Review of the History and Legislative Landscape of the South African Market for Hospital Cash Plan Insurance

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Figures and Illustrations

1. Introduction and Overview

This note was commissioned by FinMark Trust as a follow-up to the study titled "Review of the South African Market for Hospital Cash Plan Insurance" conducted by Lighthouse Actuarial Consulting for FinMark Trust in 2012[1]. The research illustrated the potential for Hospital Cash Plan (HCP) products to provide financial protection to those that are unable to afford medical scheme membership, but would still incur significant costs/co-payments at a state facility due to the UPFS tariff[2] structure. These costs could be debilitating for entire families, especially in the event of a bread winner requiring hospitalisation. The results indicated that HCPs offer low income earners an affordable option to ensure themselves against these costs and the products were found to be effective even at relatively low pay-out levels.

The research further illustrated that these benefits would be significantly impaired, should a strict demarcation between medical schemes and medical insurance be implemented. The legislative landscape shapes the products that operate in a particular market and greatly influence the format of products as well as the value offered to consumers. The current legislative landscape related to medical insurance products was detailed in the full report (Lighthouse, 2012). On 2 March 2012, the Minister of Finance gazetted draft demarcation regulations for public comment that seek to find a better balance between medical schemes and health insurance products. It outlined a proposed revised demarcation between medical schemes and health insurance products The Regulations are the outcome of a joint process between the National Treasury, Department of Health ("DoH"), Financial Services Board ("FSB") and Council of Medical Schemes ("CMS"). On 15 October 2013, National Treasury published a press release with an update on the timeline and contents of the proposed revised demarcation regulations, which are now expected to take effect in 2014.

This note follows on from the initial FinMark Trust report and provides an overview of the history and development of the regulatory landscape for Hospital Cash Plan (HCP) products. It also serves as an update on the proposed revised demarcation between HCPs and medical schemes and highlights the expected implications thereof.

The findings of this note are complemented by a FinMark Trust project to gauge the demand for hospital cash plan insurance in South Africa, based on qualitative focus group research[3].

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[1] Available at: http://www.finmark.org.za/wp-content/uploads/pubs/HospitalcashPlanInMrktRev_124.pdf

[2] Public health care services are billed according to a means test and the tariffs for each income category are set out in the Uniform Patient Fee Schedule (UPFS).

[3] Forthcoming. See www.finmark.org.za.

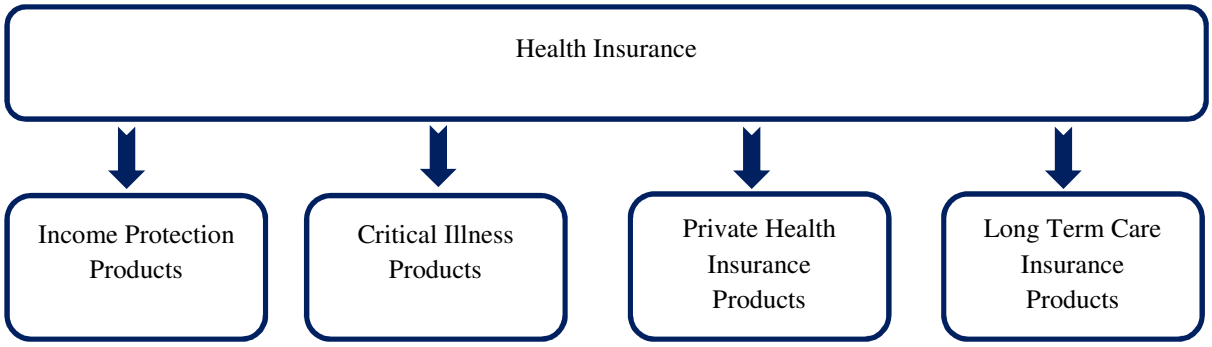
2. Hospital cash plans: History and Market Development

The regulatory structure and market characteristics of insurance products differ from country to country. Yet many product classes and insurance vehicles share a common ancestry, with new innovations quickly being adopted/ transferred to markets in other countries.

