Demarcation Products: Yes or No?

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Council for Medical Schemes

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Definitions

- **Prescribed Minimum Benefits**: Compulsory Benefits (270 DTPs + 26 CDLs) enjoyed by scheme members irrespective of option and have to be paid in FULL. Co-payments charged if there is deviation from scheme rules
- **Low Cost Benefit Option (also LIMS):** Set of benefits, Less than what is covered in PMB's, Aimed at Low income earners.
- **Demarcation Products**: Products doing the business of a Medical Scheme, Outside the MSA, Less than what is covered by PMB's, Offered by Insurer's
- **Bargaining Chamber Schemes:** Schemes attached to seasonal employers, providing less than what is covered under PMB, Regulated under MSA through Section 8(h) exemption
- **Schemes outside the CMS regulatory umbrella:** Schemes doing the business of a Medical Scheme, not registered or regulated by the CMS

Historical Background

- Existence of insurance products doing the business of a Medical Scheme, predates the MSA 131 of 1998.
- Regulatory Arbitrage “FSB or CMS or Operate unregulated”
- Consensus Treasury/ Health that FSB/FSCA: regulate insurance products & CMS: regulate entities doing the business of a medical scheme
- Demarcation Regulations aimed at addressing this issue through:
  - Referring all insurance product for regulation under FSCA
  - Referring medical scheme products to the CMS for temporary exemption from complying with MSA through an exemption framework
  - Developing a Guidance Framework for the Low Cost Benefit Option, which will be the final destination of these products under the MSA
- CMS concerned about schemes operating outside the MSA and CMS regulatory umbrella

Historical Background – Part 2

- When the Medical Schemes Act No 131 of 1998 came into effect, it introduced open enrolment, community rating, statutory solvency requirements, and the introduction of a comprehensive package of hospital and chronic outpatient services that all medical aid schemes are compelled to provide ('prescribed minimum benefits');
- This increased the cost of medical aid and resulted in lower income households not able to afford medical aid.
- This gap was identified by insurance companies by providing low-cost insurance options like primary care and hospital cash-back plans to the low-income market.
- These health insurance products were however undermining the long-term viability of medical schemes by attracting the young and healthy members away from medical schemes and thus leaving behind older and more sickly members.

Historical Background – Part 2

- To address this concern, consultation between the CMS, Department of Health and National Treasury started which resulted in the start of the demarcation process.
- On 23 December 2016, National Treasury promulgated the latest version of the Demarcation Regulations (DR) in parliament, for implementation with effect from 1 April 2017;
- The DR provide much needed clarity on the role of a medical scheme (regulated by the Medical Schemes Act of 1998) and health insurance products (regulated by the Long-term and Short-term Insurance Acts of 1998).
- The purpose of the DR was to bring insurance products offering primary healthcare in a more regulated environment under the watch of the Council for Medical Schemes.
- The aim of the DR was to provide a Low Cost Benefit Option to the uninsured market, who was previously denied access to healthcare due to affordability constraints.

