The National Treasury published the second draft regulations on the demarcation between health insurance policies and medical schemes at the end of April. While the outright banning of gap cover is no longer on the cards, the regulations in their current form would significantly water down the value of these products.

Calls for greater clarity on the latest demarcation regulations have come from all quarters, with more questions emerging from the latest draft document than answers. Product providers and associations are rallying together to ask that National Treasury address the inconsistencies. Once general acceptance is reached, implementation of the regulations can go ahead, however the regulations in their current state are felt to be premature.

Interested parties have until 7 July 2014 to comment on the second draft regulations, and National Treasury has indicated that it hopes to publish final regulations by September 2014.

“The current regulations appear unwieldy, and propose derivatives of gap cover. There are vital things that are not mentioned such as co-payments. The regulations also state that it must be mentioned in marketing that these products could change – which infers doubt in the mind of a consumer,” explains Tony Singleton, CEO at health insurance provider, Turnberry.
The regulations propose alignment of broker commission between health insurance and medical scheme products. This effectively means that commission would be calculated at three per cent of contributions received (it is currently 20 per cent of monthly premiums), and commission paid would not be able to exceed R71.07 a month. This has been decried by industry stakeholders.

The proposal to reduce broker commission from a maximum of 20 per cent to three per cent appears to be arbitrary and not commensurate with the minimum services that brokers will be expected to deliver. Many of the gap products cost as little as R100/month and as proposed the average commission will be between R2 and R5.

For this level of remuneration, it would not be financially viable for financial advisers to deliver a service that is fully compliant with the onerous obligations as outlined in the Financial Advisory and Intermediary Services (FAIS) General Code of Conduct.

Singleton and other health insurance providers urge brokers to remind their clients at this stage that the status quo remains unchanged, and those who have gap cover in place remain covered. Should there be changes in legislation that will impact policyholders, they will be advised of the implications of these.

The regulations essentially propose a number of conditions on health insurance products, including gap cover and hospital cash plans, which currently operate under either the Short-term Insurance Act or the Long-term Insurance Act. Treasury says these conditions seek to “ensure that the design, marketing and sale of health insurance policies do not undermine the social solidarity principles in medical schemes, while at the same time serving the needs of those who require additional protection against health-related risks.”

There are about 500 000 South Africans who have gap cover health insurance, and about 3.5 million South African consumers who hold hospital cash plan policies. Commentators agree that hospital cash plans appear to be where the issue lies, as South Africans who cannot afford to subscribe to medical aid schemes are opting for this cheaper cover.

Gap cover, on the other hand is most often only sold through intermediaries, to consumers who have medical aid in place as a requirement. Gap cover would step in to pay medical bills over and above those that medical aid rates would cover.

“Do I believe in the value of gap cover? Five years ago I would have said no, but today, yes I do,” affirms Peter Jordan, CEO at medical aid scheme Fedhealth. Because medical aids cannot control healthcare costs, which are increasing at rapid rates, they have been forced to cut back on what they can offer, and gap cover has become very useful as a top up, he adds.

It is interesting to note that the initial desire to ban gap cover on the part of the Council for Medical Schemes (CMS) in 2006, stemmed from the fact that this type of insurance was viewed as “conducting medical schemes business” in contravention of the Medical Schemes Act, and the CMS sought to protect medical schemes from losing members to health insurance options. However, the regulations in their current form seem to push health insurance more into “the business of a medical scheme” than ever, for a number of reasons.

Some of the major changes proposed under the latest regulations can be grouped into the following categories.

Commission

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One needs to also consider this with a backdrop of the involvement of the CMS, which has failed to ensure that financial advisers involved in medical schemes receive the inflation-linked annual increases that are entrenched in the law,” retirest Financial Intermediaries Association of Southern Africa (FINIA) CEO Justice van Putten.

“...the proposal commission structure is in line with that of a medical aid, which is 2 per cent capped at R71.07. You have to work hard for that, and medical aid relies on the volumes, which are often not the same for gap cover. This will change the landscape for brokers,” explains Jordan.

“Three per cent for advice on a gap product doesn’t reflect the value of this advice. Twenty per cent is more appropriate,” emphasises Singleton.