The post-World War Two era was marked by a period of innovation and led to one of the first major global health reforms. During this period, many countries began implementing national health insurance or state-funded type systems like the National Health Service (NHS) in the UK (established in 1948 following the Beveridge report in 1942). Private sector products are often developed to complement the benefits of a state system and as such the post-war boom also led to the growth of the medical insurance market. A period of industrial growth following the war, coupled with the scarcity of labour due to the war efforts, saw large corporations offering employees a form of medical insurance as an additional incentive and as a way to attract employees. This was particularly prevalent in the USA via employer-based health insurance schemes.

This process of innovation in both the public and private sector led to the development of the current health insurance landscape, globally. There are four main categories of health insurance products as illustrated in the diagram below:

Figure 1: Health Insurance General Product Overview



- Income protection (IP) (also known as permanent health insurance) products are long-term insurance products that provide benefits relating to the insured's income in the event that the policyholder is unable to work due to injury or illness.
- Critical illness (CI) products provide cash benefits on the diagnoses of a specified list of diseases, or in the event of a specified surgical procedure or reaching a predefined level of impairment or disability (often with an overriding decrement of mental infirmity).
- Private health insurance (PHI) generally refers to product offerings aimed at meeting the cost of medical care. Products vary greatly and the more common options relate to dental plans, optical plans, major medical expense plans, excess options, medical cash plans (similar to HCPs), waiting list plans and personal medical expense plans.
- Long term care insurance refer to policies that provide cover for the cost of care in a residential or care home facility once the insured is unable to care for him/herself. These products usually relate to elderly persons that are not expected to improve.

The HCP market originated as a form of private health insurance, with the first products offered in the USA as Major Medical Cover in the 1950s. The first HCP products were offered in South Africa in the 1980s. HCPs generally provide stated cash pay-outs based on the period of hospitalisation. The baseline structure of these products has remained fairly similar to when they were first introduced. HCPs today generally still offer stated benefits based on the length of stay, but pay-outs are often related to the ward (higher pay-outs being made available for days spent in ICU/High Care) and most of the offerings include additional riders like dread disease, CI and IP covers.

Dread disease cover is a variant of Critical Illness (CI) cover and was designed and pioneered in South Africa in the face of the initial Aids epidemic during the 1980s. Typically, these CI benefits did not provide an indemnity benefit but rather provided the policyholder with cash benefits on the diagnoses of one of the specified conditions. The South African market for CI and HCP products thus developed in tandem.

The HCP market in South Africa grew quickly, with approximately 13 insurers offering HCPs to 50,000+ active policies by the start of the 1990s. Initially, HCP products were offered by Long Term insurers as part of their group product offering. At the time the extent of the impact of HIV/Aids was not yet clear and insurers were cautious as to the risk posed by making the products freely available in the individual market. Anti-selection risks were more easily controlled in a group setting and as such HCP products were initially sold as a bundled product by life companies. Additional benefits were mainly in the form of endowments. Thus HCPs were initially regulated as long term insurance products.

As time progressed, the market became more competitive and short-term insurers also entered the HCP market. The diversification of the market and products implied that some insurers also started to develop products with specific benefits aimed at more closely matching the costs of medical treatments. This led to conflicts with the business of medical schemes as regulated by the Council for Medical Schemes. At the heart of this conflict is the inability of the medical schemes industry to extend cover to the lower income portion of the market.

Medical schemes in South Africa date back to 1889 in the form of informal institutions which pooled money for the funding of health care for their members/ employees. In 1956 their status was formalised under the Friendly Societies Act (No 25 of 1956). Healthcare risk pooling and funding regulations were later drafted to form the original Medical Schemes Act (No 72 of 1967).

Amendments to the medical schemes Act of 1967 were introduced in 1993. This led to the part-deregulation of the industry and in many cases to the effective exclusion of older and sicker people from cover through the rating of premiums based on health status and other risks (much like a health insurance product).

