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SUBMISSIONS ON DRAFT STATEMENT OF ISSUES OF THE COMPETITION COMMISSION SOUTH AFRICA – MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

1. The persons on whose behalf this document is made ("the stakeholders") are all significant stakeholders in the health insurance industry. These persons are Ambledown Financial Services (Pty) Ltd, Day 1 Health (Pty) Ltd and Stratum Benefits (Pty) Ltd

2. The stakeholders welcome this opportunity to assist the Competition Commission ("the Commission") in framing the issues and/or its terms of reference and to identify factors that prevent, distort or restrict competition in private healthcare.

3. To the extent that any aspect of this representation may be unclear, or may require further comment, it is respectfully requested that the Commission revert to the stakeholders who will be pleased to respond and elaborate.

4. The present submission has been prepared pursuant to the Commission having on **30 May 2014** invited stakeholders and all those who wish to participate to make submissions on the draft statement of issues.

5. The stakeholders take note of potential sources of harm to competition within the private healthcare sector as identified by the Commission (the "theories of harm") and intend to focus this submission on the regulatory framework within the *healthcare finance market*.[1]

6. It is in this regard submitted that there are factors within the market for private healthcare finance that are preventing, distorting or restricting competition and it is regrettable but so, that those factors emanate from the regulatory authority.

7. It is noted that the Commission has expressed a wish to understand the current regulatory framework and how it affects competitive outcomes.[2]

THE CURRENT REGULATORY FRAMEWORK AND HOW IT AFFECTS COMPETITIVE OUTCOMES

8. It is somewhat ironic that more or less at precisely the same moment as the Commission sought to turn is gaze at the regulatory environment within the market of private healthcare finance,

[1] Competition Commission of South Africa, Market Inquiry into the Private Healthcare Sector; Draft Statement of Issues, ("CCDSI") par 5, 27 - 34
[2] CCDSI, par 69

that the regulator should have caused that market to undergo profound anti-competitive change. That however, is the case.

9. On 30 April 2014 the National Treasury ("NT") released for public comment, its Second Draft Demarcation Regulations ("the Second Draft Demarcation Regulations").

10. These Second Draft Demarcation Regulations are a regulatory mechanism that is intended to comprehensively regulate health insurance products and at the same time these regulations seek significantly to limit and curtail the permissible market for health insurance products relative to the market for medical schemes.

11. The Second Draft Demarcation Regulations follow on the First Draft Demarcation Regulations which were published for public comment on 2 March 2012. Due to overwhelming public opposition to the First Draft Demarcation Regulations, they were not pursued

12. Both sets of Demarcation Regulations are designed to protect, bolster and favour medical schemes.

13. The regulatory framework associated with the Second Draft Demarcation Regulations is constituted by three key regulatory instruments:

    13.1. A new definition of "business of a medical scheme" under the Medical Schemes Act no 131 of 1998, ("the MSA"), the date of commencement of which has still to be proclaimed[3];

    13.2. New definitions of "accident and health policy" under the Short Term Insurance Act no 53 of 1998 (the STIA) and "health policy" under the Long Term Insurance Act no 52 of 1998, the dates of commencement of which have still to be proclaimed; and

    13.3. The Second Draft Demarcation Regulations[4] which are promulgated by the Minister in terms of his existing powers in terms section 70 (2B) of the STIA.[5]

    These three new instruments are hereinafter referred to as "the new schema".

[3] In terms of the Financial Services Laws General Amendment Act no 45 of 2013 which was assented to by the President on 14 January 2014, this current definition of "business of a medical scheme" has been amended. This amendment will come into operation on a date to be determined by in a subsequent Government Notice to be published in the *Gazette*. This delay is expressly intended so as to allow the present Demarcation Regulations to be finalised. (See Media Statement Commencement date for the Financial Services Laws General Amendment Act no 45 of 2013)

[4] For full detail see GN no R 325 of 29 April 2014, in GG no 37598.

[5] This legislation provides that before regulations in terms of this Act are promulgated the Minister must publish draft regulations in the GG for public comment and submit the regulations to Parliament, while it is in session, for parliamentary scrutiny at least one month before their promulgation . Section 70(2B) of Act 53 of 1998; see also section 72(2A) of Act 52/1998

14. The new schema thus consists of a set of new statutory definitions, the dates of commencement of which are still to be proclaimed and the Second Draft Demarcation Regulations read together.

