Module # 1 Component #1

Overview of the SA Health Care Policy and Regulatory Environment

Tasks for this Module

KNOWLEDGE CRITERIA
A brief history of the South African medical scheme evolution since 1998. (T17)
Provide a general overview of the industry and any issues that are currently impacting on the medical schemes. (T1,5,6,7,8)
Explain the legislation that impacts on the South African Health care Industry.
List the pending legislation affecting the SA health care environment. (T17)
Differentiate between insurance cover and medical scheme cover (advantages and disadvantages). (T17)

Purpose

This chapter will provide a broad overview of the basics of the health policy of South Africa. It covers the legislative environment, health care products and the stakeholders.

The medical scheme industry is covered in the context of current funding mechanisms of health care in South Africa.

It also provides knowledge of the governance, products and operations of medical schemes.

Please note that any reference to:
- masculine gender implies also the feminine
- singular indicates also the plural, and vice-versa.

Glossary of Terms

The Act: The Medical Schemes Act No.131 of 1998 and Amendments

Administration costs: the costs incurred for administration services such as claim processing, billing and overhead costs. Administration costs are usually expressed as a percentage of premiums.

Ambulatory care: health services that do not require hospitalisation

Benefits: health services covered under a medical scheme contract

Beneficiaries: all the individuals covered by a medical scheme including principal members and their dependants

BHF: Board of Health care Funders

Capitation: a pre-determined Rand amount per covered person. This usually refers to a negotiated monthly payment per covered person paid to a medical care provider. In return for the capitation payment, the provider assumes responsibility for the provision of health services for that person for the agreed time period.

Claims experience: the experience the medical plan or group has for total Health-related claims for a specific period.

Community rating: the process of developing premium rates based on the overall community (or plan) claims experience rather than on group-specific claims data.

Contribution: the consideration paid to a scheme for providing coverage.
Council: the Council for Medical Schemes

Demographics: refers to the demographic mix, primarily referring to age and sex, of the members within a group/medical scheme.

Drug formulary: listing of prescribed medications covered in medical scheme benefits.

FAIS Act: the Financial Advisory and Intermediary Services Act, 2002

Fee-for-service: a form of payment to health care providers where the providers receive payment on a per service basis. This payment form is generally contrasted with capitation payment.

Fee schedule: a listing of procedure codes for medical services with pre-set tariff amounts per code.

FSCA: Financial Services Conduct Authority

FSP: licensed financial service provider, intermediary, broker

Generic drug: a chemical equivalent but cheaper version of a brand original name drug.

General Code: FAIS ACT: General Code of Conduct for Authorised of Conduct Financial Services Providers and Representatives

Member: the contract holder responsible for paying premiums to the medical scheme

NHI: National Health Insurance

NHRPL: National Health Reference Price List

Open enrolment: a principle whereby no underwriting is applied to medical scheme applicants

Outcomes: the results of medical services usually measured as an improvement in health status

Out-of-pocket costs: are amounts which members are required to pay for medical coverage. These could arise as a result of co-payments, deductibles, benefit limits or exclusions.

Registrar: Registrar of the Council for Medical Schemes

Regulations: Regulations in terms of the Medical Schemes Act, 1998 and Amendments

Risk analysis: the process of evaluating the expected medical care costs for a group and determining what product, benefit level and price to offer in order to best meet the needs of the group.

Service providers: doctor, pharmacist, dentist, physiotherapist, hospital, etc.

Underwriting: a prospective risk assessment for the purposes of determining contribution premium level and/or benefit eligibility.

Waiting period: a time period which must elapse following a member's enrolment before which they are eligible to submit a claim. This may apply to non-emergency services only.

Evolution of the Medical Scheme Industry

Introduction

The first medical scheme in South Africa was established by the employees of the De Beers Consolidated Mines in 1889. Since that time there has been a proliferation of medical scheme-type entities in various forms.