These trends were reversed with the implementation of the new medical schemes Act (No 131 of 1998) that was based on the principles of open enrolment and community rating. The revised act also implemented minimum benefit requirements in the form of Prescribed Minimum Benefits (PMBs) that all schemes needed to fund at cost for all members. While these changes offered higher levels of protection to members, it meant that medical schemes were vulnerable to the impact of cost escalations due to anti-selection. The absence of protection mechanisms like mandatory membership and a risk equalisation fund further exacerbated the impact of these changes. Consequently, medical

scheme contributions have generally outstripped inflation year on year. If anything, the market has become less affordable today than when the act was first introduced.

The medical scheme industry thus rely heavily on the cross subsidisation from the young to old and healthy to sick and one of the key risks for this industry relate to losing young and healthy members to insurance products. To combat this, the medical schemes Act of 1998 was drafted in tandem with the Long Term and Short Term Insurance Acts with the aim of designing the regulations in a manner that excluded insurance-based products from offering benefits aimed at meeting the cost of care. When considering the legislative structures that govern the markets for medical scheme and health insurance products it should be noted that demarcation legislation and related regulatory considerations to date have been designed with this aim in mind.

3. Regulatory Structure and Demarcation

Long term and short term insurers are regulated by the Long Term insurance Act (no 52 of 1998) and the Short Term Insurance Act (no 51 of 1998), respectively. The regulation is enforced by the Financial Services Board (FSB). Medical schemes are regulated by the Council for Medical Schemes (CMS). As part of refining the regulatory landscape and ensuring the protection of medical scheme risk pools, the regulators and industry bodies deemed it necessary to clearly distinguish between medical schemes and health insurance products. In 2004 the CMS, FSB and the Life Offices' Association (LOA), the then industry representative body for long-term insurers, released a demarcation document to provide clarity to all stakeholders regarding the definition of the "business of a medical scheme"[4] as defined in the Medical Schemes Act (MSA). The aim of this initial demarcation agreement was to protect medical schemes and ensure that the core principles of solidary and community rating were not undermined by the risk-rated approach of health insurance products. While this demarcation agreement does not have full legislative standing, it does set out the proposed conditions under which health insurance products are classified.

The demarcation agreement contained requirements for the marketing, sales, policyholder communication and promotional information that insurance products would have to meet. This included that no reference to medical schemes or to products being sold conditional to the policyholder being a member of a medical scheme is permitted.

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[4] According to the Medical Schemes Act, 1998, "*[the] "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution*

- *to make provision for the obtaining of any relevant health service;*
- *to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; and*
- *where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme."*

In the demarcation process it was generally accepted that the Medical Schemes Act would be interpreted to mean that all products aimed at meeting the cost of health care would fall within the business of a medical scheme. This document included a demarcation guideline for long-term insurers illustrating the types of products that could be written within the confines of what is deemed to be outside the role of medical schemes[5].

The CMS considered Gap cover products to be non-compliant with the demarcation and in 2006 challenged the validity of these products in court. In the court case (Case No. 168, 2008) a short-term insurer providing Gap cover products, Guardrisk, was taken to court by the CMS on the grounds that it was contravening the demarcation agreement. The CMS considered the fact that Gap cover products offered benefits that were directly related to the cost of treatment to mean that insurers offering them were conducting the business of a medical scheme. The CMS was also concerned that these products encouraged buy-down behaviour (members selecting to buy lower cover options and then "top up" with Gap cover). To date a conclusive link between Gap cover and significant increases in buy-downs has not been proved – affordability is arguably a much stronger driver for reducing cover.

Guardrisk countered by arguing that because policyholders had to belong to a medical scheme in order to buy the Gap cover product, this would in fact encourage medical scheme membership. They further argued that the benefits offered by Gap cover products did not compete with the benefits of any existing medical schemes.

In December 2006, the High Court ruled in favour of the CMS and Guardrisk was ordered to stop all marketing and sale of policies. Guardrisk appealed the judgement and the case was heard by the Supreme Court of Appeal. On 28 March 2008, the Supreme Court ruled in favour of Guardrisk and the company was able to resume its operations. The ruling was based on a literal interpretation of the definition of a business of a medical scheme in the Medical Schemes Act and semantic considerations of the listed activities of a medical scheme.

