National Treasury
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COMMENT ON THE PROPOSED AMENDMENT OF THE REGULATIONS TO THE SHORT-TERM INSURANCE ACT 1998, AS AMENDED.

Introduction

Alexander Forbes Health (Pty) Limited ("Alexander Forbes Health") is a wholly owned proprietary company of Alexander Forbes Financial Services Holdings (Pty) Ltd. Alexander Forbes Health is an authorised Financial Services Provider and is accredited with the Council for Medical Schemes ("CMS"). As a leading corporate healthcare consultancy in South Africa**,** Alexander Forbes Health delivers healthcare consulting advice and member support services to 490 corporate clients including 185,000 individual members, of which approximately 44,000 (24%) have voluntarily purchased gap cover products. Alexander Forbes Health also provides actuarial and technical consulting services to 11 restricted and 1 open medical scheme, covering 670,000 principal members in total.

Alexander Forbes Health welcomes the opportunity to provide a submission on the proposed amendment of the regulations to the Short-Term Insurance Act aimed at facilitating a clear demarcation between what constitutes health insurance business and what constitutes the business of a medical scheme. This demarcation is achieved by identifying certain categories of contracts as health policies to be excluded from the medical schemes regulatory environment and regulated under the Short-Term Insurance Act.

Alexander Forbes Health supports the need for a clear demarcation between accident and health insurance policies and medical schemes in order to protect the principles of community rating, open enrolment and cross-subsidisation entrenched in the Medical Schemes Act and acknowledges that in the absence of such a demarcation consumers may mistakenly believe that accident and health policies offer the same level of protection as a medical scheme or are in fact medical schemes or substitutes thereof.

Furthermore Alexander Forbes Health supports the need to identify categories of health policies which will not undermine medical schemes and for policy benefits, marketing activities, disclosure and reporting requirements to be prescribed in a fair and reasonable manner.

Limitation of Submission

In making this submission Alexander Forbes Health limits its commentary to the need for health insurance gap cover products to be recognised and appropriately catered for within the regulations.

Rationale for the Inclusion of Gap Cover Products Within the Regulations

1. Cost of Providing Equivalent Gap Cover Benefits Within a Medical Scheme Versus Offering a Stand-Alone Product

According to the CMS' Annual Report 2010-2011, of the 316 benefit options offered by 100 registered medical schemes, only 22% provide in-hospital cover in excess of 100% of the relevant medical scheme tariff. These options comprise of mainly rich comprehensive benefits catering to a population of higher claiming members who require additional cover and high income individuals who can afford the additional cover. These top-end options are generally loss-making due to a worse-than-average claims profile and they rely on the cross-subsidy from mid-range options to remain viable.

As indicated in the table below, of the 70 benefit options providing in-hospital cover in excess of 100% of the relevant medical scheme tariff, only 26 or 37% made a net healthcare surplus at the end of 2010 totalling R 1.067 billion. The majority of these benefit options, 44 in total or 63% made a combined net healthcare deficit of R 1.350 billion.

Options with a Positive Net Healthcare Result		
Number of Options	Percentage of Options	Total Net Healthcare Result
26	37%	R 1.067 billion

Options with a Negative Net Healthcare Result		
Number of Options	Percentage of Options	Total Net Healthcare Result
44	63%	- R 1.350 billion

The reality is that medical schemes themselves cannot afford to offer in-hospital benefit coverage in excess of 100% on all benefit options. Comprehensive benefit options have to be subsidised by other options because of affordability. At the same time, lower-end options are also subsidised because the contributions are deliberately set at a level that is deemed to be affordable to low income earners.

Overall there is a high reliance on the cross-subsidy of mid-level options to achieve net surpluses at a total scheme level, despite the prescription of the Medical Schemes Act, section 33(2) which requires each benefit option to be financially self-supporting.

This is illustrated in the case studies below.