From 1956, schemes had to register as "friendly societies" under the Minister of Finance in terms of the Friendly Societies Act 25 of 1956, but there was no statutory control or coordination of these entities by the Ministry of Health from a perspective of health policy.

At the time that the "old" Medical Schemes Act, 1967 was approved by Parliament, there were 256 such schemes, covering 1.87 million of a total white population of approximately 3.25 million. This Act sought to regulate and coordinate the functioning of the two most important medical scheme-type entities providing financial protection in respect of health services, namely medical aid schemes and medical benefit schemes.

The 1993 "risk-rated" environment

1993 saw major changes to the Act with a primary focus on deregulation in the industry. The changes included:

- ☑ the abolition of compulsory direct payment to providers of services.
- ☑ the abolition of the statutory status of RAMS and the scale of benefits.
- ☑ that schemes could vary benefit levels and structures as they saw fit.
- ☑ that medical schemes were allowed to operate pharmacies, hospitals and similar health establishments.

The effects of the 1993 deregulation were the following:

- ☑ Benefits for the elderly were diminished with the 1993 deregulation
- ☑ Benefit structures attracted the young and healthy members
- ☑ High-risk individuals and groups were discouraged by loading their premiums on the basis of risk profile.

The 1998 "New" Medical Schemes Act

The 1998 "new" Medical Schemes Act was legislated and introduced significant changes regarding benefits, risk management methodologies and regulatory control. The Act:

- ☑ Introduced the Prescribed Minimum Benefits which were compulsory benefits for all medical scheme options.
- ☑ Prohibits discrimination of membership on the basis of age, medical history and health status.
- ☑ Requires that contributions be determined only on the basis of income and/or number of dependants.
- ☑ Enables schemes and public hospitals to have an agreement for the provision of minimum benefits to its members with payment for hospitals.
- ☑ Forbids schemes from excluding applicants or their dependants for membership, except on certain prescribed conditions.
- ☑ Regulates and accredits contractors to medical schemes, e.g. administrators, managed care organisations and brokers.

The new legislation is aligned with national health policy and is concerned with increased equity of access to medical scheme membership within a cross-subsidised environment of contributions between the elderly and the young, the healthy and the sick and between low and high income earners.

While the 1993 changes to the Act allowed detailed and individual-specific risk rating and many variations in both the level and structuring of benefits, the 1998 changes brought about community risk rating and more controlled levels and structuring of benefits. The focus has shifted to managing risk within the medical scheme population without risk rating and underwriting.

The 1998 new Act provides for the Council for Medical Schemes to be more purposeful and consumer-oriented in its functions with a defined focus on the protection of the interests of medical scheme members.
The Act also introduced the concept of the business of a medical scheme and that of relevant health services.

The South African Health Care Industry

The South African health system consists of a combination of two systems (dual system) to serve the health needs of the country.

- ☑ A large public sector, mainly catering for all people who do not have access to private sector health care
- ☑ A private sector looking after the health needs of people having access to private sector health care.

Out of a total population in South Africa of 57 million, (Statistics SA, 4), the private sector only provides health care services to approximately 8 million people or 16% of the population. The public sector provides health care to 84% of the population.

Funding of Health Services

The reality of providing access to and the delivery of health care services to patients entering the health care system is that it needs to be funded from somewhere. In South Africa the current system of funding of health care mirrors the dualistic nature of the current delivery system:

- ☑ The public health care sector is funded from the national budget. Expenditure on health remains a key priority for government, with R205.4bn to be spent in 2018/19, an allocation projected to rise by an average of 7.8% per year in the medium term. This makes health expenditure the third biggest item in terms of consolidated state expenditure (after education and social development), with 12.3% of total expenditure allocated to health. The R205.4bn allocation is split between the following focus areas: district health services (R90.2bn), central hospital services (R38.6bn), provincial hospital services (R34.3bn), other health services (R33.8bn) and facilities management & maintenance (R8.5bn).