The ruling had mixed outcomes. Certain insurance companies closed their health insurance products to new business based on discussions with the CMS, but the ruling also led to a number of new Gap cover products being launched in the market, as well as more aggressive HCP offerings.

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[5] The guidelines include that insurance benefits cannot be set on the basis of lists of procedures or services. Health insurance benefits will not be regarded as the business of a medical scheme where they are clearly linked to a contingency other than the payment of medical expenses. The guidelines furthermore require that long-term insurance marketing must not be conditional upon membership of any particular medical scheme. There must be a mandatory standard warning that it is not a medical scheme and that cover is not equivalent to that of a medical scheme. "Sales and marketing material should also make it clear that a health insurance policy is not a substitute for medical scheme membership. It is recommended that the word 'medical' is not used in the name of the product, and health insurers may not offer cessions to medical service providers." (Interview with Gerhard Joubert, LOA, December 2004 in: http://insurance-times.net/article/demarcation-between-life-assurers-and-medical-schemes-finalised)

The interest of insurers are represented by two industry bodies, the Association for Savings and Investments in South Africa (ASISA) and South African Insurance Association (SAIA), representing the long term/life and short term insurers respectively. ASISA fulfils a more formal self-regulatory role and strongly encourages its members to adhere to the demarcation code of conduct as drafted in 2004. SAIA, on the other hand, applies a less formal form of self-regulation and allows its members to test their products based on market forces and legal standing. SAIA has issued a code of conduct, but the onus is on the insurer to ensure that it adheres to this code and measure its own compliance. Should a dispute arise, an insurer would likely rely on court rulings and precedent to determine if a product is deemed to be in conflict with the demarcation.

This distinction in the enforcement and interpretation of the regulations has led to a wide variety of product offerings. Long-term health insurance products are usually restricted to traditional HCP products, while short-term health insurance products vary from HCP offerings to Gap cover and other products that provide cover similar to medical scheme benefits.

4. March 2012 Revised Demarcation Proposals

On the 2nd of March 2012 released draft demarcation regulations for public comment outlining a proposed revised demarcation between medical schemes and health insurance products, to be contained in proposed changes to the Long Term Insurance Act and Short Term Insurance Act.

The main proposed changes relating to HCP products were:

- The benefits of health insurance products cannot be related to the cost of treatment. This is not a change *per se* but rather a re-emphasis and clarification of the current provisions;
- Daily HCP benefits are to be capped at 70% of net daily income of the policyholder;
- Additional regulatory requirements to be introduced relating to stricter marketing and member communication requirements as well as product design features. This will include the potential removal of all terms associated with “health” or “medical” from marketing material, as well as the CMS being directly involved in the vetting and launching of new and existing health-related products.
- Updated marketing and distribution requirements to be introduced, requiring insurers to be more explicit regarding the cover provided and the fact that these products are not designed to meet the cost of health care.

The majority of HCPs provide benefits that are unrelated to the cost of care and thus would not be significantly impacted by the first requirement. The cap of daily cash benefits to 70% of the policyholder’s income would, however, have a significant impact on policyholders and the value of these products. Capping the daily benefit at 70% would severely limit the benefit amounts paid out to policyholders and would imply additional underwriting and administrative costs for insurers. Products would thus become more expensive but would offer lower benefits.

The impact of the revised demarcation on Gap cover products would be significant. It is likely that none of the products would be able to function in their current form under this proposed revised structure. This will necessitate insurers to either update their offering to provide a pre-defined set of stated benefits or to remove their products from the market.

It is also envisaged that the CMS will play a more significant role under the revised demarcation and will fulfil a regulatory and supervisory role for both medical schemes as well as insurance products. In general, the more stringently a market is regulated, the larger the impact on the levels of innovation and development in the market.

