



national treasury

Department:
National Treasury
REPUBLIC OF SOUTH AFRICA



**UPDATED FREQUENTLY ASKED QUESTIONS
SECOND DRAFT REGULATIONS ON THE DEMARCATION BETWEEN HEALTH
INSURANCE POLICIES AND MEDICAL SCHEMES**

17 JULY 2014

Given the public interest in the second draft Demarcation Regulations and several extension requests, the National Treasury (“NT”) and Financial Services Board (“FSB”) hereby extend the deadline for submission of comments from **7 July 2014** to **31 July 2014**.

The purpose of this Frequently Asked Questions document¹ is to provide further clarity to some of the questions already received from stakeholders.

1. DIFFERENCE BETWEEN A HEALTH INSURANCE POLICY AND MEDICAL SCHEME

1.1 What is a health insurance policy?

A health insurance policy² is issued by an insurer to a policyholder in terms of the Long-term Insurance Act, No. 52 of 1998 (“LTIA”) or Short-term Insurance Act, No. 53 of 1998 (“STIA”) and is subject to regulatory oversight by the FSB. The policy promises to pay for certain stated benefits when the policyholder is ill, or injured, in return for a premium. Generally, the premium is directly related to the age, health status or income of the individual covered by the policy (i.e. “individually risk-rated”). Specific types of exclusions and conditions may also be built into a policy, which can have the effect of limiting who the policy can be sold to, or excluding certain circumstances under which the policyholder can claim under the policy.

1.2 What is a medical scheme?

Medical schemes are regulated in terms of the Medical Schemes Act, No. 131 of 1998 (“Medical Schemes Act”) and are subject to regulatory oversight by the Council for Medical Schemes (“CMS”). 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 or health status. This means that any individual is entitled to be a member irrespective of their age or health status.

¹ This FAQ document will be regularly updated to reflect new questions received from stakeholders.

² Referred to as health policies under the LTIA and accident and health policies under the STIA.

Contributions apply universally to all members who are enrolled and may only vary in respect of affordability and family size. 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 within options for high and low risk members, which promotes social solidarity in the form of cross-subsidisation amongst the members of the scheme.

In terms of the Medical Schemes Act, medical schemes must cover the costs of Prescribed Minimum Benefits (“PMBs”) related to the diagnosis, treatment and care of:

- any emergency medical condition.
- a limited set of ±270 medical conditions.
- 25 chronic conditions.

Members are entitled to these benefits regardless of the medical scheme option they have selected.

2. SCOPE OF THE DRAFT DEMARCATION REGULATIONS

2.1 What is the objective of the second draft of the Demarcation Regulations?

The second draft Demarcation Regulations³ aim to clearly define and separately regulate health insurance policies from the business of medical schemes. The regulations seek to address concerns that certain long-term and short-term health insurance policies may undermine the sustainability of medical schemes by attracting younger and generally healthy members out of medical schemes. In addition, there are health insurance policies which are being misleadingly marketed as alternatives to medical scheme cover, while the protection they offer against health events is not equivalent to that of medical schemes.

Pooling healthier and sicker individuals into a medical scheme facilitates a form of cross-subsidisation that improves the overall affordability of medical schemes and protects more vulnerable individuals. A clear demarcation between health insurance policies and medical schemes is therefore necessary to support and enhance the objectives and purpose of the Medical Schemes Act, which entrenches the principles of community rating, open enrolment and cross-subsidisation within medical schemes.

The revised second draft Regulations acknowledges that while health insurance products have a role in the market place, these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical schemes. It is in this context that the second draft Regulations seek to strike a better balance between health insurance and medical schemes.

The proposed conditions on health insurance products therefore seek to ensure that the sale of health insurance policies complement medical schemes and do not undermine the social solidarity principles, while at the same time serving the needs of those who require additional protection against health-related risks.

³ Published in Government Gazette No. 37598 on 29 April 2014.

2.2 What were the public concerns with the first draft Demarcation Regulations?

The two key proposals in the first draft Demarcation Regulations⁴ which elicited the most public responses relate to the prohibition of Gap Cover and product restrictions on Hospital Cash Plan insurance policies.⁵ The public concern was that these insurance policies meet a real need for protection in covering the cost of medical care. In the absence of such cover, unnecessary debt will be incurred to cover short falls in medical expenses.

The comments also highlighted affordability and market conduct concerns with respect to medical schemes; specifically the need for medical schemes to seek ways to be more affordable and to improve disclosure to their members. The NT will engage the Department of Health and the CMS on these issues, in line with the market conduct reforms proposed for the rest of financial sector as part of the Twin Peak review.

2.3 How will the recent amendment to the definition of a “*business of a medical scheme*” affect health insurance policies?