- ☑ The private health care sector access is funded through a funding vehicle called medical schemes. Funds are voluntary contributions from members and employers. The average gross contribution increase for all medical schemes in 2017 was 11.3%. On average, restricted schemes instituted larger increases in contributions (12.0%) than open schemes (10.8%).The gross contribution increase is based on the actual number of principal members as well as adult and child dependants

These statistics have always been used as follows in the equity debate:

- ☑ 55% of the total expenditure in health care in South Africa is used to serve 84% of the population who are mainly dependent on the services provided through the public sector (state).
- ☑ The other 45% of expenditure on health care is spent in the private sector to serve only 16% of the population.

In other words, the inequitable distribution of financial resources to the private sector serving only 16% of the population has always been questioned by policymakers and forms the basis around which health reform is motivated.

This inequitable distribution of resources favouring the private health care sector does not only refer to financial resources, but extends to human resources, including doctors, nurses, pharmacists and technology, which also includes high-tech diagnostic equipment.

The General Funding Mechanisms for Health Care in South Africa

The funding of the public and private sector systems in our country is completely different:

The public health care system is funded by government through a general tax allocation. South Africa currently spends 8.8 % of GDP on healthcare

User fees are raised by public sector health facilities and hospitals for people with the financial means to pay but electing not to be a member of a medical scheme and to use the public health sector. The user fees have a strong cost-recovery purpose, but the system of charging user fees is still inefficient.

Private individuals access health care in the private sector mainly through the medical scheme funding mechanism. This funding through medical schemes is based on a voluntary membership to a medical scheme.

- ☑ The member pays monthly contributions to the medical scheme.
- ☑ In return, the member is eligible to receive certain benefits to fund the cost of receiving health care in either the public or private sector (although medical scheme members usually utilise the private sector doctors and facilities).
- ☑ The specific benefits a member is entitled to are determined by the rules of the medical scheme.
- ☑ The monthly contribution carries a capped tax rebate.
- ☑ Members can still have out-of-pocket costs, as benefits often do not cover the total costs of the health services received or fees charged by health professionals.

Certain individuals choose not to contribute towards a medical scheme, but elect to manage their personal financial risk through a health insurance product. This alternative is to provide for the financial risk associated with an adverse health situation through purchasing a health insurance product. These products are very different from medical scheme products. The benefits of these products cover certain health events, which are clearly stipulated in the contract.

The reality is that many individuals don't have any type of medical scheme or insurance cover for health care and access care in the private sector by personally carrying the financial burden. This is mainly restricted to out-of-hospital or ambulatory primary care services. This represents a level of self-funding.

The Legislative Environment in Health Care

The health care industry is a complex and highly-regulated environment. There is different important legislation involved:

National Health Act, 2003 (Act 61 of 2003)

The National Health Act, 2003, provides a framework for a single health system for South Africa. It highlights the rights and responsibilities of health providers and health care users, and ensures broader community participation in health care delivery from a health facility level up to national level. It establishes provincial health services and outlines the general functions of provincial health departments.

The National Health Act provides for the right:

- ☑ to emergency medical treatment.
- ☑ to have full knowledge of one's health condition.
- ☑ to exercise one's informed consent.
- ☑ to participate in decisions regarding one's health.
- ☑ to be informed when one is participating in research.
- ☑ to confidentiality and access to health records.
- ☑ to complain about service.
- ☑ of health workers to be treated with respect.

The Medical Schemes Act

The Medical Schemes Act was passed in November 1998. The new Act repeals in full the Medical Schemes Act, 72 of 1967, and all the Amendments to that Act which followed. The new Act has been in effect since January 2000.

The Medical Schemes Act and Regulations aim to widen access to private health care, which is consistent with the aims of government policy. At the moment, only about 16% of South Africans have regular access to health care in the private sector.

The Act also:

- ☑ aims to improve governance and management of medical schemes.
- ☑ aims to improve and maintain the solvency of medical schemes.
- ☑ prohibits any unfair discrimination, either directly or indirectly, against any person, based on their age, gender, claims experience, or past or present state of health. This means that medical schemes cannot exclude people with any chronic condition or for being HIV-positive.