Medical scheme vs Insurance

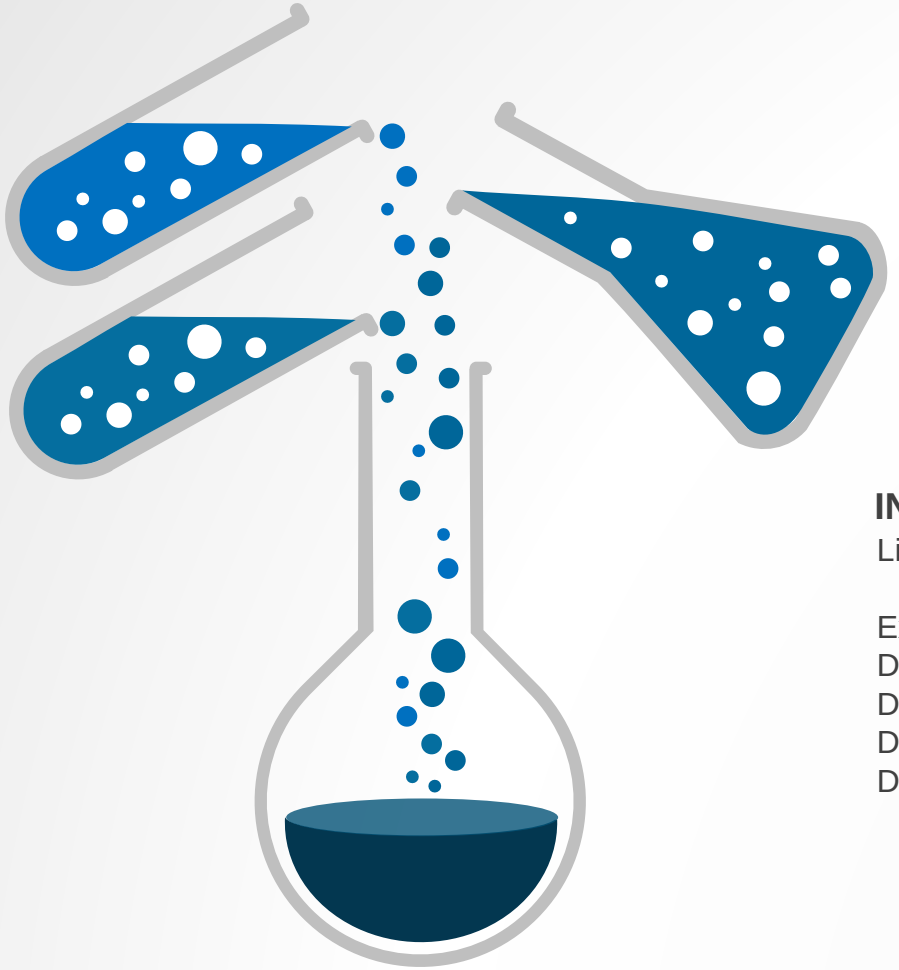
Medical scheme	Insurance
Not for profit entity	For profit entity
Focus is on providing medical care to members	Focus is on creating profits for shareholders
Governed by the Medical Schemes Act	Governed by the Short and/or Long-Term Insurance Act
Owned by members of the medical scheme	Owned by shareholders
Full cover for Prescribed minimum benefits	No cover for Prescribed minimum benefits
No or very high annual limits: based on the option selected	Very low overall annual limits and sub-limits
High in-hospital sub-limits	Low rand amounts per day of stay in hospital (limit of 21 days in hospital)
No maximum entry age (no discrimination)	Products still have maximum entry ages
Open enrolment - open schemes cannot refuse membership; no discrimination;	Membership is still be refused based on risk profile
No discrimination based on age, health status,	Discrimination based on age, health status: some policies cease to exist post the policyholder reaching the age of 55/65;
Universal contribution –all members pay the same contribution according to the selected option and the number of members; • Equal premium contribution for high or low risk members;	Risk rated premium related to: • Age; • Health status;
Accepted by private hospitals for all procedures (elective and emergency)	Most polices only cover for emergencies due to accidents; The hospital will however first request a guarantee of payment (GOP) prior to admission

Benefits on PHC insurance policies

OUT OF HOSPITAL BENEFITS

GP consultations, prescribed medication, chronic medication for specified chronic conditions, basic radiology, pathology, dentistry and optometry.

Benefits are offered via provider networks and for hospitalisation, members of these products would still have to rely on state hospitals.



IN HOSPITAL BENEFITS

Limited benefits offered at daily rates:

Example:
Day 1 - R 7 000 limit
Day 2 - R 5 000 limit
Day 3 – R 3 000 limit
Day 4 – Day 21 – R 1 500 limit

Low Cost Benefit Options: **YES or NO?**

Exemption Application & Renewal Frameworks

Applicable to:

- Insurance policies **doing the business of a medical scheme;**
- Insurance policies **underwritten by registered insurers;**
- Insurance policies **that were in the market as at 31 March 2017;**
- Insurance policies with **active beneficiaries as at 31 March 2017;**
- Renewal Framework: Only applicable to entities that were granted exemption in 2017

Not applicable to:

- Medical scheme products and other non-insurance products;
- Non-insurance products offered by registered medical schemes, administrators or other entities;
- New products that did not exist as at 31 March 2017;
- Policies with no active beneficiaries as at 31 March 2017