Case Study 1

In the case of a restricted medical scheme covering 3,000 principal members on one benefit option, an actuarial pricing exercise was recently performed to determine the additional percentage contribution required (over above normal inflationary increases) to provide for varying levels of gap cover benefits within the medical scheme. The cost impact was significant ranging from 27% to 109% for an additional scheme reimbursement tariff of between 150% and 300%.

Multiple of Scheme Tariff	Claim Cost PMPM	Additional PMPM Contribution Required on 1 January	Percentage Additional Contribution Required Over and Above the "Base" Increase
100%	R 3,648		
150%	R 4,559	R 911	27%
200%	R 5,471	R 1,823	54%
250%	R 6,382	R 2,734	81%
300%	R 7,292	R 3,644	109%

** PMPM = per member per month*

Case Study 2

In the case of a restricted medical scheme offering three benefit options and covering 7,000 principal members, an actuarial analysis was performed to determine the impact of introducing an additional option that doubles the reimbursement rate offered to members for in-hospital treatments. As part of this analysis, the risk claims data for a defined group of members on an open medical scheme, was compared between two options, where the main difference between the options was the reimbursement rate for in-hospital claims. The analysis found that the risk claims per member on the more comprehensive option were 2.5 times higher than those of the existing option, whereas the contributions were only 1.2 times higher.

In the case of these two options, setting the contribution level 2.5 times higher would not be affordable and as a result, the actual contributions (set at 1.2 times higher) are not sufficient to sustain the more comprehensive option which achieves net deficits on a consistent basis that need to be subsidised by other, surplus-achieving options on the Scheme.

2. Addresses the Problem of Member Affordability

It is our experience that medical scheme members make decisions on benefit option choice based largely on affordability constraints. In a recent analysis of how 125,000 members of a large open medical scheme chose to select benefit options for the 2012 year, the vast majority (93.2%) chose to remain on their current benefit option. Only 3.9% of members elected to upgrade to a higher-end option and 2.9% elected to downgrade to a lower-end option.

The view that members choose benefit options based largely on affordability is further supported by the CMS, who in their Annual Report 2010-2011 quote:

"An online survey was conducted to understand how members of medical schemes choose or change a benefit option. The study revealed that the most common reason why members change from one option to another is due to affordability, i.e. when contributions become too expensive and unaffordable, members buy down to cheaper benefit options."

The reality is that members will generally continue with the benefit option that is the most affordable to them and incur the costs of any shortfalls in cover as and when they occur. For the vast majority of medical scheme members cover for in-hospital professional services and medical procedures is limited to 100% of scheme tariff. Although a level of protection against out-of-pocket shortfalls is afforded under regulation 8 of the Medical Schemes Act, which requires Prescribed Minimum Benefit ("PMB") claims to be paid at full invoiced cost, the average member still faces the very real possibility of large unexpected shortfalls in the cover of in-hospital expenses caused by the ever-widening gap between the scheme reimbursement level (generally 100%) and the cost of professional fees (upwards of 200%).

The impact of this gap is best illustrated by the case study below where we consider the cost differential of upgrading to a higher benefit option compared to purchasing gap cover.

Case Study 3

If we consider a hospital plan that reimburses members at 100% of scheme tariff, and then consider the two main choices of a member who requires cover that is more aligned to the actual cost of treatment, these choices can be summarised as follows:

Upgrade to a benefit option that reimburses in-hospital medical expenses at 200% of the scheme tariff.
Purchase gap cover that could cover up to 450% of the scheme tariff if required.

The tables below illustrate the financial impact of these choices to the member, for varying family sizes and income levels.

Note that this example is based on two existing benefit options in the medical schemes market where the main difference in the benefits offered is the reimbursement rate for in-hospital events.

The first table shows that the increase in contribution / premium payable is significantly higher where a member chooses to upgrade benefit options within the medical scheme as compared to purchasing gap cover.