Medicines and Related Substances Control Act

This act makes provision for the establishment of the Medicines Control Council (MCC). The MCC is a statutory body with a purpose to oversee the regulation of medicines in South Africa. It is appointed by the Minister of Health and its main purpose is to safeguard and protect the public through ensuring that all medicines that are sold and used in South Africa are safe, therapeutically-effective and consistently meet acceptable standards of quality.

Acts Regulating Health Professions

These different acts make provision for the registration and regulation of health professionals. To be able to provide "relevant health services" within the context of the Act, professionals need to be registered with the appropriate professional board as is legislated for in the different acts.

- ☑ Medical, Dental and Supplementary Health Services Professions Act
- ☑ Pharmacy Act
- ☑ Nursing Act

The Medical Schemes Act, no 131 of 1998

This legislation is based on the principles of open access and community rating. This means that medical schemes have to accept all individuals, irrespective of their state of health and age, and premium rates have to be determined on the same basis for everyone.

The main benefits expected to result from the system of community rating are:

- ☑ expanding access to those currently excluded from medical scheme cover.
- ☑ protecting the delivery of cost-effective and necessary health care.
- ☑ better cross-subsidisation of the less healthy by the healthy and of the older by the younger people.
- ☑ curbing schemes from "dumping" members who have used up their benefits onto public sector hospitals.

The Act's provisions are mainly about the ways and means of establishing oversight and regulatory mechanisms and structures to better monitor and control the activities of medical schemes. Provisions in this respect are concerned with broadening the capacity, functions and powers of the Council for Medical Schemes; appointing a Registrar and Deputy Registrar and providing for stricter terms of reference for auditors and brokers. The Act also sets out all the mandatory procedures for the registration and operation of individual medical schemes. The regulations in terms of the Medical Schemes Act, 1998 deal more specifically with provisions for contribution and benefit structures of medical schemes.

The Purpose of the Medical Schemes Act

The Medical Schemes Act reflects the legislative changes that represent underlying changes in government policy regarding health reform.

The main focus of the Act is to:

- ☑ create the Council for Medical Schemes as a juristic person responsible for the regulatory oversight of the medical scheme business environment.
- ☑ make provision for the registration and control of medical schemes, and
- ☑ to create an environment that will protect the interest of members of medical schemes.

It furthermore deals with the regulatory control of:

- ☑ medical schemes.
- ☑ third party administrators.
- ☑ managed care organisations.
- ☑ brokers.

Key Organisation of the Act

The Act consists of twelve (12) chapters and two (2) schedules. The main focus is as follows:

- ☑ To consolidate the laws relating to registered medical schemes
- ☑ To provide for the establishment of the Council for Medical Schemes
- ☑ To provide for the appointment of a Registrar
- ☑ To make provision for the registration and control of medical schemes
- ☑ To protect the interest of members
- ☑ To provide for measures for the co-ordination of medical schemes
- ☑ To provide for incidental matters.

Regulation of Medical Schemes: Council for Medical Schemes

The Act makes provision for the establishment of the Council for Medical Schemes. The alignment with the objectives of the National Health Policy is clearly evidenced in the functions of the Council for Medical Schemes.

The Council for Medical Schemes is a statutory body established by the Medical Schemes Act (131 of 1998) to provide regulatory supervision of private health financing through medical schemes.

Functions of the Council for Medical Schemes

The functions of the Council as stipulated in Section 7 of the Act, clearly gives a mandate and the power to Council to:

- ☑ protect the interests of medical scheme members at all times.
- ☑ control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy.
- ☑ make recommendations to the Minister on criteria for:
  - the measurement of quality and outcomes of the relevant health services provided for by medical schemes.
  - and such other services as the Council may from time to time determine.
- ☑ investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in the Act.
- ☑ collect and disseminate information about medical schemes but also private health care in general.
- ☑ make rules, not inconsistent with the provisions of the Act, for the purpose of the performance of its functions and the exercise of the Council's powers.
- ☑ advise the Minister on any matter concerning medical schemes.
- ☑ perform any other functions conferred on the Council by the Minister or by the Act.