Gap cover provider, Zen Life, agrees that the commission issue will definitely be strongly contested as the three per cent limit on gap cover premiums results in commission much lower than on medical scheme contributions.

The regulations propose the introduction of product standards which limit policy benefits, and limitations of bundled type health insurance products that replicate medical schemes.

In terms of medical expense shortfall, the following criteria is required for any policies providing cover: Rand value of cover must be stated in the policy contract; maximum benefit may not exceed R3 000 per person per day for hospital cash plans, and R50 000 for a defined health event; the insured person must be a member of a medical scheme, and the policy contract must be an annual policy with premiums payable monthly.

The contract is required to state: any representations made by, or on behalf of the policyholders, which are material to the assessment of risk under the policy; the premium payable monthly and the benefits provided under the policy; and the events in respect of which benefits will be paid and when they will not be paid.

Capping of benefits of R3 000 for hospital cash plans, and R50 000 for a defined health event are largely viewed as being insufficient. Singleton notes that because of escalating healthcare costs and expensive treatments, Tumberry has clients claiming for procedures in excess of R100 000. Capping the benefit would leave clients exposed...
to significant medical expenses, or there could even be over payments in some cases. Therefore Turnberry will generally pay up to 500 per cent of the medical aid, he says.

“There is a need for clarity on which product category the proposed limits apply to. Health insurance products by design complement or supplement a deficiency in medical schemes. A R50 000 limit may be grossly limited for a top-up product to give access to cancer treatment that costs R500 000, for example,” adds van Pletzen.

“We expect, following public comment, that the limit of R50 000 may be increased. Although our average claim amount is R3 500 and, out of the last 6 360 claims, only 10 claims exceeded R50 000,” says Zest Life.

Marketing and disclosures

National Treasury says that the new demarcation regulations draft puts forward enhanced disclosure and marketing requirements. The regulations further state that: the product name may not contain the names ‘medical’ or ‘hospital’ or any derivative thereof; Policy contract or marketing material may not create the perception that policy covers the policyholder against medical expenses for health services, or that the policy is a substitute for medical scheme membership. Products must display in clear legible print and in a prominent position, “This is not a medical scheme and cover is not equivalent to that of a medical scheme. This is not a substitute for medical scheme membership,” and, the product should clearly explain premium, benefits, terms and conditions and cancellation periods.

It is suggested that health insurance products are creating confusion among consumers. Gap cover providers do not feel that this is the case, and stakeholders agreed that it is likely hospital cash plans that are creating the confusion, and have many terms that are not actually beneficial to clients.

Stakeholders do not seem convinced that there are massive amounts of people dropping their medical aid schemes in favour of hospital cash plans. Medical aid is costly, and when money is tight it is often one of the first things people change to a lower plan, but instances of dropping it altogether are rare.

Requirements for products already being marketed include: within three months of the regulations coming into operation submit a summary of benefits, terms and conditions and marketing material of all policies introduced. Health insurance products are currently managed through the Financial Services Board (FSB) and FAIS accredited intermediaries. These structures are clear on what they require from intermediaries in terms of finding the right products for their clients, explains Singleton.

If the amendments to regulation are implemented, this would mean that an insurer wishing to introduce a new accident and health policy would have to submit to the FSB and the registrar of medical schemes, or CMS, at least one month prior to launching the product. The registrar of medical schemes may, within one month, indicate to the registrar that some or all of the requirements submitted are contrary to the objectives and purpose of the Medical Schemes Act.

Within one month, the registrar may: prohibit the insurer from launching the product; instruct the insurer to stop offering or renewing, by giving 90 day notice of cancellation from a date determined by the registrar; and require the insurer to make amendments.

Reporting structures

The new regulations propose enhanced regulatory reporting and monitoring.

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or launched on or after 15 December 2008 to the Registrar (FSB) and the Registrar of Medical Schemes. The same process will then be followed as described above, with the exception that the Registrar and the Registrar of Medical Schemes will have three months to complete the process.