15. The date of commencement of this new schema is all dependant on the Minister[6] proclaiming a date of commencement for these various statutory and regulatory instruments.

16. The draft Demarcation Regulations specify which types of health insurance policies are permissible under the Short-Term Insurance Act no 53 of 1998 (and accordingly excluded from regulation under the Medical Schemes Act no 131 of 1998) despite such health insurance products meeting the definition of the business of a medical scheme.[7] [emphasis added]

17. The key words referred to above, are "despite such health insurance products meeting the definition of the business of a medical scheme".

18. This statement is not strictly correct. The current in force definition of *"business of a medical scheme"* provides:

> "business of a medical scheme" means the business of undertaking liability in return for a premium or contribution –
> (a) To make provision for the obtaining of any relevant health service;
> (b) To grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; **and**
> (c) Where applicable, to render a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.

19. As to the meaning and effect of this definition see *Guardrisk Insurance Co Ltd v Registrar of Medical Schemes* 2008 (4) SA 620 (SCA) at par [15].

20. The new definition of "business of a medical scheme", to which reference is made in the Demarcation Regulations is quoted in Annexure 1 to the Explanatory Memorandum[8], fundamentally alters the old definition of this term by replacing the word **"and"** with the word **"or"**.

21. In so doing the definition of business of a medical scheme has been widened at the stroke of a pen. Whereas hitherto in order fall within the definition, one was required to perform all of the acts referred to in paragraphs (a) to (c) of that definition, now one is required merely to perform any one of the said acts in order to do so.

[6] The Cabinet Minister responsible for Finance, see section 1 of STIA.
[7] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998
[8] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 10

22. In the same way as the above, a similar amendment has been effected to the current definition of "accident and health policy" under the Short Term Insurance Act no 51 of 1998. The current definition which consists of various subparagraphs which fall to be read conjunctively,[9] is amended and replaced by a definition which seeks to exclude from the ambit of this term, all contracts which provide for the conduct of the business of a medical scheme, save for those contracts identified by the Minister by regulation in terms of section 70(2A) of the Short-Term Insurance Act as an accident and health policy.[10]

23. The date of commencement of the new definition of "accident and health policy" has also yet to be proclaimed and falls to be determined by the Minister by notice in the *Gazette*.[11]

24. The schema, although outwardly complicated, is in fact remarkably simple.

25. In terms of the still to be implemented new definitions of "business of medical scheme" and "accident and health policy", all health insurance products will fall within the scope of the business of a medical scheme, save for those permitted by the Minister of Finance by regulation under section 70(2A) of the Short-Term Insurance Act no 53 of 1998. These latter products will become legitimate accident and health policies. (Note a similar provision applies in respect of health policies under the LTIA).

26. As such the Second Draft Demarcation Regulations, read with the still to be proclaimed new statutory definitions of "business of a medical scheme" and "accident and health policy", seek to fundamentally alter the regulatory environment within which long and short-term insurance products and medical schemes currently operate.

27. In terms of the Second Draft Demarcation Regulations only a specified limited number of types of insurance contract are identified as permissible "accident and health policies". All others are prohibited. [12] Very significantly so-called "bundled health insurance products", which replicate medical schemes, are outlawed.[13]

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[9] Guardrisk Ins Co Ltd v Registrar of Medical Schemes 2008 (4) SA 620 (SCA) at par [10]

[10] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 9

[11] See Insurance Laws Amendment Act no 27 of 2008

[12] For full detail see GN no R 325 of 29 April 2014, in GG no 37598, Contracts identified as Accident & Health Policies under Paragraph (b) of the Definition of Accident and Health Policy; Permitted policies in terms of this *numerous clausus* are Medical expense shortfall cover in respect of minimum benefits provided for under Regulation 8 of the Regulations under section 67 of the Medical Schemes Act 1998; Lump sum or income replacement policy benefits payable on a health event; Motor; third party liability; Property third party liability – covers the costs of a relevant health service following injury of third parties whilst at the property of insured persons; HIV and Aids treatment on an employee group basis for employees and their dependants; International travel insurance; Domestic travel insurance; and Emergency evacuation or transport.