Low Cost Benefit Options: **YES or NO?**

Exemption Application Statistics

Details of submissions:	Phase 1 (Initial phase – complete product information not submitted)	Phase 2 (Detailed phase – product information and details of insurer/financial service provider)	Phase 3 – Renewal (Renewal applications)
Due date	31 March 2017	30 June 2017	31 March 2019
Exemption expiry date	31 March 2019 (2 years)	31 March 2019 (2 years)	31 March 2021 (2 years)
Number of exemption application received	38	36	Phase 3 will be submitted to Council for consideration - February 2020
Number of exemption applications approved	35	18	
Number of exemption applications rejected	3	18	
Reasons for rejection	3 applications were not approved on the basis of not doing the business of a medical scheme (e.g. household insurance products);	8 applications: Accident and health policies – not doing the business of a medical scheme. (Accidental injury or death – lump sum payments to beneficiaries) 7 applications: New products – no existing policyholders; 3 applications: Non-insurance products • Products doing the business of a medical scheme, but not registered with the FSCA (Old FSB); • Not provided by registered insurers; • Non-insurance product	
Exemption applications considered by Council	31 May 2017	17 October 2017	
All applicants informed of the exemption application outcome	YES	YES	

Low Cost Benefit Options: **YES or NO?**

Exemption applications post 31 March 2017

- Exemption applications that were submitted post 31 March 2017 and that had no active beneficiaries as at 31 March 2017, were not granted exemption as the exemption criteria was not met.
- Number of exemption applications received: 3
- Number of exemption applications declined: 3
- Reasons: new product, no active policyholders, no exceptional circumstances

- Exemption applications by registered medical schemes were also rejected, as they do not meet the criteria:
  - Products are not insurance products, but medical scheme products;
  - Number of applications:
    - Medshield – 4 options
    - Platinum health – 1 option
    - Umvuzo Health – 1 option
    - Makoti - 1 option
    - CompCare – 1 option
    - Health Squared – 1 option

Low Cost Benefit Options: **YES or NO?**

Progress On Demarcation Exemptions

- Two-phased Application process took-off slowly
- Not all insurers applied within the designated period
- Technical difficulties in developing the Guidance Framework on Low Cost Benefit Option
- Process complicated further by policy developments (Non approval of reviewed PMB's; Rejection of the previous LCBO offering, Prioritisation of the NHI; Delayed PMB Review process)
- Extension of Demarcation period was canvassed and implemented April 2019 for another 2 years
- Extension has not removed the need for CMS and NDOH to provide a Guidance Framework on LCBO
- End Game: Guidance Framework that provides final destination to exempted demarcation products, New LCBO applications
- End Game to deal with Bargaining Chamber Schemes as well as those falling outside the CMS regulatory umbrella

Low Cost Benefit Options: **YES or NO?**

Section 8(h) Exemptions

- Exemption from compliance with the MSA
- Provided by Council on recommendation by Registrar
- “ Exceptional Circumstances” have to be exceptional
- Approval cannot be the default position
- Exceptional Circumstances cannot be “permanent”, but should hold until certain actions to comply are taken
- Regulation by Exemption is poor regulation
- Need to look at member/ beneficiary interests, scheme and industry interests, public interests, broader socio-economic goals

Problem statement

- Develop a Low Cost Benefit Option Guidance Framework/ Equivalent
- Ensure that the exempted and non-exempted Demarcation products are carefully migrated to the LCBO/Equivalent
- Ensure that a mechanism is developed that would ensure that those exempted and non-exempted Demarcation products that wish to proceed and register as medical schemes under MSA are supported to do so
- Ensure that the Bargaining Chamber Schemes that operate inside and outside the MSA are accommodated in this dispensation
- ALL entities that are doing the business of a Medical Scheme should be REGULATED by the CMS under the auspices of the MSA and its regulations

Previous attempts at developing LCBO

- Focused on presenting an affordable subset of the PMB
- Targeted low income earners
- Package was developed with industry inputs
- Presented for approval by the Health Minister
- Rejected on the basis that it did not cover the essential Primary Health Care Services
- Re-tweaking this package was considered by CMS and NOT supported
- The new approach was to determine whether an LCBO was feasible or not, considering the current and future socio-economic circumstances and national health policy trajectory

Discussion Document on LCBO: Circular 28 of 2019

- CMS developed a discussion document on the LCBO
- This approach on LCBO considered all previous publications on the subject, examined previous attempts at developing the LCBO, considered international best practice based on experiences by other countries
- This discussion document also considered the current social and economic circumstances and examined the feasibility and sustainability of an LCBO
- The discussion document was published on the 30TH March 2019, for comment by industry stakeholders
- All the relevant feed back from the industry was considered before the publishing of Circular 80 and 82 in December 2019

