PSG KONSULT CORPORATE

Linking your healthcare options

NEWSFLASH

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DRAFT DEMARCATION REGULATIONS -THE WRONG PREMISES-

John Cranke, Regional Manager of PSG Konsult Corporate 'PSGK Corporate', explains why he believes the proposed Draft Demarcation Regulations are based on inaccurate assumptions.

"Although we are in agreement with the broad positioning of the Draft Regulations as they pertain to certain health insurance products, we feel that bundling gap cover insurance with other health insurance products is fundamentally flawed."

Why have draft regulations been formulated?

The Department of Treasury believes that:

- Health insurance products harm medical schemes by drawing away younger and healthier members.
- The Regulations will strengthen and preserve the social solidarity principle that underpins medical schemes.
- In determining whether health insurance products will or will not be allowed to be sold to the public, regard was given to the objectives of the Medical Scheme Act and the current or potential harm that a health insurance policy may cause to the medical schemes environment.

PSGK Corporate points out the following:

- Gap products can only be sold to medical scheme members and not as stand-alone cover (while other health insurance products can be). Gap products are therefore sold purely to complement medical scheme cover, and never to replace it.
- A recent survey conducted by PSGK Corporate showed that of the 1000 respondents, 98.2% are on a medical scheme, with 72.9% also opting to subscribe to Gap Cover. 62% of these members had not changed their medical aid option because of Gap Cover but rather used it to compensate for any shortfalls and as a top up system.
- Gap products are priced across the risk pool at either employer or product specific level (although sometimes there is a premium based on age). For this reason they uphold the social solidarity principles of cross-subsidisation.
- If downgrades impact the cross–subsidy principle then why are schemes allowed to have options? Added to this is the fact that Prescribed Minimum Benefits (PMBs) in principle protect cross-subsidisation.

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

Josh Billings

PSG Konsult Corporate 'PSGK Corporate' is part of the PSG Konsult Group - one of the largest independent financial services providers in South Africa today and focused on serving the SME, institutional and public sector markets.

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Draft Demarcation Regulations continued…

Why we believe gap cover insurance does NOT have the negative impact stated in the draft regulation:

How do members select their options?

- In our experience, very few medical scheme members select cover based purely on need, and often the ***most important consideration is affordability*** (as stated by the Council of Medical Schemes (CMS) themselves in their annual report of 2011/2012).
- The medical needs analysis form, completed by all our consultants when providing assistance to members with the selection of medical scheme options, has been altered to ask what the available budget is for scheme contributions, as one of the opening questions which ***confirm that affordability is the over-riding factor when choosing a scheme option.***
- It is also our experience that members ***rank day-to-day benefits and chronic illness*** benefits ahead of hospital benefits when it comes to selecting options, as these are the high volume items covered by schemes (and are therefore top of mind).
- It is only after the decision regarding a suitable scheme and option has been made that consideration is given to whether the member has sufficient budget to add Gap Cover to also protect themselves against the shortfalls expected for in-hospital cover.

Upgrading and downgrading

Our experience over the past few year-ends is that more members have in fact upgraded their medical scheme cover, to those who downgraded. Moreover, the upgrades are usually due to younger members who originally joined entry level options (due mainly to affordability constraints) moving up to richer options as their incomes increase. The survey shows that those members who did change options did so primarily due to job or lifestyle changes, increased family size or the employer selected medical scheme changing, rather than the introduction of Gap Cover.

As a generalisation, the downgrades are often due to pensioners being forced to seek more affordable options. The reasons for this are that;

- Most pensioners have lost post retirement subsidies (due to buy-outs),
- Medical scheme inflation (and hence the medical scheme increases) has comfortably outstripped inflation, and
- In many cases pensioners' incomes have not kept pace with inflation.

In addition Gap Cover insurers can validate that pensioner members are also more likely to be hospitalised for elective procedures like joint replacements and simply can't afford the shortfalls – or the deductibles / co-payments - which have been introduced by the schemes over the recent past.

How do downgrades affect members?

- Downgrades within a medical scheme generally impact the day-to-day benefits and chronic illness benefits to a far greater degree than hospital benefits because PMB's (of which there are in excess of 270 relating to the in-hospital treatment of life threatening / emergency conditions) have to be covered in full by all options on all medical schemes.
- The difference in hospital benefits usually relates to the imposition of Designated Service Provider (DSP), and in some cases, reimbursement rates.
- However, there is a significant difference on all schemes in the day-to-day benefits and chronic illness benefits. By way of example, the richer options in almost all medical schemes cover members for a number of non-PMB chronic illnesses. In addition, members usually also have access to broader medication formularies.

Due to this, it would therefore make little sense to downgrade one's option in order to replace the lost cover with Gap insurance, as the Gap insurance only covers in-hospital shortfalls.

Draft Demarcation Regulations continued…

Gap Cover is the only way to cover unavoidable shortfalls
Many schemes don't offer cover for in-hospital service providers at anything above 100% of the "scheme rate" – so in the absence of Gap Cover members will always be faced with shortfalls even on the top-of-the-range options. In addition, even on top-of-the-range options few medical schemes offer more than 200% of the MS rate, resulting in costly shortfalls with non PMB hospital admissions. The survey also revealed that 40% of the Gap Cover members had claimed from their policies – 32% of these claimed between R2501 and R5000.

Removing the Gap Cover products would therefore mean that medical scheme members would lose the ability to cover themselves for these shortfalls – and face potential financial hardship in order to meet the same.

Medical Scheme costs are increasing and benefits decreasing
An important concluding point on Gap Cover, is that it's in the absence of some kind of tariff setting agreement/s that medical schemes have introduced a variety of benefit changes/ reductions to remain viable (e.g. reimbursement rates have decreased, deductibles and co-payments introduced for elective procedures). This has severely compromised members' ability to provide affordable comprehensive cover for themselves. This created the need for Gap Cover products. Overall, the insurance products are by nature reactionary – surely the solution lies in addressing the underlying problem the schemes are faced with? The proposals in their current form leave medical scheme members extremely vulnerable to financial loss. This was confirmed in the survey when respondents were asked how they would finance a shortfall of between R5000 and R10 000 in the event of needing surgery - 64% of the respondents said they would need to borrow from the bank and only 20.4% said they could afford the shortfall.

In conclusion, although we are in agreement that there are health insurance products that may be considered as substitutes for medical scheme cover (and have no problem with these being addressed via the Draft Regulations); we are not in agreement with the premises on which the proposed exclusion of Gap Cover is based. They are fundamentally flawed and require further investigation and discussion.

John Cranke –PSG Konsult Corporate

14 JUNE 2012 IS WORLD BLOOD DONOR DAY

On 14 June, countries worldwide celebrate World Blood Donor Day with events to raise awareness of the need for safe blood and blood products, and to thank voluntary unpaid blood donors for their life-saving gifts of blood.

The theme of the 2012 World Blood Donor Day campaign, **"Every blood donor is a hero"** focuses on the idea that every one of us can become a hero by giving blood. While recognising the silent and unsung heroes who save lives every day through their blood donations, the theme also strongly encourages more people all over the world to donate blood voluntarily and regularly.

If you are in good health and between the ages of 16 and 65, weigh more than 50 kg, and lead a sexually safe lifestyle, make your way to your nearest donor centre to assist the South African National Blood Services in reaching their goal of collecting 65 000 units of blood this month.

Contact your PSG Konsult Corporate advisor for more information
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