[13] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 3

28. The extent to which this new regulatory framework will adversely affect competitive outcomes is thus very extensive and this is designedly so.

29. In terms of the Second Draft Demarcation Regulations a number of health insurance products which are currently on sale and marketed to the public will fall to be outlawed. These include a number of the products marketed and sold by the stakeholders. The number of consumers of products of the stakeholders, (being health insurance policyholders and their dependants), which are affected by this change runs to many hundreds of thousands.

30. The explanatory memorandum accompanying the Second Draft Regulations under a heading **"the current market challenge"** clearly and candidly sets out the statutory purpose behind the Second Draft Demarcation Regulations:

> **"One of the concerns which the Draft Demarcation Regulations seek to address relate to the contention that certain health insurance products (which provide similar benefits to medical schemes) in the long-term and short-term insurance market cause harm to the medical schemes environment by attracting younger and generally healthy members out of medical schemes. This practise if left unchecked could result in increasing costs for the older and less healthy who remain dependent on medical schemes for this cover. Pooling healthier and sicker individuals facilitates a form of cross-subsidization whereby sicker people do not pay contributions according to their health status; this improves the affordability of medical schemes. A clear demarcation between health policies and medical schemes is therefore necessary to support and enhance the objectives and purpose of the Medical Schemes Act no 131 of 1998……..."**[14]

31. In short the regulations are intended to address the threat which private insurance expenditure and cover allegedly poses to private medical schemes and in so doing the regulations seek to reduce the number of market players in the private healthcare finance space.

32. The stakeholders are profoundly concerned about this development.

33. While this development obviously prejudices the stakeholders, it also prejudices all who are concerned about the provision of affordable and accessible high quality private healthcare.

34. The stakeholders accordingly seek **the Commission <u>to urgently intervene</u> and liaise with the regulator <u>(National Treasury)</u> to prevent a distortion in the market for the financial provision of private healthcare.**

[14]Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 4.

35. **The stakeholders in short wish that the regulator, National Treasury, be advised to pend these proposed changes until it has had the opportunity to consider and be informed by the report of this Commission.**[15]

36. In seeking the above intervention, the stakeholders make two key submissions:

    36.1. this alleged threat posed by health insurance products to medical schemes is not as great as is believed; and

    36.2. medical schemes are not as worthy and deserving of statutory protection as is assumed.

37. In making the above submissions the stakeholders are assisted by information to which the Commission is already privy and which it has indeed already published.

NATURE OF HEALTHCARE MARKET

38. Thus this Commission has noted that South African healthcare is characterised by many challenges including challenges relating to access to funding and coverage.

39. Figures quoted by the Commission in this regard are instructive.

40. Whereas in 2012, 42.5 million South Africans were dependant on the public sector for the provision of healthcare services, only 8.7 million were serviced by the private sector.[16] In 2011/2012 the per capita expenditure on healthcare in the private sector was R13 800 whilst the per capita expenditure in the public sector was R2880.[17] In 2011/2012 private health care funding covered 17% of the population whilst public sector funding equated to 49.3%.[18]

41. Medical schemes are responsible for the bulk of private healthcare expenditure – some R98.1 billion or (81.2%). Private insurance and employers are responsible for a further R4.6 billion (3.8%) of private healthcare expenditure.[19]

42. The significance of this statistical information will be returned to and dealt with later below.

ASSUMPTIONS BEHIND THE SECOND DRAFT DEMARCATION REGULATIONS

[15] It is to be noted that Second Draft Demarcation Regulations remain open for public comment until **31 July 2014.**

[16] Terms of Reference for Market Inquiry Private Healthcare Sector notice 1166 of 2103, GG 29 November 2013, no 37062, p. 76

[17] Terms of Reference for Market Inquiry Private Healthcare Sector notice 1166 of 2103, GG 29 November 2013, no 37062, p. 76

[18] Terms of Reference for Market Inquiry Private Healthcare Sector notice 1166 of 2103, GG 29 November 2013, no 37062, p. 77

[19] Terms of Reference for Market Inquiry Private Healthcare Sector notice 1166 of 2103, GG 29 November 2013, no 37062, p. 77