Circular 80 of 2019

- Signaling our intention not to allow Low Cost Benefit Option proposals and the Demarcation products beyond March 2021
- Review all options not compliant with the MSA to be wound down before March 2021
- Low Cost Benefit Option Guidance framework: Consider the Comprehensive Primary Healthcare Package as a basis to develop a Comprehensive Single Option across all schemes which would serve as the LCBO Guidance Framework
- Indicated that a detailed report would be published on the 13th December 2019, that fully explains the thinking behind this decision
- Requested inputs from all key stakeholders
- Received a number of inputs for stakeholders: “Let us engage before the implementation of this decision in March 2021”

Circular 82 of 2019

- Circular 82 is based on a detailed report on the Demarcation products, Standardisation of Options, Prescribed Minimum Benefit Review, Health Market Inquiry report
- Detailed report based on the analysis of the exempted Demarcation products vs Medical Schemes
- Report indicates key areas of concern with these products
- Report details why these products may not be desirable in terms of “value for money”
- Provides for inputs by stakeholders
- Feedback received from stakeholders
- Further engagement with key stakeholders planned for Jan - March 2020 in groups and individually where necessary

What we have not done?

- Imposed an immediate ban on all LCBO's
- Stopped any entity from applying for exemption at the CMS on Demarcation products using the Framework
- Stopped any entity from applying for exemption based on Section 8(h)
- Made a decision NOT to engage all affected entities prior to March 2021
- Destroyed the private sector in preparation for the implementation of the NHI
- Denied access to health care