The Act provides that the Council for Medical Schemes will have the powers necessary to carry out its statutory functions and it is clear that the Council has delivered in terms of its mandate.

Governance of Council

The governance of the Council is vested in a board appointed by the Minister of Health, consisting of a non-executive Chairman, a Deputy Chairman and thirteen (13) members. Council members are elected based on their skills and expertise, which include inter alia disciplines of law, accounting, medicine, actuarial sciences, economics and consumer affairs.

The names of those appointed are published in the Government Gazette, also indicating the period of the term of appointment. The Minister also appoints the Chairperson of the Council. The period of office is stipulated as the minister deems necessary but will not be for more than three (3) years. Council members can be re-appointed for a further term.

The individuals appointed to Council must be fit-and-proper and the qualifying criteria, as well as the disqualifying factors, to be able to be appointed as a Council member, as well as what the grounds to vacate the position will be, are specified in the Act.

Management of Council

The executive head of the Council is the Registrar, also appointed by the Minister in terms of the Act. The Registrar's function is the equivalent of a Chief Executive Officer in any organisation. The Council determines overall policy, but the day-to-day decisions and management of staff, the appointment of the necessary staff to support the operations of the Council and the control and evaluation of performance, are the responsibilities of the Registrar and the executive managers.

The Registrar will fulfil his function within the provisions of the Act and policy guidelines from the Council. The powers of the Registrar include:

- ☑ the registration of medical schemes.
- ☑ inspection of reports and documents of medical schemes.
- ☑ address enquiries to medical schemes with regard its business.
- ☑ investigate the business of any entity not registered as a medical scheme, to establish whether that entity constitutes the business of a medical scheme.
- ☑ removal of members of the Board of Trustees from a medical scheme if there is sufficient reason to suspect that such a person is not fit and proper.

Current Developments

The new National Health Insurance Bill and the Medical Schemes Amendment Bill have been introduced, but how will they affect the medical aid sector.

The amendments that have been added are meant to give patients that have financial problems due to the prices of healthcare, relief.

According to the Minister of Health, Medical aid schemes are keeping in reserve R60 billion that is not being made use of.

Around two-thirds of medical schemes pay R2,2 billion to brokers without their knowledge.

The Medical Schemes Amendment Bill that was introduced by the Health Minister highlighting the changes that it will make to the Medical Schemes Act.

Here are the changes:

1. No more co-payments

The first amendment talks about the elimination of co-payments. This means that medical schemes will have to pay the full amount charged to a patient.

2. Goodbye brokers

The amendment bill removes the role of brokers because close to two-thirds of medical scheme clients pay R2,2 billion to brokers without them having any of knowledge of it.

The Minister questioned the role of medical schemes because medical schemes have been stagnant.

3. Take away Prescribed Minimum Benefits

This amendment is the elimination of Prescribed Minimum Benefits (PMBS). PMBs will be replaced by comprehensive service benefits. The new benefits will include services like family planning and screen services. These services are not generally paid for by schemes under the present system

4. Unequal benefit options

The fourth amendment stops any medical scheme from introducing any benefit option without approval from the Registrar of the Council of Medical Schemes. This will decide whether the benefit is in the best interest of the member rather than any other party.

5. Offence for false medical schemes

This amendment makes it an offence for a company to call itself a medical scheme if it has not met the necessary requirements under the Act.

According to the Health Minister, this is in relation to all the health and cash plans that are in the media to sell products that are similar to medical schemes but are not registered with the right authorities.

6. Establishing a central beneficiary registry

This will allow the Registrar of Medical Schemes to understand the trends and behaviour of consumers when they are choosing a medical scheme.

This will include things like age and disease but excludes the consumer's personal information.