Family Size *	Percentage Increase in Contribution / Premium	
	Upgrade Option	Purchase Gap Cover **
P	16.4%	11.4%
PA	18.9%	6.5%
PAC	18.4%	5.3%

** P is a principal member, A is an adult dependant and C is a child dependant*
*** Assume gap cover premium is R120 per family*

The second table (below) shows the impact to a family's net income of choosing to upgrade benefit options within a medical scheme compared to purchasing gap cover. As an example, a family consisting of three members with combined net earnings of R 17,500 per month, would use 1.7% more of their monthly income if they chose to upgrade their option within the medical scheme, as opposed to purchasing gap cover. This equates to an additional R 300 per month in this example.

Family Size	Combined Net Monthly Income			
	R 7,500	R 12,500	R 17,500	R 22,500
P	0.7%	0.4%	0.3%	0.2%
PA	3.1%	1.8%	1.3%	1.0%
PAC	4.0%	2.4%	1.7%	1.3%

3. Supports Rather than Competes with Medical Schemes

National Treasury and the Department of Health argue that health insurance products cause hardship to the medical schemes environment by attracting younger and healthier members out of medical schemes and thereby undermining the principal of cross-subsidisation. This does not hold true for gap cover products as membership of a medical scheme is a pre requite for gap cover. Thus gap cover is a supportive product and not a replacement product for medical schemes.

4. Negative Impact on Gap Cover Policyholders if Gap Cover Products Are Withdrawn

In their current form, the draft regulations do not make appropriate provision for gap cover products. To survive, gap cover products would require substantial restructuring into lump sum or income replacement policies. In this form the cost of gap cover products is likely to increase significantly since a value would need to be assigned to each procedure or event and a benefit would be paid irrespective of whether a shortfall in reimbursement tariff occurs. Furthermore the policy benefits under an income replacement structure would be limited to 70% of the member's net income which could result in insufficient benefits.

The withdrawal or fundamental restructuring of gap cover products would have a significant impact on policyholders, especially those who cannot afford to purchase a more comprehensive medical scheme benefit option, as shown in Section 2 above. It is estimated that there are approximately 300,000 gap cover policyholders in a population of approximately 3.6 million medical scheme principal members. This represents a coverage rate of less than 10% of all medical scheme members and therefore shows that the impact of gap cover products on medical schemes is small, whilst the impact on the average gap cover policyholder would be significant if these products were withdrawn from the market.

5. Proposed Solution for Shortcomings in Medical Scheme Benefit Design

In the 2008 Supreme Court Ruling in the matter between Guardrisk Insurance Company Limited and the Registrar of Medical Schemes, the judgement included the following statement "*Practical reality has shown that there exists a need for this type of insurance and there seems to be no reason why it should not be permitted*".

The reality is that in a perfect medical scheme environment there would be no need for gap cover products. These products exist in direct response to systemic shortcomings in the medical schemes regulatory environment. It is our view that issues such as mandatory membership and risk equilisation (proven mechanisms for risk pool stabilisation) together with regulated provider tariffs, need to be addressed before gap cover products are removed in order to limit the impact on members.

Concluding Remarks

Alexander Forbes Health believes that there is a need for gap cover products and for these to be appropriately regulated. We further believe that product designs aimed at specific benefit shortfalls within medical schemes e.g. scope co-payments, deductibles for medical devices and out-of-network hospital deductibles amongst others, undermine the risk management and cost containment strategies of medical schemes and thus should not be allowed via gap cover products.

Medical schemes should be able to channel members to have procedures performed in more cost-effective treatment settings, without the threat of gap cover products discouraging members from using the most cost-effective setting, as this has a direct impact on scheme costs (i.e. hospitalisation costs versus day facility costs). This could be achieved by limiting the scope of gap cover product coverage.

In conclusion we urge the regulators to make appropriate, reasonable and rational space in the demarcation regulations for gap cover products. A middle ground can be found where the interests of both medical schemes and individual members, seeking to limit their out-of-pocket exposure in a cost effective manner, are recognised and protected.

This commentary was compiled by ***Technical and Actuarial Consulting Solutions (TACS)***, a division of Alexander Forbes Health (Pty) Ltd.

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