A more onerous regulatory process would imply that insurers would have to spend additional time and funds to get potential (and existing) products approved. Innovation would also be hampered by extra time to get the offerings to market as well as the costs associated with research, staff and development that will be lost in the event that new offerings are not approved. Due to these risks the proposed additional level of regulation would likely lead to insurers simply offering vanilla type offerings and could potentially lead to the inability of the market to react to the normal forces of demand. Ultimately, if the process becomes extremely onerous it could lead to insurers exiting the market.

However, the updated set of marketing and distribution requirements proposed could ensure that policyholders better understand the differences between products. A more informed market would ensure that policyholders do not underinsure themselves when they could afford a medical scheme.

5. 2nd Round of Revised Demarcation

The publication of the March 2012 draft regulations saw widespread reaction from the market and received a significant amount of media attention, especially about the impact on Gap cover[6].

The majority of insurers active in this space, as well as some individuals and both industry bodies, submitted comments on the proposed demarcation, as did a number of medical specialist societies[7]. A total of 343 submissions were received[8].

During the review period Lighthouse, on behalf of Finmark Trust, engaged the CMS, Treasury and FSB via targeted meetings and presentations. The aim of these sessions was to highlight the potential value of HCPs and present the results of the 2012 FinMark Trust research to the key decision makers on demarcation. Through these interactions it was apparent that those drafting the legislation did not

[6] The emphasis on Gap cover was disproportionate given the fact that HCPs serve a much larger client base. Gap cover is expected to represent approximately 500 000 insured lives, while the market for HCPs is estimated to be four or five times larger and cover approximately 2.24 million lives. The disproportionate emphasis on Gap cover was likely due to the more affluent and financially aware membership base for this product, as well as the more obvious impact of proposed legislative changes compared to the HCP market.

[7] The main thrust of the medical specialist submissions related to the benefits of Gap products in funding claims up to 500% of normal medical scheme tariffs. While medical specialist societies argued that Gap products enabled members to afford their services, some would argue that consequently Gap products are one of the key cost drivers in the industry and encourages overcharging by specialists.

[8] A summary of all submissions can be accessed on the National Treasury website: http://www.treasury.gov.za/comm_media/press/2013/2013101502%20-%20Public%20submissions%20on%20the%20draft%20Demarcation%20Regulations.pdf

initially consider HCPs as a viable stop-gap for those that could not afford medical scheme membership. Rather, they viewed the main use of these products as income replacement products in the event that the insured would become unable to work. It was apparent that HCPs were not given significant credence as a viable health insurance product. This view, however, does not consider the potential cost impact of a major medical event for those not on medical schemes.

The findings of the initial research clearly defined the value of HCPs in defraying both the direct and related costs of a major medical event. Illustrating that HCP products could provide affordable cover to low income earners proved to be a key step in the process. The quantification of the value and affordability constraints of HCPs, as well as the direct comparisons to alternative products, was also of interest to the relevant parties on the demarcation commission and legislative bodies. It is agreed both by insurers and legislators that HCPs are not the ideal vehicle to fund the health needs of those that cannot afford a medical scheme. However, in the absence of any alternative low cost schemes, HCPs currently offer an effective interim solution.

During the interactions it became apparent that the aim of the demarcation was to provide protection to medical scheme risk pools from insurance products that could potentially lure the young and healthy away to cheaper offerings. The intention was not to limit/impede products that offer value to those that could not afford medical scheme cover.

This view was reaffirmed in a press release by National Treasury on 15 October 2013 to provide an update on the plans for the second draft revised demarcation regulations[9]. The publication of the revised demarcation regulations is now planned for the end of 2013 or after the enactment of an amendment to the definition of the "business of a medical scheme" contained in the Financial Services Laws General Amendment Bill, 2013 which was tabled in Parliament in September 2012. A further 60 day period for public consultation will be provided once the revised demarcation regulations are gazetted and implementation of the regulations is expected by late 2014.

