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‘Health is like money, we never have a true idea of its value until we lose it’

Josh Billings

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Message from John’s Desk

Welcome to May’s Newsflash. In this month’s edition we bring you the latest health insurance news, and a reminder to all Discovery Delta members on chronic medication to familiarise themselves with the MedXpress process.

For more information on any of the topics contained in this newsflash, contact your PSG Employee Benefits advisor.

Treasury takes the knife to health insurance policies

INSURANCE plans that combine cover for hospitalisation with benefits for primary healthcare will be closed down, potentially leaving thousands of low-income earners to rely on overburdened state facilities for basic healthcare, if the second draft of the demarcation regulations under the Short-Term Insurance and the Long-Term Insurance Acts are adopted. The proposed regulations, which were published last week, are the second attempt at clearly defining the business of a medical scheme versus that of health insurance. The proposed regulations allow for the continuation of gap-cover policies for medical scheme members. These policies have been under threat of being banned for the past two years. But gap-cover policies will be subject to an annual benefit limit of R50 000 and will not be able to pay the actual amount of an out-of-pocket medical expense, the draft regulations propose. Currently, gap-cover products cover the exact difference between what a health practitioner charges and what a medical scheme pays. National Treasury said the aim of the proposed conditions for health insurance products is to ensure that these policies provide additional protection against health-related risks that complement medical schemes without undermining the social solidarity that schemes provide by pooling contributions and covering claims. Insurers will be allowed to sell hospital cash plans if the benefits are limited to R3 000 a day. But if the regulations are adopted as proposed, they will stop the sale of new combined policies and phase out existing ones. These policies combine hospital cash plans, or plans that cover hospitalisation after an accident, with access to a network of general practitioners and limited benefits for medicine, optometry, dentistry, radiology and pathology. The providers of combined policies include Day1Health, EssentialMed and OnePlan. They are also put together for large employer groups or industry sectors. The National Bargaining Council for Road Freight and Logistics, for example, uses such a plan to provide some 90 000 truck drivers with ambulance and private hospital care after an accident, as well as primary healthcare benefits, for R90 a month. The cheapest medical scheme options typically cost more than R700 a month, but have unlimited cover the prescribed minimum benefits (PMBs), which cover all medical emergencies and life-threatening conditions, as well as a number of chronic conditions. Medical schemes argue that combined health insurance plans undermine their business because they

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typically attract younger, healthier people. Medical schemes rely on the young and healthy to subsidise the healthcare costs of the sick and elderly because schemes are prohibited from basing contributions on one's state of health or denying membership. Medical schemes also argue that gap-cover products undermine schemes by allowing the young and healthy to join low-cost medical scheme options and then to top up with gap cover.

Medical scheme members have increasingly turned to gap cover because of the growing shortfall between what medical practitioners charge and what schemes pay out. This shortfall is largely a result of the absence of official guidelines for medical tariffs. If the draft regulations are adopted gap-cover policies will be allowed to provide cover for these shortfalls only as a pre-determined benefit stated in rands, for a particular health "event". This, together with the R50 000 benefit limit, could leave some shortfalls in medical cover. The proposed regulations are the second attempt at demarcating the business of medical schemes and health insurance. The first draft regulations, which were published more than two years ago, proposed banning gap cover outright and limiting to 70 percent of net daily income the benefits of policies that pay a cash amount for days spent in hospital. The first draft attracted much criticism for banning insurance products that filled the needs of both medical scheme members exposed to shortfalls in their cover and low-income earners who cannot afford medical scheme membership. Treasury says the second draft of the regulations takes into account the comments received. The second draft of the regulations proposes the following:

- No health insurance policies will be allowed to base premiums on age or state of health. Currently, the premiums of most gap-cover policies are not based on age or health.
- Brokers or financial advisers who sell health insurance products will be subject to the same commission limit that applies to medical scheme brokers and advisers. This limit is three percent of contributions, to a maximum of R69 a month (excluding VAT). The regulation of commissions is aimed at introducing parity between medical schemes and health insurance and limits product providers from incentivising brokers to sell health insurance products instead of medical scheme membership, according to Reshma Sheoraj, the director of insurance at National Treasury.
- Policies covering medical expense shortfalls, such as gap-cover policies, will provide benefits for medical expenses that are not covered by the PMBs, or that are covered by the PMBs but are not paid for in full by a medical scheme. Sheoraj said gap-cover policies will be allowed to pay only the difference between the cover provided by a scheme for a PMB and the cost of the service when a scheme does not pay these costs in full. Schemes are obliged to pay for PMBs in full, unless the scheme has appointed a designated service provider to provide PMB services and a member voluntarily uses a different provider.
- Gap cover will have to be provided as a contract that is renewed annually and for which the premiums are paid monthly.
- The benefit limits of R3 000 (cash plans) and R50 000 (gap cover) will escalate annually in line with inflation, as measured by the consumer price index (CPI). Medical inflation is typically higher than CPI, so benefits that are close to the maximums could erode over time.

Sheoraj said the aim of the R50 000 limit on gap cover is to reduce some of the cost pressures on medical schemes, while also removing the scope for healthcare providers to set their prices based on how much gap cover their patients have. The proposed conditions in the draft regulations are likely to affect the premiums of the insurance policies that need to comply with them. Sheoraj said the regulations will not affect dread disease policies, which pay a lump-sum benefit or an annuity income when one is diagnosed with a severe illness, such as cancer or heart disease.

Closure of combined health insurance products will be 'a disaster' for policyholders



The closure of combined health insurance products will be disastrous for more than 200 000 policyholders and a tragedy for the country, according to Richard Blackman, the chief executive of Day1Health. Day1Health's combination of primary healthcare cover and hospital insurance provides cover for 22 000 lives. He said that if the draft demarcation regulations under the insurance laws are implemented, it will undermine competition in the healthcare market and destroy an important aspect of private healthcare funding before the Competition Commission has begun its inquiry into the sector. Blackman said the combined products save costs in the public healthcare sector, and National Health Insurance is not ready to provide for those who use them, whereas

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expensive medical schemes cover only about 8.5 million lives. He said the health insurance industry and everyone who is concerned about the provision of healthcare should oppose the regulations. Both Blackman and Tiago de Carvalho, the managing director of Ambledown, which underwrites health insurance policies, said the proposal to close the products goes against the constitution, which guarantees access to healthcare. De Carvalho said medical schemes are a luxury, and nothing has been done to develop a low-income medical scheme option. The Board of Healthcare Funders (BHF) said it is pleased with the extent to which National Treasury, in the draft regulations, has supported the principles that underpin schemes. Heidi Kruger, the spokesperson for the BHF, said the BHF believes medical schemes are the correct vehicle for funding healthcare, but until reforms are implemented to make schemes affordable to more people, there is a place for gap/shortfall insurance products and some hospital cash plans. Although the proposal to ban risk-rating in health insurance products is laudable, Kruger said there may be unintended consequences in that the cost of gap cover and hospital cash plans may rise. This could make them less affordable and thereby potentially increase medical scheme members' out-of-pocket expenditure. This may result in people relying more on the state or buying down to cheaper medical scheme options, which, in turn, could lead to the consolidation of schemes and options. Herman Schoeman, the managing director of Guardrisk, a subsidiary of MMI and one of the largest providers of gap-cover policies, said the proposed limit of R50 000 on gap-cover benefits probably covers the top two events for which gap-cover policies pay out. Guardrisk has had some claims that are well in excess of R100 000, he said.

Schoeman said a number of things in the draft regulations need to be clarified. However, he still welcomes the fact that the regulations have brought greater clarity on what health insurance products will be allowed in future. Barry Childs, a healthcare actuary with Lighthouse Actuarial Consulting, said the limits on benefits need to be clarified, and it is unclear whether it will be unfair to charge higher premiums by age for health insurance products, or limit cover to a certain age. Childs said the draft guidelines seem to permit products that cover any shortfall in medical scheme benefits apart from the prescribed minimum benefits. This could leave scope for significant product innovation if the insurance products do not contravene the revised definition of the business of a medical scheme.