Performance of Demarcation Products

Mr Michael Willie,
General Manager: Research and Monitoring

23 January 2020

Objectives and Data sources

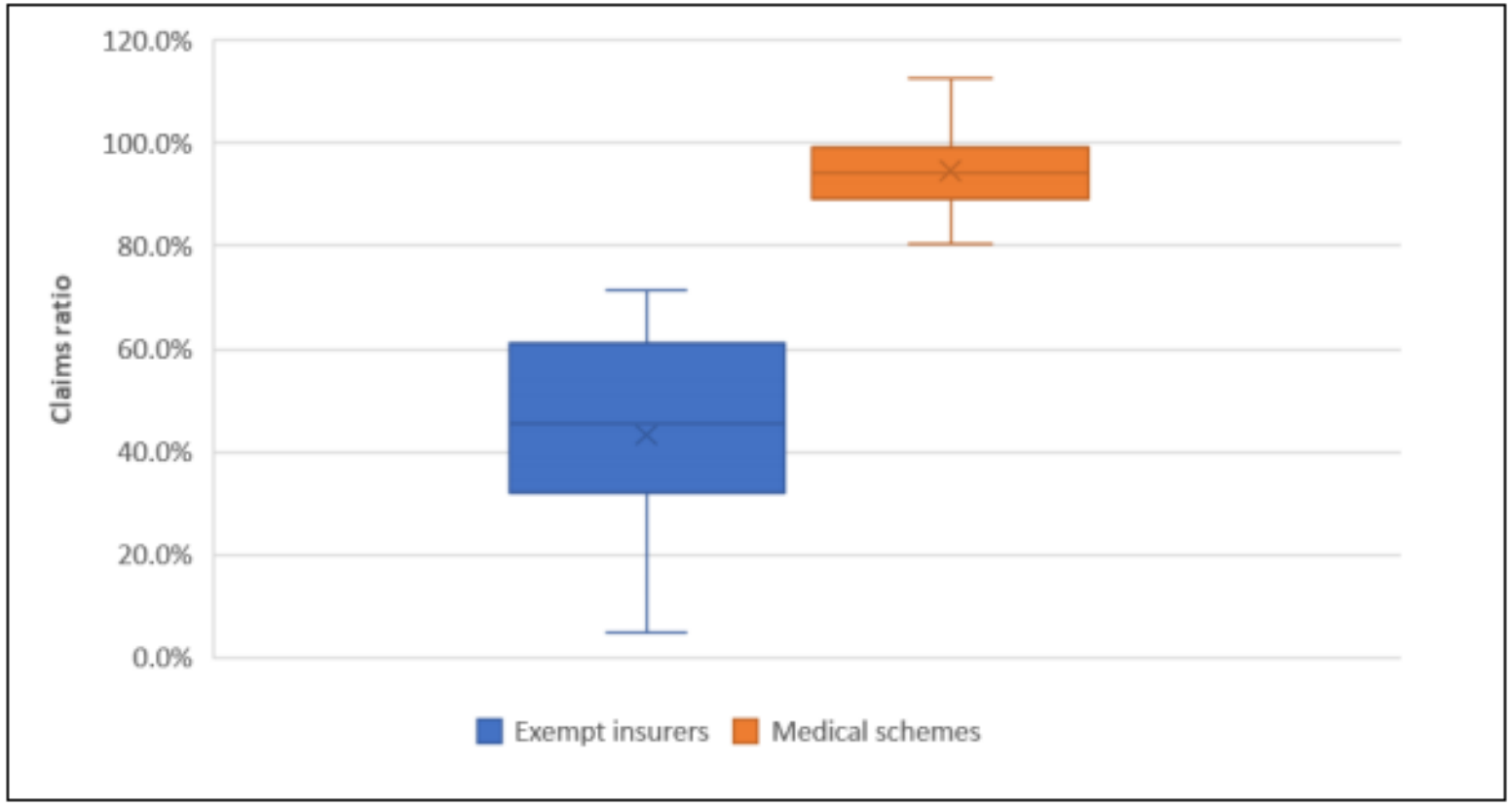
Objectives

- To provide insights of demarcation products
  - Data provided to the CMS
  - Renewal applications
  - Primary healthcare insurance products
- Asses impact on medical scheme risk pools;

Data sources and Methods

- Financial statements (N=9)
- Data submitted
  - 2017 to 2019
- Triangulation
  - Annual statutory returns data
- Descriptive analysis
  - Median
  - Interquartile range