43. The Second Draft Demarcation Regulations assume that: -

43.1. medical schemes as defined by Act no 131 of 1998 perform a social good in that they are strictly regulated and provide equitable outcomes for their members; and

43.2. the medical schemes are subject to social solidarity principles. These principles include the principles of community rating,[20] open enrolment[21], cross-subsidization[22] and prescribed minimum benefits ("PMB's")[23] within medical schemes;[24]

43.3. medical schemes offer more extensive protection than health insurance policies sold in terms of the Long and Short Term Insurance Acts[25], the latter of which are much less rigorously regulated than medical schemes and which only offer partial and conditional cover;[26]

43.4. "medical schemes …….. are non-profit organisations and belong to their members. Medical Schemes operate through the collective pooling of good and bad risks and may not discriminate between individuals based on age and health status. Contributions apply universally to all members who are enrolled and may only

[20] "Community rating" refers to the practice of charging a contribution to all members on a specific benefit option within a medical scheme that does not discriminate against them unfairly. In other words all members on a particular option pay the same contribution, regardless of their age or health status or any other arbitrary ground. Community rating is the opposite of individual risk-rating, where the latter describes the practice of distinguishing "high-risk" and "low-risk" individuals and charging an individual more if he/she is more likely to claim a benefit and therefore poses a high insurance risk. Explanatory Memorandum to the Second Draft Demarcation Regulations.

[21] "Open enrolment" is a social solidarity principle that requires every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme. Put differently, the principle of open enrolment ensures non-discriminatory access to private healthcare financing. Every person who applies for membership, as well as any member who applies for the membership of a dependant, is guaranteed membership of an open medical scheme. Applicants must be accepted into the scheme regardless of factors such as their age or past and medical history." Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 5.

[22] The "cross-subsidization" between low-risk and high-risk individuals refers to the principle that all members on a specific medical scheme benefit option pay the same contribution for the same benefits but access benefits on what they need. The most vulnerable members enjoy affordable access to healthcare and are protected against the potentially catastrophic effects of an illness and/or medical exposure, and price discrimination against people with high-risk medical conditions is prevented (they would have been excluded in risk-rated market).

[23] Prescribed minimum benefits (PMB's) extend the social security net to various vulnerable groups, ensuring access to healthcare and providing protection from catastrophic out-of-pocket expenditure. By compelling the funding of the PMB package from the common risk pool in the medical scheme, the principle of community rating is achieved across all medical schemes so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join. Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 5.

[24] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 2, 4.

[25] The STIA no 53 of 1998 and LTIA no 52 of 1998.

[26] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 4.

vary in respect of the cover provided. Different benefit options are priced differently depending on the level of cover afforded and are determined by the rules of the scheme. The effect is that there are equal premium contributions for high and low risk members, which promotes greater equity in the scheme.";[27]

43.5. The protection provided by a health insurance policy is partial and conditional and that health insurance policies discriminate against persons on the basis of age, gender and other criteria[28]

43.6. Short and long term insurance products cause harm to medical schemes by attracting younger and healthy members out of medical schemes.[29]

43.7. Medical schemes need to be protected by a clear demarcation between medical schemes and health insurance products

FALLACIOUS NATURE OF ABOVE ASSUMPTIONS

44. It is denied that these assumptions are correct. In this regard:

44.1. While it may be so that medical schemes *per se* are non-profit, for the consumer of a medical scheme, and whether the consumer be a member of a self-administered scheme like Bestmed or a medical scheme which outsources its scheme administration like Discovery Health, every contribution which that consumer makes to a medical scheme contains a component of non-healthcare expenditure which goes towards scheme administration which is in turn invariably provided on a for-profit basis. Scheme administration expenses account for approximately just over 10% of medical scheme contributions. Discovery Health which according to its own annual report for 2013 constitutes 31% of the medical scheme market, made R1.534 billion in comprehensive income for the 2013 financial year.[30]

44.2. Medical schemes do not practice community rating and open enrolment. Medical schemes customarily, for example, impose late joiner penalties. A contribution loading or late joiner penalty is based on age and discriminates against that person. These penalties particularly affect the previously uninsured. This penalty is arbitrary given the inequalities of the past. Late joiner penalties create a barrier to entry to medical schemes. Persons who could not previously afford to join a medical scheme therefore