Contracts will have to favour policyholders' interests



Greater protection for policyholders is proposed in the draft regulations for health insurance policies that fall under the Short-Term Insurance and the Long-Term Insurance Acts. The draft regulations state that no health insurance policy may discriminate directly or indirectly on the basis of race, age, gender, marital status, ethnic or social origin, sexual orientation or state of health, or because one is pregnant or disabled. Insurers will not be allowed to reject claims on these policies on the grounds that one suffered a health event or had a health condition before the cover was taken out (a pre-existing condition). Insurers will not be allowed to cancel cover because one is in poor health or because one submits numerous claims. The waiting periods on these health insurance products will be limited to six months if the regulations are adopted. These health policies will have to have a 90-

day notice period if the insurer wants to withdraw the cover. This measure is designed to prevent insurers from suddenly closing down a product if policyholders claim more than they expected. An insurer will have to explain in clear and easily understandable language what must be disclosed, what it regards as material to assessing the risk posed to it the premiums and the "events" for which one is covered. The draft regulations also propose that no health policies may be identified by the terms "medical" or hospital or derivatives of these words, and insurers may not make out that the policies indemnify one against medical expenses or are a substitute for medical scheme cover.

Existing policies will be allowed to see out their term

National Treasury plans to finalise the draft regulations on health insurance policies by September and to make them effective shortly thereafter, Reshma Sheoraj, the director of insurance at National Treasury, said. The deadline for public comment on the draft regulations is July 7, and Treasury, the Financial Services Board (FSB) and the Council for Medical Schemes will then work together to finalise the regulations. All new policies will have to comply with the final regulations from the effective date. Treasury is considering setting a timeline by which existing policies that do not comply with the final draft regulations will have to comply, or close down. Sheoraj said the FSB expects insurers to warn consumers who take out policies between now and September that the policies are likely to be subject to regulatory changes. The explanatory memorandum to the draft regulations states that the amendment to the definition of a medical scheme, which was made in terms of the Financial Services Laws General Amendment Act last year, will take effect when the regulations are finalised. The amended definition of the business of a medical scheme extends to insurance policies such as gap cover, but health

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insurance policies covered by the draft regulations under the Short-Term and the Long-Term Insurance Acts are exempt from complying with the Medical Schemes Act. All new health insurance policies and existing policies (within three months of the effective date of the regulations) will have to be submitted to the relevant registrar of insurance at the FSB, as well as the Registrar of Medical Schemes at the Council for Medical Schemes, for approval. The registrar will have the authority to instruct the insurer to terminate the product within 90 days, or change the benefits, terms and conditions of the policy in line with the registrar's requirements.

Who may sell what

The second draft regulations provide for the following health insurance policies:

Short-term insurers and life assurers (long-term insurers) will be allowed to provide:

- Lump-sum or income replacement policies that pay out for a health "event". These policies include hospital cash plans.
- Employer group cover for both employees and their dependants for the actual expenses related to treating HIV.
- Cover for the actual expenses of emergency evacuation or transport. Only life assurers will be able to provide cover for frail care. Only short-term insurers will be allowed to provide:
- Cover for shortfalls in medical expenses, such as gap-cover policies.
- Cover for medical expenses incurred when you travel domestically or internationally.
- Cover for the actual medical expenses incurred by a third party as a result of an accident that involves one's motor vehicle or occurs on one's property. Source: *Laura du Preez: Personal Finance, 3 May 2014*



"Unfortunately, you have what we call 'no insurance.'"

Chronic Medication Changes : Discovery



From 1 July, if you are on a Delta Plan, you have full cover for approved chronic medicine when making use of MedXpress to fill your repeat prescriptions.

If you, as a Delta member, decide not to use MedXpress for your monthly chronic medicine repeats, then a **20% co-payment** will apply, which you will have to pay yourself.

Follow these three easy steps to register for

MedXpress:

Step 1 – Clearly mark your prescription with the words “MedXpress” and your membership number.

Step 2 - Email your prescription to medxpress@discovery.co.za or fax it to 011 539 1020

Step 3 - Once the prescription has been received, you will receive you an SMS advising you to call Discovery MedXpress on 0860 99 88 77 to place your order. We'll send you an SMS approximately two hours after you fax or email the prescription to us.

After placing your order, MedXpress will deliver your approved medicines to your door. There is **no cost** charged for the delivery. Source: *Discovery Health*

Contact your **PSG Employee Benefits** advisor for more information on any of the topics contained in this newsflash

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