7. Income cross-subsidisation model

Keeping with the NHI, the Minister said that medical schemes must make sure that the rich subsidise the poor, the young must subsidise the old and the healthy must subsidise the sick.

8. No profit for medical schemes

Medical schemes should not profit so any savings should be given to patients. Medical schemes require members to visit designated service providers to save money.

The savings are then taken by the scheme or administrator instead of being given to the members as premium reduction.

9. Membership cancelled

This amendment says that penalties for joining a scheme late in life will no longer be allowed. Also, members would have to pay for a period before they were allowed to benefit, however, this is problematic because members would still be paying even after they cancelled their membership.

10. Medical schemes governance

This amendment means that are minimum education requirements before a person can take an executive position in a medical aid scheme.

11. NHI and medical schemes

According to the Department of the NHI is a financing system that will ensure that all citizens of South Africa (and legal long-term residents) are provided with proper healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund.

People that are covered by the medical aid schemes will still have to pay towards the NHI's fund. The bill makes it compulsory for all South Africans that can afford to pay towards the fund contribute to the NHI fund.

Discussion Paper on Brokers

- ☑ brokers who act as agents of a medical scheme or "marketing agents".
- ☑ brokers who act as independent agents of consumers or "independent advisers".

The broker will be accredited with the Council in terms of the Act as one or the other and not both. Once more, the purpose of this is to eliminate potential bias and conflict of interest.

In terms of the proposal:

The marketing agents of medical schemes should:

- ☑ be accredited to be the agents of only one medical scheme at a time and be prohibited from being the agents of any other medical scheme.
- ☑ be paid by the medical scheme concerned and not by the administrator or any other party that may have an interest in marketing any other scheme.
- ☑ operate in terms of a written contract with that medical scheme, which contract may provide for various remuneration types (e.g. salary, commission, etc).
- ☑ not be subject to regulated ceilings on remuneration payable by the medical scheme.
- ☑ be required by law to clearly state to the consumer verbally and in writing that he or she is a marketing agent of a medical scheme and is not an independent adviser.

Independent Advisers

Consumers (individuals or employers) wishing to receive independent advice and assistance vis-à-vis choice of medical scheme and/or ongoing relationship with their medical schemes, should be able to purchase that service independently of the medical scheme.

As with any other service provider, if the consumer sees value in the service, the consumer should be prepared to pay for the service. If the consumer perceives that she or he is no longer receiving value for the service, he or she will not continue paying for the service and will terminate the contract. These independent advisers would therefore operate in terms of a contract negotiated with the consumer, based upon an agreed tariff.
To be consistent with the principle in the employment context, if the party appointing and contracting with the independent adviser is an employer, the employer would pay for the services of the adviser.

If the party appointing and contracting with the independent adviser is an employee, the employee would pay for the services.

This requirement to pay for the services of an independent adviser, while consumers not making use of the service are not required to pay for these services, will ensure that value is provided for money spent on independent health advisers and that the flow of funds to advisers terminates if the advisers stop rendering a satisfactory service or any service at all.

To prevent advice and assistance being tainted by conflict of interest, the independent adviser would not have any contract with any medical scheme or administrator and would not be able to receive any form of remuneration or incentives for broker service or any other type of service directly or indirectly from a medical scheme or administrator. There would be no possibility of schemes or administrators paying extra to bias advice being rendered by these advisers.

Under these circumstances, there would be no need for a regulatory ceiling to be placed on the amounts that may be charged by independent advisers for their services. The market would dictate what is charged, based upon the quality of the service being rendered. However, there would still need to be some regulation of how these payments are structured. For example, if one allowed upfront commission to be charged on admission of a member to a medical scheme, it would still incentivise brokers to churn members between medical schemes and would not encourage ongoing services to be provided. It would therefore be necessary to retain the restriction that no differentiation should be made between the fees charged for admission of a member and fees charged for ongoing services.