These reporting structure proposals have drawn a significant amount of criticism. “The gap cover industry simply cannot ignore the blatant bias and unfounded allegations leveled against it by the CMS and now, simultaneously, subject itself to de-facto regulation by this same entity. “If the CMS demonstrates contemptuous defiance of the Supreme Court of Appeal [the 2008 case], the second highest court in the country, then what hope does a gap cover provider have of receiving an objective assessment by the CMS?”

questions Xelus Specialised Insurance Solutions MD, Michael Settas.

He reiterates that this structure will not provide an objective and balanced product approval process and is substantially worsened by an extremely vague benefit definition of gap cover in these proposed regulations, passing the way to a product approval process that will be prone to prejudiced conjecture rather than adherence to a clearly pre-defined set of criteria.

It is also perhaps worth mentioning that at the time of writing, the current CMS CEO and Registrar for Medical Schemes, Monwabisi Qantsha, has been suspended on allegations of corruption. The outcome of this is yet to be determined, and CMS chief financial officer, Daniel Lehrhotz, has been appointed acting chief executive and registrar of the CMS, if it does highlight the potential pitfalls of giving one individual this kind of approval power. Particularly within the entity which previously tried to ban these products.

Requiring approval from the CMS certainly seems to push health insurance into the business of a medical scheme. “The current legislation under FAIS and FSB is an excellent mechanism, and I wouldn’t see the logic of moving this type of insurance to be governed by the CMS,” adds Singleton.

At the heart of it

The crux of the matter is that quality, timeous healthcare in South Africa is pricey. Intermediaries wishing to ensure that their clients are comprehensively covered against the risk of these sky-high medical costs will use the array of products available to ensure their clients are protected.

Gap cover in particular has proven that it is valuable and appreciated by consumers in the South African market. All of this scrutiny on gap cover has highlighted the problems and weaknesses of medical aids. There are incredibly high costs in the healthcare industry, and medical aid members are being left out of pocket. Premiums contributions are high, because thanks to technological advances and exorbitant specialist fees, medical inflation is moving faster than consumer inflation.

The question remains, if the CMS was successful in banning gap cover as it aimed to in 2006, how would this have helped to lower the cost of specialist fees? Unfortunately the CMS declined to comment when approached by RISKS.A. “There are systemic problems with medical schemes and this piecemeal approach is like applying a sticking plaster to a gaping wound. The crux of the matter is that access to quality health is unaffordable for the majority of South Africans. We have a shortage of doctors and the few that we have can charge high fees, because demand is higher than supply. Compounding this problem of unregulated prices is the burden of disease, and medical schemes that are priced out of reach,” concludes Van Pletzen.

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The demarcation timeline

2006
Guardrisk faces court action when registrar of medical schemes Patrick Masobe files for a declaration order at the Johannesburg High Court to stop the company from “conducting medical schemes business” in contravention of the Medical Schemes Act.

2008
The Council for Medical Schemes (CMS) loses its court battle at the Supreme Court of Appeal, with leave to appeal the Constitutional Court. The Supreme Court stated that gap cover was legal and has a role to play in the South African market.

2012
March, first draft demarcation regulations published for comment. Prohibition of gap cover products and hospital cash plan products was proposed.

2013
October, National Treasury published the 343 comments received decrying the proposal of banning gap cover, as it is a valuable product in the market. Treasury says gap cover will stay, but structural changes will be required.

2014
May, National Treasury releases the second draft regulations on the demarcation between health insurance policies and medical schemes. Industry stakeholders call for greater clarity.

Going forward in a nutshell:

Medical aid schemes: Don’t drop medical aid in favour of hospital cash plans. Stopping medical aid to save costs and then attempting to get back onto a scheme will result in an individual being underwritten and paying a late-joining penalty.

Gap cover providers: Business continues as usual, policies remain unchanged. “There are a large number of gap policyholders who have contracts in place. These contracts will continue to be managed in accordance with the policy conditions. This position will only change once the current demarcation debate has been finalised following discussion and debate with all stakeholders,” says Tony Singleton, CEO at Turnberry.

CMS: Declined to comment. The CMS advised RISERA that the task team dealing with demarcation had not yet formulated its response to the last draft as it had until July 7 to comment. We were also directed to the Department of Health, which had not responded to questions or requests for an interview by the time of going to print.

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