The Financial Services Laws General Amendment Act, No. 45 of 2013 (“the Act”) came into operation on 28 February 2014. The Act amends the definition of a “*business of a medical scheme*.” This amendment makes it clear that each of the activities (and not all the activities collectively) referred to in that definition constitutes the business of a medical scheme that is regulated under the Medical Schemes Act.

Health insurance policies that fall within the ambit of this amended definition will be subject to the Medical Schemes Act and therefore deemed illegal unless the Minister of Finance, through the Demarcation Regulations, identifies those policies as health insurance policies that are excluded from the medical schemes regulatory environment and subject to regulation under the Long-term and Short-term Insurance Acts, respectively. The amendment to the definition of a “*business of a medical scheme*” will come into effect at the same time as the draft Demarcation Regulations are finalised.

2.4 Are all health insurance policies required to comply with the regulations?

No. Only the categories of contracts identified in the Demarcation Regulations are subject to the Regulations. These categories relate to contracts that may be interpreted as doing the business of a medical scheme within the amended definition of the “*business of a medical scheme*” in the Medical Schemes Act if it were not for the fact that they have been specifically identified as health insurance policies by the Demarcation Regulations. Other types of health insurance policies are not listed in the Demarcation Regulations because they are fully removed from or unrelated to the business of a medical scheme, and accordingly do not need to be excluded from the amended definition of the “*business of a medical scheme*”. Examples of such health insurance policies include dread disease, personal accident and disability policies which offer a lump sum benefit or annuity income when you are diagnosed with a severe illness or disability, or when a death event occurs.

⁴ The first draft Demarcation Regulations were published for comment in March 2012.

⁵ In October 2013, the NT released a summary of the 343 comments received during the initial consultation process. The release of these public comments were meant to inform the public of the challenges in balancing various stakeholder interests and striking a good balance between the regulation of health insurance products and medical schemes. All supporting submissions are contained in a folder titled “Public Submissions” which is available on the NT website www.treasury.gov.za.

The regulations under the LTIA identifies four categories of contracts that may be interpreted as doing the business of a medical scheme within the amended definition of the “*business of a medical scheme*”, but are specifically identified as health insurance policies, namely: lump sum or income replacement policy benefits payable on a health event; cover for frail care; cover for actual expenses related to HIV on an employer group basis for both employees and their dependants; and cover for the actual expenses of emergency evacuation or transport.

The regulations under the STIA identifies eight categories of contracts that may be interpreted as doing the business of a medical scheme within the amended definition of the “*business of a medical scheme*”, but are specifically identified as health insurance policies, namely: cover for short fall in medical expenses; lump sum or income replacement policy benefits payable on a health event; motor car third party liability cover and property third party liability cover; HIV and Aids cover; international travel insurance; domestic travel insurance and cover for emergency evacuation or transport.

2.5 What informed the R3 000 per day limit on hospital cash plans?

The draft Demarcation Regulations propose that no health insurance policies may be identified by the terms “medical” or “hospital” or derivatives of these words, and may not imply that the policies indemnify you against medical expenses or are a substitute for medical scheme cover. This proposed limitation is intended to counter the misleading impression that these policies provide adequate protection to cover the actual medical costs associated with private hospitalisation and/or that they are an alternative to medical scheme cover.

The first draft Regulations proposed to cap the daily benefit at 70% of the net daily income of the policyholder. Comments received on the first draft suggested that this would severely limit the benefit amounts paid out to policyholders and would imply additional underwriting and administrative costs for insurers. Products would thus become more expensive and offer lower benefits. It was suggested that a more appropriate condition would be to limit the daily benefit limit in Rand terms.

A 2012 FinMark Trust report found that the R3 000 per day limit was the highest level of cover affordable to low income earners. The study also indicated that a cover level of R3 000 per day was more than sufficient to cover incidental costs associated with a major medical event.

The R3 000 per day benefit limit will be applicable to lump sum or income replacement policy benefits payable on a health event. They are similar to the “hospital cash plans” currently sold in the market. These policies will be allowed to be sold by both long-term and short-term insurers.

2.6 What informed the R50 000 per annum benefit limit on medical expense shortfall (“gap cover”) policies?

The first draft Regulations proposed to ban gap cover products. Comments received suggested that in the current environment there should be a role for gap cover. The compromise that is presented is that these policies can continue, provided that they operate under a framework where there is very strict product parameters and monitoring by the FSB. The R50 000 per annum per individual benefit limit on gap cover policies was also informed by public submissions received. The submissions indicated that a gap-cover benefit of R50 000 covers the top two events for which gap-cover policies pay out. The limit was also informed by the need

to remove the scope for health care providers to set their prices commensurate to the gap cover available.

2.7 Will gap cover policies be allowed for Prescribed Minimum Benefit (PMB) and non-PMB conditions?

Policies covering medical expense shortfall, such as gap-cover policies, will be allowed to provide benefits for medical expenses that are not covered by the PMBs, or that are covered by the PMBs but are not paid for in full by a medical scheme. Gap-cover policies will be allowed to pay only the difference between the cover provided by a scheme for a PMB and the cost of the service when a scheme does not pay these costs in full. Medical schemes are obliged to pay for PMBs in full, unless the scheme has appointed a designated service provider to provide PMB services and a member voluntarily uses a different provider.