It is recognised, that while the requirement for independent advisers to collect fees directly from clients would be easily done in relation to clients who are employers, it may disincentivise brokers to work within the market for individual members because of the cost of collection when weighed up against the relatively small amounts being collected monthly for services rendered. However, this is no

different from other service sectors where relatively small fees are charged but to a potentially high volume of clients. Independent advisers would be able to outsource their debt collection services to debt collection agencies that have the economies of scale to manage such a service.

Health Insurance Products

Health insurance policies are provided by short-term insurers and life offices. These products are not registered as medical schemes and the provisions of the demarcation decisions clearly define the benefits paid from these products.

Difference between medical schemes and health insurance products

The core differences between a medical scheme and health insurance policies are that:

- ☑ medical schemes reimburse their members for actual expenditure on receiving relevant health services from registered health professionals (indemnity business).
- ☑ health insurance policies may not indemnify policyholders against actual medical expenses incurred for relevant health services but must offer a sum assured defined in advance of any health care provision.

The products operate under different legislation:

Health insurance products operate under the Long-term and Short-term Insurance Act.

Medical schemes operate under the Medical Schemes Act.

Regulation differs:

Health insurance products are regulated by the Financial Services Conduct Authority.
Medical schemes are regulated by the Council for Medical Schemes.

A health event is defined as "an event relating to the health of the mind or body of a person or an unborn".

A policy benefit is defined as "one or more sums of money, services or other benefits, including an annuity".

The following table summarises the main differences:

	Health Insurance Products	**Medical Scheme**
Relevant Legislation	Long-term and Short-term Insurance Act	Medical Schemes Act
Regulatory Body	Financial Services Conduct Authority	Council for Medical Schemes
Benefits	Triggered by a diagnosis of a health condition	Triggered by obtaining a relevant health service
Policy Benefit	"one or more sums of money, services or other benefits including an annuity"	Reimbursement for actual expenditure or part thereof for health services obtained (indemnity business)
Underwriting	Allowed, can risk rate	Not allowed, cannot risk rate
Product	Based on a health event	Based on services obtained

Health insurance products **may not:**

- ☑ pay a benefit and there may not be a link between benefits paid to the client and actual medical expenses incurred.
- ☑ provide benefits that are linked to lists of procedure codes, i.e. NHRPL or a list of tariffs associated with the procedure codes.
- ☑ pay benefits directly to a service provider, i.e. a hospital, to cover the cost of an admission, but instead must be paid to the policyholder.

Health insurance products **may:**

- ☑ pay out a percentage of the sum for which a policyholder is assured, depending on the severity of the health event.
- ☑ pay out benefits on a periodic basis.

The insurance industry was reluctant to close the products as the insurance Acts allowed risk rating and the payment of much higher commissions.

Gap Cover

The National Health Reference Price List (NHRPL) is commonly used by medical schemes as the standard for payment or the medical scheme tariff. This tariff is the benefit available to members as reimbursement for services provided by doctors and other service providers. Service providers frequently charge fees that are substantially higher than the NHRPL or medical scheme rate. The difference in the case of a specialist's account during a period of hospitalisation can be significant.

The so-called "gap cover" products were designed to offer cover for the difference between the amount actually charged by a health care provider and the benefit paid by medical schemes.

Guardrisk, a short-term insurer, sold two products, "Admed Gap" and "Admed Pulse" in the market as gap cover products. Council took Guardrisk to court because it was deemed to be doing the "business of a medical scheme".

In a High Court judgment in December 2006, these two products sold by Guardrisk, were found to be doing the "business of a medical scheme".

This original judgment in favour of the CMS and Registrar of Medical Schemes is significant as it confirms the view long-held by the Council that these products were doing "the business of a medical scheme".

During 2008, the Supreme Court of Appeal however found that paragraphs (a), (b) and (c) of the definition of "business of a medical scheme" in the Act should be read conjunctively [(a) AND (b) AND (c)] instead of disjunctively [(a) OR (b) OR (c)]. (Harrison, 2008,1). Therefore as it stands, the business of a medical scheme must include all three aspects as defined. If the wording included the word "or" after each subsection, it would have made it difficult for any other business to compete legally.