Results- Claims Ratio

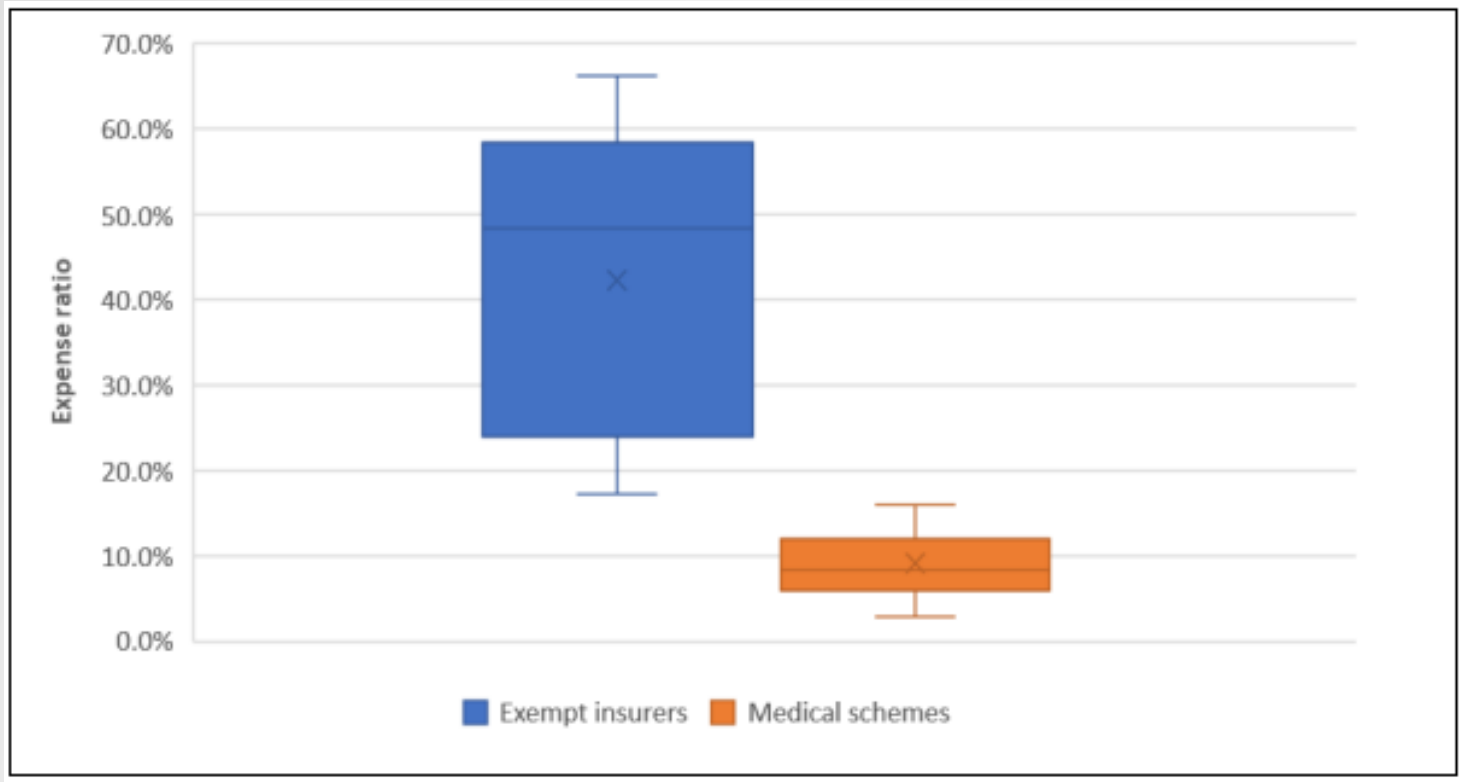


Insurance group	Median claims ratio
Exempt insurers	45.5%
Medical schemes	94.3%

54,5% (EI) vs 5,7%(MS) accounts for Non-relevant health care expense

Low Cost Benefit Options: **YES or NO?**

Non-Healthcare Expense



Medical schemes : 8,4%
Exempted products: 48,4%

Non-Healthcare Expense (MS)

NHE as % of RCI		
Sector	**2017**	**2018**
Open schemes	11,56%	11,52%
Restricted schemes	6,26%	5,95%
Overall Industry	8,23%	9,08%

Administration Cost :83,10%
Broker fees: 14,93%
Net impairment losses: 1,97%
Net Income/(expenses) on commercial reinsurance < 1%

Regulation 28 (2) limits commission payable to brokers

Non-Healthcare Expense (EI) CS

	Average proportion
Administration costs	69,40%
Commission fees	1,00%
Binder fees	0,60%
Third Party service fees	1,60%
Total NHE as % of retail premium	72,60%

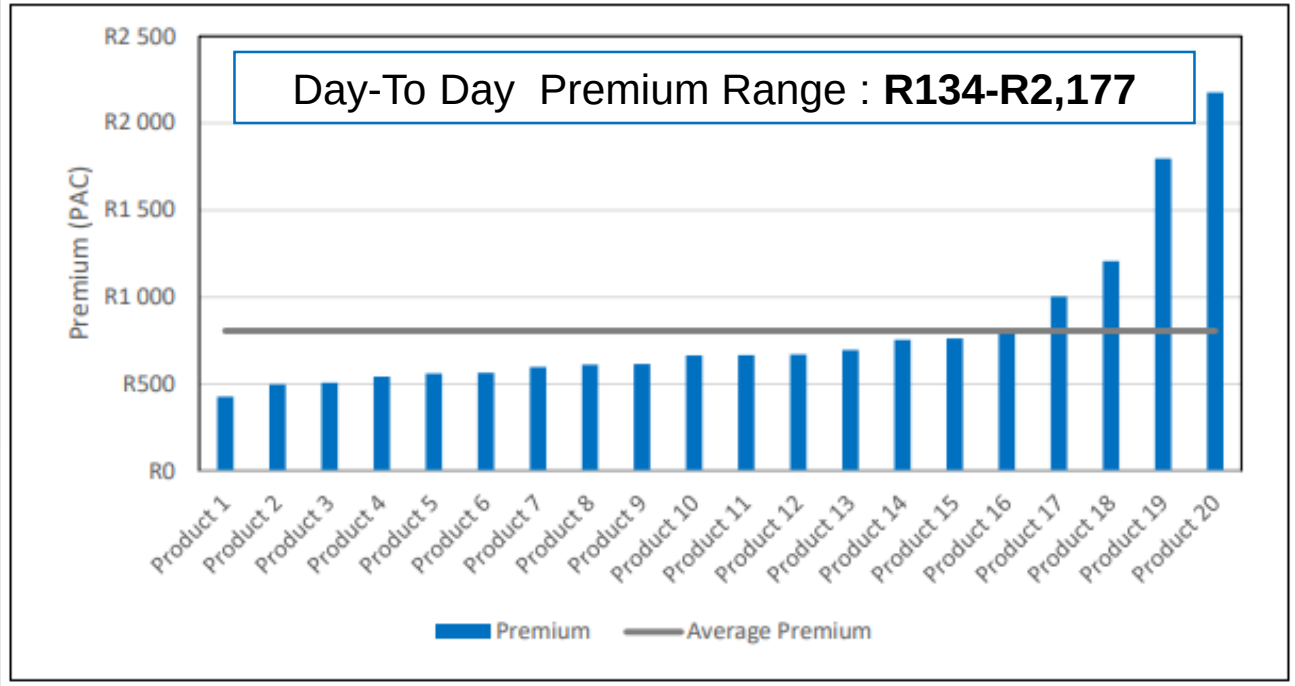
72.6 % of the premium is allocated towards payment of expenses