[27] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 4.
[28] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 4.
[29] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 4.
[30] Highlights of the Discovery Health Scheme's Financial Results for 2013, It is to be noted that Discovery Health's medical scheme is exempt from tax in terms of section 10(1)(d) of the Income Tax Act

are obliged to pay more to join a medical scheme when and if they are eventually able to do so;

44.3. Cross-subsidies are only partially applied by medical schemes. The Second Draft Demarcation Regulations completely overlook the fact that medical schemes by and large do not provide day-to-day primary cover and this benefit is instead provided by means of a personal savings account. The result is that the chronically ill or the aged incur out of pocket expenses or they simply have no means to provide for essential primary care services. No cross-subsidization is involved in this process.

44.4. In addition, the medical scheme market is marked by fragmentation and barriers to entry. Appropriate methods of cross-subsidization have been ignored since social reforms were introduced to the MSA in 1998. If real reforms, as were intended by the legislator had been imposed and instituted, then salary-based contribution tables would be mandatory. The existence of a mandatory salary-based contribution practice would have removed some of the inequities in access to healthcare, and medical schemes would now be faced with a more stable distribution of age bands.

44.5. It is submitted that the continued existence of restricted medical schemes is the most significant factor which has resulted in the so-called "actuarial death spiral" of open medical schemes and is the primary reason for the deterioration of the general health risk pool of open medical schemes. In this regard, the MSA expressly permits a "restricted membership scheme" that in principle permits a restricted scheme that limits membership only to employees and which thereby *ipso facto* discriminates against former employees and the aged.[31]

44.6. The Government Employees Medical Scheme ("GEMS") was registered on **1 January 2005** under the MSA with a view to meeting the healthcare needs of government employees. GEMS is a restricted medical scheme and only Employees qualifying to be registered as members, and their dependants, may be registered as beneficiaries under the scheme.[32] The stakeholders contend that, in establishing GEMS, government openly selected against the industry as a whole, by deliberately failing to market GEMS to pensioners and carefully hand-picking pockets of favourable risk within every organ of state that would not jeopardise the GEMS risk pool – leaving the open medical schemes to carry the burden of those quasi-government institutions that had poor membership profiles.

44.6.1. It is important to note that GEMS membership represents 20% of the total medical scheme membership; it has a 4,1% pensioner ratio (beneficiaries aged 65 and over);

[31] In terms of the MSA (s 1) a restricted medical scheme means a medical scheme, the rules of which restrict the eligibility for membership by reference to (a) employment or former employment or both employment or former employment in a profession, industry or calling; (b) employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers; membership or former membership or both membership or former membership of a particular profession, professional association or union or (d) any other prescribed matter.

[32] Registered rules of GMS, rule 6.1

whilst the pensioner ratio for industry is 7.1% . Only in 2012 did government agree to move its 16,000 pensioners from Medihelp to GEMS. It is also noteworthy that in the latest Council for Medical Scheme ("CMS") Annual report, the Registrar of Medical Schemes reported that:

"A negative impact was subsequently experienced on some of these open schemes' claiming patterns as the profile of members who left them to join GEMS tended to be young and healthy, and was not necessarily replaced by members of a similar profile".

44.6.2. The CMS has demonstrated that since the introduction of GEMS, the pensioner ratio of open medicals schemes has increased from 5.9% to 8.2%, whilst the pensioner ratio for restricted scheme decreased from 7.7 to 5.7%.

44.6.3. The age factor in a medical scheme membership profile determines the survival of the medical scheme itself.

44.7. Medical Scheme benefits, contrary to the assumption made in the Second Draft Demarcation Regulations, are partial and conditional. Medical Schemes for example DO NOT provide Prescribed Minimum Benefits (PMB's).

44.7.1.1. Under the PMB dispensation that is sanctioned by the Council for Medical Schemes it is the State which is instead ULTIMATELY burdened with this duty to provide PMB's. Thus Medical schemes under the Medical Schemes Act are permitted to contract the State as a designated service provider (DSP) for certain diseases. A DSP is a healthcare provider (doctor, pharmacist, hospital etc) that is the medical scheme's first choice when a member's PMB needs attention.