This means that, in terms of the current version of the Medical Schemes Act, gap cover products do not fall within the definition of the "business of a medical scheme". They are continued to be sold to cover the difference or gap left between what doctors charge and what the scheme pays as a benefit.

The Council and Registrar are on record as expressing their concerns regarding the likely adverse implications of a conjunctive interpretation for the ongoing protection of a community-rated medical schemes environment. They have recommended to government that an urgent amendment should be made to the definition of "business of a medical scheme" in the Medical Schemes Act.

For many years this issue was not been resolved.

The implication of this ruling is that the products are being sold in the market to help clients to make provision for the shortfall in tariff and benefit payment by medical schemes.

Afterfour years of consultation, Treasury gazetted final demarcation regulations in late December 2016, ending years of uncertainty on the future of gap cover, hospital cash plans and primary healthcare policies.

At the time Finance Minister Pravin Gordhan and Health Minister Aaron Motsoaledi published the final demarcation regulations under the Long-term and Short-term Insurance Acts in December.

The issue at stake has been about where the line should be drawn between medical scheme products and health insurance. Medical scheme products are regulated by the Medical Schemes Act of 1998, and health insurance products are regulated by the Long-term and Short-term Insurance Acts of 1998.

Gap cover, which covers clients for co-payments/shortfalls incurred for in-hospital private doctors' bills, and hospital cash plans, which pay clients a lump sum per day they spend in hospital, will continue to exist, but strict regulations will be enforced from 1 April 2017 with regards to maximum payouts allowed to be made by both these products to their clients.

Existing policies will have to comply with the new regulations from January 2018, and new policies from 1 April 2017.

The new payout limits

The new regulations stipulate that hospital cash-back plans are limited to paying their clients a maximum of R3 000 per day, or a total lump sum of R20 000 per year. Currently there are no limits in place for these payments.

In the past, Motsoaledi criticised gap cover policies, as their existence "gives doctors a free reign to charge much higher tariffs, as they have no need to compete on either price or quality in order to attract patients".

Gap cover policies will now be limited to a payout of R150 000 per annum per client.

Primary healthcare policies to go

Primary healthcare policies are not full medical schemes, and they provide limited medical service benefits, such as GP visits, basic dentistry and optometry, and some acute and chronic medication.

These policies are not governed by the Medical Schemes Act, and because they do not cover private hospitalisation costs, their contributions are much lower than those of full medical schemes, or even hospital plans.

These have been criticised for discouraging people from becoming medical scheme members, thereby contributing to the essential cross-subsidisation within schemes. Medical scheme membership in South Africa has been almost static for the last 20 years, with only 1.4 million new principal members (with 2.2 million beneficiaries) joining since the year 2000.

The medical schemes industry and the Council for Medical Schemes are currently looking at low-cost benefit options (LCBO), which would fall under the Medical Schemes Act, but that would possibly entail having to make changes to the current medical schemes legislation. One of the issues at stake is the stipulation that all schemes have to provide 270 Prescribed Minimum Benefits to all members at cost. This increases the cost of medical-scheme membership, and can make it more difficult for schemes to remain financially viable.

The new regulations outlaw primary healthcare policies from 1 April. These policies are seen as straying into the territory of medical schemes, and will no longer be seen as insurance products, but will have to be amended to comply with the stipulations of the Medical Schemes Act.
The relatively high cost of medical scheme membership is, however, seen as a deterrent to many prospective new members, and it is hoped that the proposed new low-cost benefit options will cover this gap.

Products that are not regarded as doing the business of a medical scheme

Travel insurance

Providing cover for health events occurring outside the border of RSA

Disability insurance that has nothing to do with actual medical costs but provide other benefits, i.e.:

- ☑ lump-sum payouts for disability.
- ☑ income replacement benefits.
- ☑ paying outstanding debts benefits.