Possibly unregulated non- healthcare expenses

Benefit Design – Demarcation Products

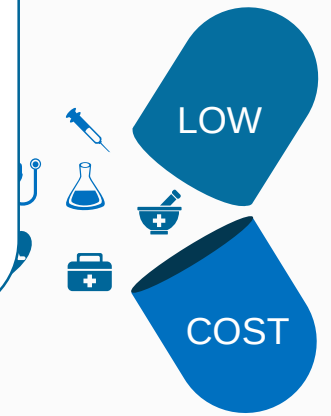
- Day to day:
- Hospital
- Comprehensive
- Limited

- Risk rating
- Promote cherry-picking



Average Cost of a GP visit in Medical Schemes = **R400-R450**

Caters for an average of **3** visits per year



Low Cost Benefit Options: **YES or NO?**

Benefit Design – Demarcation Products

Product Type	Premium Range	Number of products
Day-to-Day	R427-R2 177	20
Hospital product	R134-R1 712	12
Limited insurance product	R86-R1 017	9
Comprehensive insurance product	R638-R3 242	39

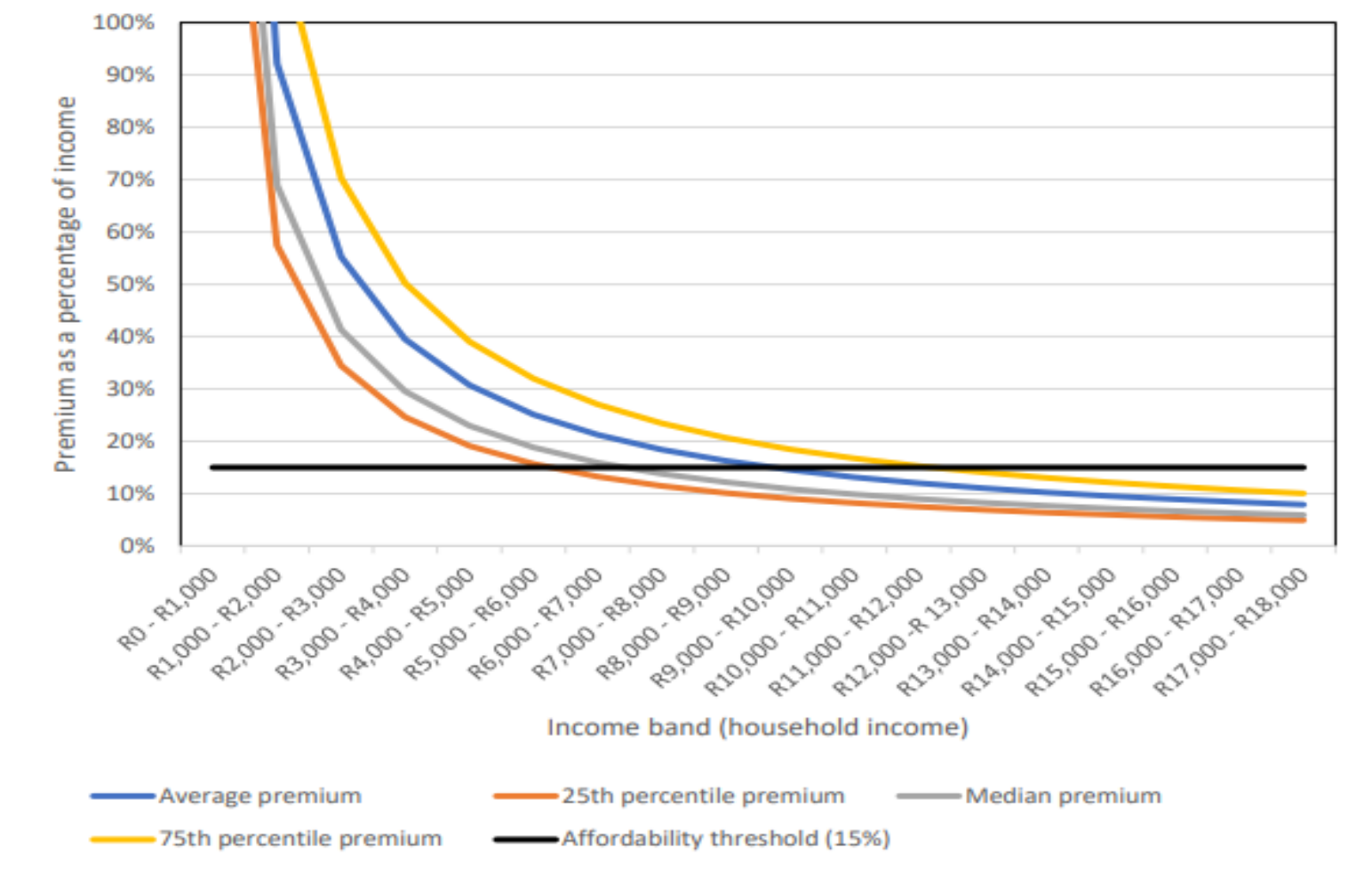
Assume 45% of the premium accounts for healthcare expenses