2.8 Will individuals be allowed to have only gap cover and not medical scheme cover?

No. The draft Demarcation Regulations provide that medical expense shortfall cover may only be provided to insured persons that are members of a medical scheme.

2.9 Will all health insurance policies be prohibited from individual risk rating?

Yes, the proposal is that all health insurance policies covered by the regulations may not be subject to individual risk-rating based on health, age, gender, etc. Effectively, the policies must be group risk-rated – in other words, policies must be priced the same for all policyholders, regardless of health, age, gender, etc. Health insurance policies not covered by the Regulations may continue to individually risk-rate. From certain preliminary comments received on the draft Regulations it appears that the wording of the draft Regulations allows for individual risk-rating as long as such risk-rating does not constitute unfair discrimination. This is not the intention of the draft Demarcation Regulations – the intention is as set out above.

2.10 Why are HIV/AIDS policies explicitly provided for in the Regulations?

The Regulations provide for employer group cover for both employees and their dependants for the actual expenses related to treating HIV/AIDS. The proposed limitations allow employers to continue to provide HIV-related benefits to their staff who cannot afford to belong to a medical scheme and seeks to reduce some of the pressure on the public health system.

2.11 Can an insurer refuse to pay my claim due to a pre-existing condition?

No. Insurers will not be able to refuse your claim on the grounds that you suffered a health event or had a health condition before the cover was taken out. In addition, insurers will be unable to cancel your cover on the grounds that you are in poor health or have had high or numerous claims. This is designed to ensure that individuals continue to have insurance cover when they need it most.

2.12 What is the waiting period for health insurance policies?

In terms of the draft Regulations, insurers are allowed to impose a maximum six month waiting period.

2.13 When can an insurer cancel my policy?

An insurer can only cancel your policy if it will no longer provide that cover to anyone or the cover relates to a non PMB that becomes a PMB. The insurer will need to give you 90-days' notice. This requirement will prevent insurers who find that their policyholders are claiming more than they expected from immediately closing the product down or withdrawing the cover.

2.14 Is the limitation on combined policies confined only to categories of policies covered by the Regulations?

Yes, the limitation on combined policies is confined only to categories of policies covered by the Regulations.

2.15 Why is broker commission limited on the sale of health insurance policies?

Brokers or financial advisers who sell health insurance products covered by the draft Demarcation Regulations will be subject to the same commission limit that applies to medical scheme brokers and advisers. This limit is currently three percent of contributions, to a maximum of R69 a month (excluding VAT). The regulation of commission is aimed at introducing parity in the incentives to sell medical schemes and health insurance policies covered by the Regulations and limits product providers from incentivising brokers to excessively sell health insurance products instead of medical scheme membership.

2.16 Why must information on health insurance policies be reported to the FSB and CMS?

All health insurance policies covered by the Regulations launched on or after 15 December 2008 must submit a summary of the benefit, terms and conditions and marketing material to the FSB and the CMS. The enhancement of the legislative framework relating to demarcation between health insurance policies and medical schemes commenced with the enactment of the Insurance Laws Amendment Act No. 27 of 2008. This Act introduced provisions in the LTIA and the STIA, to facilitate a clear demarcation between what constitutes insurance business (namely, "health policies" and "accident and health policies", in the respective Acts), and what constitutes the business of a medical scheme, in instances where there appears to be uncertainty and ambiguity in the legislative framework. In 2008, the FSB signaled that certain health insurance policies were operating in an environment that may be subject to regulatory change, given the stated concerns that certain business practices were not aligned with fair customer outcomes and a sustainable medical schemes environment.

All health insurance policies covered by the Regulations launched prior to 15 December 2008 are not required to submit a summary of the benefit, terms and conditions and marketing material to the FSB and the CMS. These policies seem to be structured in line with acceptable market practice.

3. COMMENT PERIOD AND IMPLEMENTATION

3.1 Who do I send my comment to?

Written comments should be sent to Ms Reshma Sheoraj at LTdemarcation@treasury.gov.za (for the Long-term Insurance Regulations) or STdemarcation@treasury.gov.za (for the Short-term Insurance Regulations) or faxed to 012 315 5206.

3.2 When are the Regulations expected to be finalised?

The final Demarcation Regulations are expected to be published by October 2014, after taking into account public comments.

3.3 What is the implementation timeline?

It is the intention that the effective date of implementation of the Demarcation Regulations will be on or very soon after the final Regulations are published. All health insurance policies written after the Regulations come into operation must be aligned with the requirements set out in the Regulations. Existing health insurance policies must align to the Regulations requirements upon renewal of the health insurance contract.