The press release confirms that the two key proposals in the first draft regulations which elicited the most public responses are the prohibition of Gap Cover and product restrictions on Hospital Cash Plan insurance policies. The revised second draft Regulations will acknowledge that, "while health insurance products have a role in the market place, these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical schemes." Thus the continued sale of Gap Cover and Hospital Cash Plan insurance will be allowed, but defined regulatory product parameters will be set within which they must operate. "These parameters, by explicitly requiring that health insurance products be provided on similar terms as medical schemes, seek to ensure that medical schemes are not compromised."

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[9] http://www.treasury.gov.za/comm_media/press/2013/20131015O1%20-%20Demarcation%20media%20statement.pdf

The amendment to the definition of the "business of a medical scheme" contained in the Financial Services Laws General Amendment Bill 2013 will imply that many health insurance products would fall within the ambit of this definition. Thus they would be required to conform to the requirements of the Medical Schemes Act of 1998, unless explicitly excluded. Accordingly, the revised second draft demarcation regulations will provide for the conditions under which certain health insurance policies will be excluded from the definition of the "business of a medical scheme". According to the press release, "[the] conditions will include but are not limited to product standards which define the benefit offering; enhanced product disclosure/marketing requirements; alignment of broker commission between health insurance and medical schemes products; and closer regulatory reporting and monitoring requirements. These conditions are designed to prevent health insurance policies from undermining the business of a medical scheme."

In discussions with representatives from Treasury, indications are that many of the more onerous requirements as per the original demarcation (income vetting, minimum income requirements, the proposed cap on HCP benefits to 70% of net daily income and underwriting) will be removed for cover levels below R 3 000 per day. During the full analysis in the 2012 FinMark Trust report, this was found to be the highest level of cover affordable to low income earners. The results also indicated that cover levels of R 3 000 were more than sufficient to cover both the direct and related costs of a major medical event, given hospitalisation in the public sector. The impact of the proposed revised demarcation on Gap cover remains uncertain. Currently, the industry is engaged in a debate as to which services can and should be insured, and which should form part of the standard medical scheme offering.

Overall, the media statement seems to be more positive towards health insurance products than the original demarcation regulations. However, it would seem that the envisaged provisions in the revised draft demarcation regulations are aimed at ensuring that health insurance products are provided on similar terms to medical schemes. This could be quite onerous for many insurers.

One of the main unanswered questions relating to the market for HCP products relates to the reason for policyholders to purchase the products and what the benefits are used for. Legislation states that pay-outs from insurance products like HCPs are to be made directly to the policyholder. There is thus no record of what the funds are actually used for and during the interview phase for the 2012 FinMark Trust report insurers indicated that they did not really have any sense of the main needs towards which policyholders apply pay-outs.

FinMark Trust has recently initiated a second phase for this project aimed at identifying typical HCP policyholders, their reasons for buying HCPs and the uses to which the pay-outs are put. This analysis was conducted via focus group discussions with current and potential policyholders. It is expected that the results from this research will be an important next step in understanding the market and potential benefits of HCPs.

6. Conclusion

Access to health care is one of the fundamental building blocks of the South African constitution. Few, if any, in the industry argue with the validity and fairness of this goal. However, the challenges around funding and the level and quality of both access to and service levels related to health care raise unique and complicated questions.

The medical schemes market succeeds in funding quality health care, but fails in making it accessible to all or even the majority of the population. While all South Africans can attend a public hospital, few can do so free of charge and, as indicated in the 2012 study, a large majority will incur significant co-payments while in a state hospital.

The plans of moving the country towards a National Health Insurance System aim to address the challenges relating to access and quality of care, but this intervention is expected to only be implemented within the next 25 years. In the interim, some form of funding or insurance product offering is required for those that cannot afford medical scheme membership.

The results of the full 2012 FinMark Trust report indicated that HCPs can potentially be very effective and affordable products for the low earning, uncovered sector of the population. As illustrated, the impact of the original proposed demarcation requirements would have serious consequences for this market and consequently for low income earners. Current indications are that the second round of the regulations will be much more accommodating toward HCPs, but until the revised regulations are published the verdict is still out.