underwritten on group basis) ;
- enhanced product disclosure/marketing requirements;
- alignment of broker commission between health insurance and medical scheme products;
- enhanced regulatory reporting and monitoring;
- product standards which limit policy benefits; and
- limitations on waiting periods, termination/varying contract

Scope of demarcation regulations contd..

- The regulation of commission is aimed at introducing parity in the incentives to sell medical schemes and health insurance policies covered by the Regulations and limits product providers from incentivising brokers to excessively sell health insurance products instead of medical scheme membership.

Monthly premium band	Maximum Commission Level
Above R1,200	5%
R601 to R1,200	10%
R300 to R600	15%
Less than R300	20%

- A sliding scale commission structure has been adopted - a maximum of 5% monthly commission is applicable to premiums above R1,200/month, a maximum of 10% for premiums between R601 to R1,200, a maximum of 15% on premiums between R300 to R600 and a maximum of 20% for premiums less than R300. T
- This structure will only apply to LTIA Category 1 and 3; and STIA Category 1, 2 and 3 products. The normal commission regulations will apply to the remaining products.

Scope of Demarcation Regulations contd ..

Reporting requirements

- Before a product is launched it must be submitted to the Registrar of Insurance and Registrar of Medical Schemes– only file and use, not for approval
- Registrar of Insurance may at any time request information on a product from an insurer
- Registrar of Insurance is empowered to, by notice, object to any benefit, terms and conditions and marketing material of a health product and instruct insurer to stop marketing, offering, renewing or terminate such product

Scope of demarcation regulations contd ..

Supervisory / enforcement approach

- The FSB will be issuing a guidance document on the demarcation regulations clarifying any areas of uncertainty
- The Demarcation Regulations represents the “twin peaks” approach to regulation- i.e. product regulation
- The FSB is committed to working with the CMS to ensure that insurance products offered under the regulations do not undermine the medical schemes environment- a MoU / Protocol is in the process of being drafted
- FSB to conduct onsite monitoring, new market conduct returns to collate relevant health insurance data, investigating complaints

Primary healthcare products

Primary healthcare products

- These types of benefits will, going forward, have to be provided in accordance with the MSA
- The Minister of Health has requested that the CMS grant a two year exemption, subject to certain conditions, for primary healthcare insurance policies, while further research is being led by the Department of Health into the development of a Low Cost Benefit Option (LCBO) guideline
- It is envisaged that the existing primary healthcare insurance policies will be required to transition into a LCBO framework once finalised

Implementation timelines

- The Regulations will take effect on 1 April 2017.
  - All new health policies (LTIA) and accident and health (STIA) policies written after the Regulations come into operation must comply with the requirements set out in the Regulations.
  - Existing health policies (LTIA) will be expected to align to the Regulations as and when such contracts are varied or renewed after the Regulations come into operation.
  - Existing accident and health policies (STIA) will be expected to align to the Regulations by 1 January 2018.

Background to process

- The Regulations are the outcome of an extensive consultative process lasting several years between the Ministers of Finance and Health as well as the CMS, the FSB and affected stakeholders
- In 2000, a demarcation agreement between the FSB and CMS aimed to make a clear distinction between health policies & medical aids:
  - Insurance products cannot provide benefits which are linked to lists of tariffs for medical services and procedures.
- Long-term insurers stopped selling gap covers, while short-term insurers continued to sell gap covers.
- In 2006, the CMS took action against Guardrisk for selling short-term gap related products (case raised legal interpretation questions regarding “definition of business of medical scheme”)
- In 2008, the Insurance Laws Amendment Act allowed the MoF with the concurrence of the MoH, by way of regulations, to provide for health insurance products to be sold, despite such products constituting the “business of a medical scheme”.

Background to process contd..

- First draft Demarcation Regulations released for public comment on 2 March 2012, with 343 comments received
  - The principle underpinning the drafting was that health insurance policy should not undermine the social solidarity objectives and should seek to compliment as opposed to subsituting medical schemes
  - The proposal to prohibit Gap Cover and restrictions on Hospital Cash Plan insurance policies elicited the most public comment
- 15 October 2013, NT released a summary of the 343 comments received
- The Second draft Demarcation Regulations was published for comment on 30 April 2014, with 461 comments received
  - Provided for the continued sale of Gap Cover and Hospital Cash Plan insurance within defined product parameters.

Background to process contd..

- The Financial Services Laws General Amendment Act, No. 45 of 2013, amended the definition of a "business of a medical scheme" to support the Demarcation Regulations and resolve legal ambiguity
  - The Act came into operation on 28 February 2014. The amendment was deferred to come into effect at the same time that Demarcation Regulations take effect ie 1 April 2017
  - Health insurance products that fall within the ambit of this amended definition will be prohibited, unless they are explicitly exempted through the Demarcation regulations.
- On 28 October 2016, the Minister of Finance, with the concurrence of the Minister of Health, tabled the draft Demarcation Regulations in Parliament for review, as required in terms of sections 72(2B) and 70(2B) of the LTIA and the STIA.
  - One objection noted from Day1 Health regarding limitations on primary health insurance policies
- Final Regulations published on 23 December 2016 and will take effect 1 April 2017 and will bring about much needed policy certainty

QUESTIONS