Only R192 accounts for healthcare benefits

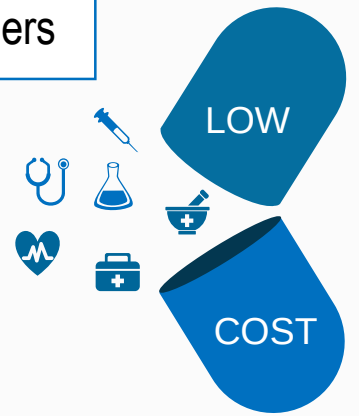
Only R1 459 accounts for healthcare benefits

Low Cost Benefit Options: **YES or NO?**

Socio-economic Impact



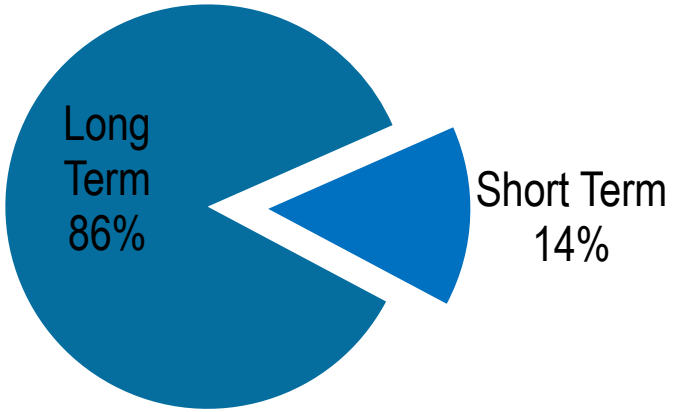
Premium accounts for almost 100% of the income in some cases Increase financial burden on Low Income Earners



Low Cost Benefit Options: **YES or NO?**

Economic Impact- Exempted products

Number of exempted entities : 159
Number of products : 44
Number of lives: 502 000
Median Premium:R560
Average Age: 33 years
Dependency ratio: 0.25 (Mainly covers Main members)



Assume Premium of R560 > R281mil

Assume Premium of R861 > R432mil

Assume Premium of R1 756 > R881mil

Low Cost Benefit Options: **YES or NO?**

Concluding remarks

- Products seem to preform poorly in terms of value for money?
  - Members get less than half of premium for healthcare benefits
- Not aligned to social solidarity principles
- Low levels of regulatory oversight
  - Incentive for brokers is a concern
  - Cherry-picking of young and healthy
  - Price differentials between employer groups and individuals
  - Rating of premium by age

Concluding remarks

- Lack of consistency and transparency in benefit design
- Do not appear to successfully the promise to low income earners
  - Some evidence on lack of affordability
- An industry worth a sizeable impact on the economy but lack regulation
  - Account for nearly a Billion on current exempted products