44.7.1.2. In the case for example of cancer which is a PMB, the Discovery Health Classic Priority option which professes to provide a comprehensive benefit structure effectively outsources medical care to the State as a DSP in the case of cancer. In this regard it permits an individual R200 000 for treatment in the private sector and allows for further treatment provided that 20% of the charges are paid by the member as a co-payment. But members cannot in practice pay for these exorbitant expenses.

44.7.1.3. For example a patient diagnosed with Neo Endocrine Carcinoid Syndrome (NECS) may not be responsive to chemotherapy and the only treatment in this setting for patients whose cancer expresses chromagranin and which is positive on an octreotide scan is Sandostatin. (there is no radiotherapeutic procedure that can be done for metastatic carcinoid unless it is limited to one site such as the liver and is amenable to chemo or radio embolization or radiofrequency ablation). Sandostatin is not a new biological drug, it was synthesized in the 1970's and the cumulative costs of the injection over a period of 12 months exceeds R500 000. It is common for public insitutions

to administer a reduced strength of Sandostatin due to financial limitations regardless of whether the patient is a member of a medical scheme or not, so that they hospitalise the patient and monitor the impact of the reduced dosage.

44.7.1.4. The aforementioned example illustrates that cross-subsidization and PMB's are a myth – the very sick who are the very people one might have expected to receive benefits from a medical scheme receive only limited cover from such instruments. DSP's in the above circumstances cannot be regarded as anything other than a means by which medical schemes may dispose of the risk of caring for the sick to the oversubscribed and ailing public health system. In certain medical schemes benefit options, it a condition that all PMB's be treated by the State.

44.7.1.5. A further effect of this extraordinary dispensation is that the very poor – namely those who cannot afford private medical healthcare compete with the wealthiest sector of the population who can afford private healthcare for access to limited state health resources. Perversely, under the current dispensation, the poor may be said to be subsidising the wealthy.

44.7.2. That the CMS can, without seeming embarrassment, permit the State to be a Designated Service Provider for PMB's and for it to admit to doing so is extraordinary. For it is a notorious fact, scarcely worthy of repetition, that the South African public health system is oversubscribed and ailing.

44.7.3. Thus while the MSA imposes an obligation on a medical scheme to provide PMB's, because these PMB's are so expensive and cannot be covered by either the scheme or the member, at the end of the day, the PMB is reduced to healthcare provision via a DSP, that is the State.

44.7.4. The unfortunate truth is that PMB's cannot be funded in any other way.

44.7.5. This admission exposes the fallacy of PMB's and discloses that these alleged benefits of medical schemes are hollow and without substance.

44.8. Medical schemes impose and are permitted under the Medical Schemes Act to impose waiting periods on applicants for membership (this is customarily done with reference to applicants who have been admitted to hospital in the previous 12 months and who are currently taking regular, ongoing medication for a medical condition); reserve the right to impose conditions applicable to membership such as waiting periods and late joiner penalties and risk rate the health status of members and dependants.

44.9. The assumption that health insurance policies discriminate on the basis of age, gender and other criteria is unsubstantiated. All persons are permitted to purchase health insurance cover. Any discriminatory limitation would in any event be unlawful.[33]

44.10. Medical schemes are not only profit-making, but are expensive. Their expensive nature is in part a function of the statutory obligation to provide the sham PMB's referred to above. Albeit that medical schemes cannot and do not in fact adequately provide these PMB's, the obligation to do so necessarily increases costs. This increase in costs makes the product unaffordable to the wider market and certainly does drive away consumers.

44.11. This exodus is caused by the unaffordable and unsustainable nature of medical scheme membership.

44.12. Treasury has certainly provided no evidence to support the assumptions that health insurance products undermine medical schemes. This was an argument rejected for lack of evidence by the Supreme Court of Appeal in *Guardrisk Insurance Co Ltd v Registrar of Medical Schemes* 2008 (4) SA 620 (SCA) at 626 - 627 and nothing which has happened in the period subsequent thereto has changed the nature of this proposition.

44.13. The assumption that medical schemes need to be protected by a clear demarcation between medical schemes and health insurance is an old one and indeed dates back to at least 1994 and is strongly fostered by an influential, energetic, well-organised and statutorily sanctioned lobby group, namely the CMS. [34] This fear that medical schemes are vulnerable to health insurance has never been realised despite copious rhetoric and claims to the contrary by the CMS. According to statistics published by the CMS itself, during the period 1998 to 2012 the aggregate number of medical scheme beneficiaries grew by some 43% from 5.7 million to 8.6 million, being a statistic that would seem to contradict the fears of the CMS.[35]

DATE OF COMMENCEMENT OF REGULATIONS

45. It is contemplated, in the case of the Second Draft Demarcation Regulations that these will be followed by Final Demarcation Regulations that are expected to be published in **September 2014** after taking into account public comments.[36] It is the intention that the effective date of

[33] See section 9(3) and 9(4) of the Constitution; see also Guardrisk at par [20].
[34] See section 3 of Act 131/1998. It noted that the CMS has long ago for example established contact with the Competition Commission. See annual reports of the CMS.
[35] See Annual Reports of the CMS
[36] Explanatory Memorandum to the Second Draft Demarcation Regulations made under section 70(2b) of the Short-Term Insurance Act no 53 of 1998, p. 3.

implementation of the Demarcation Regulations will be on or soon after the Final Demarcation Regulations are published.[37]

CONCLUSION AND KEY REQUEST MADE OF THE COMMISSION

46. It is thus submitted that:

46.1. the rationale for the Second Draft Demarcation Regulations is unproven – there is no evidence that health insurance policies undermine medical schemes.

46.2. Furthermore and in any event, medical schemes are health regulatory instruments which are expensive and a sham (in that they do not provide the benefits which they proclaim) and that they are not necessarily ideally suited to the South African private healthcare industry.

47. It is further noted that:

47.1. Firstly the annual premium price of the health insurance products is in certain cases less than the average per capita expenditure of healthcare in the public sector (R2880), and is in many cases less than the average annual per capita expenditure on healthcare in the private sector, being R13 800.

47.1.1.1. In this regard for example, the premium of a product that is sold by stakeholder, Ambledown, to a wide group of truck drivers, packers security and maintenance workers and which provides for extensive day to day care over including G-P Visits and basic dentistry and in-hospital treatment in case of accident, is R1143,00 per annum; similarly Day 1 Health and Stratum Benefits have products that provide both capitated primary (day to day) and hospital care for a member and dependants that are significantly less than the average annual per capita expenditure on private sector healthcare.

47.2. Secondly the total cost of health insurance expenditure relative to the total cost of medical scheme expenditure is low and a mere 4.7%.

48. The above figures highlight:

48.1. the affordability and relative accessibility of the threatened health insurance products; and

48.2. That health insurance as currently constituted does not pose an immediate and substantial threat to medical schemes.

[37] Release of the Second Draft Regulations on the Demarcation between Health Insurance Policies and Medical Schemes issued by National Treasury dated 30 April 2014, p. 2

49. When insight gained from the above fallacious assumptions about medical schemes, (including that medical schemes are a highly flawed regulatory instrument), is combined with the above statistical analysis, there is compelling reason why this Commission should in terms of its powers under the Competition Act,[38] advise Treasury not to proceed with the implementation of the Second Draft Demarcation Regulations until the outcome of this Commission's investigation.

50. The regulations in short are both an irrational and blunt instrument. This is so because their only likely ultimate result is to increase the burdens and stresses on the already strained public healthcare system. This outcome will regrettably occur when former consumers of both health insurance and indeed medical schemes are driven to accept the already overburdened public healthcare system, they being unable to afford medical scheme membership.

51. In the circumstances, it is submitted that the Commission should actively, publicly and transparently advise against the enactment of the regulations prior to the outcome of the investigation that is contemplated by this Commission. The enactment of these regulations in effect undermine a major purpose of the Commission – namely to make recommendations on the appropriate policy and regulatory mechanisms that would support the goal of achieving accessible, affordable, innovative and quality private healthcare. This goal is fundamentally compromised when the regulator, prior to the issue of the report, takes regulatory steps which will serve not only and save for very limited exception, to outlaw health insurance, but to promote an anti-competitive outcome within the market for private healthcare finance..

[38] Section 21(1)(j) of Act 89/1998