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Draft Demarcation Regulations – Gen Re Response

1 Introduction

This document sets out Gen Re's response to the proposed draft demarcation regulations as proposed in the Government Gazette of 2 March 2021 (No. 35114).

The response is focused on the Long-Term regulations.

2 General Comments

The proposed legislations aims to clarify and provide certainty about the situations under which health policies that previously considered doing the business of a medical scheme can be done within the ambit of the long-term insurance act.

However we feel that this certainty has not been attained for the following reasons:

a) The regulation is not clear and provides for significant additional uncertainty. There is for example much uncertainty in the product approval process as well as the definitions of the product categories.
b) The regulations unintentionally impacts on critical illness products which forms a major product of the life insurance industry.
c) The regulation needs to be clear on the fact that certain health policies may remain health policies but not be affected by the draft regulations (such as critical illness).
d) The regulation puts undue pressure on the difference between health and disability policies. Because this regulation focuses on health policies only the distinction becomes much more important.
e) The fact that it wants to clarify the product structure and benefits as well as provide for one-sided approval process for products seem to be contradictory. In our opinion clarifying the products that could be offered should be sufficient.

An alternative to the draft regulation is to provide a clear and transparent guidelines setting out the terms under which any policy (health or disability) can be considered doing the business of the medical scheme. The regulations can simply specify the principals and the process under which either Registrar can object to a product and the process which then gets initiated which also allows participation of the insurance company etc. and allows for the courts to make the final call.

3 Section 7.2 (1)(a)

There is a lack of clarity whether all health policies need to classified as per category 1 to 4 or whether policies can remain health policies without being one of the 4 categories defined in the regulations.

It should be made clear that health policies can exist that do not match any categories as defined in 7.2(1)(a) and do not constitute the business of a medical scheme. A clear example

of this is critical illness/dread disease policies which should not be treated as per category 1 to 4 and do not in general constitute the business of a medical scheme.

The wording in (a) is unclear. It is unclear what classifies as a policy and what should be criteria for policies classified as such. The wording is also vague in terms of what constitutes a "matching". Wording around matching needs to be clarified. It should be clarified that all the matching needs to occur on the policy benefits provided and that the relevant criteria then need to be met.

4 Table – Category 1

The name of this category in theory includes all health policies. The name also creates confusion with disability policies, which provide loss of income cover.

The limitation of 70% of net income per day is rather arbitrary. There is no real limitation of contingency expenses in relation to income, and these are very likely to exceed income over the short-term. Also for low-income earner these are likely to exceed income. This would also restrict competition with regard to benefit levels provided. Various disability covers also provide 100% replacement levels over the short term. The limit could be specified as the greater of a 70% per day limit or a fixed rand amount (say R5 000) increased each year by inflation.

Net income is not defined in general but also specifically for those not earning any easily measurable income. An example would be home makers, the unemployed, students and pensioners, and those in irregular employment. It is suggested to scrap the percentage of net income entirely and merely limit the policies in size in absolute terms.

The regulations do not stipulate how the maxima will be calculated for policies which provide lump sum covers rather than income replacement covers. As the regulation is written it could be interpreted that lump sum is limited to 70% of daily income. The intention here should be clarified.

The requirement for severity levels is also arbitrary. The restriction on the number of severity levels is unnecessary.

It could be construed that Critical Illness benefits fall into the definitions here. It should be clarified that Critical Illness falls outside the scope of the draft regulations (on the basis that these are not doing the business of a medical scheme).

5 Table – Category 2

The allowance to defray expenses here are welcomed and would certainly lead to life insurance products that target the funding of frail care nursing and related services.

In terms of the definitions in the act firstly, a Frail Care (or Long-term care policy) strictly meets the definitions of a disability policy, but now seem to be reclassified as health policies. These are typically payable under disability events. This category potentially covers policies that currently are disability policies. One may have thought that this type of cover - related to the functional abilities as defined by activities of daily living - are in fact disability benefits. Provision should be made to allow these policies to continue as disability policies where preferred.

6 Table – Category 3

The allowance to provide treatment and testing for HIV/AIDS is welcomed.

The limitation to employer groups only is somewhat disappointing as there may be other groups where testing and treatment is allowable. An example is the many products that could provide for post-exposure counselling and testing (and prophylactic treatment with short course ART drugs). These could be provided to groups of policyholders, and other customers. Treatment and testing (or at least post-exposure testing and prophylactic treatment) should be permitted for any type of group or for individuals. This would not impact the business of medical schemes and also provide a useful service to the population of SA.

7 Rehabilitation Benefits

Most countries allow insurers providing disability income benefits to claimants of disability benefits the ability to pay for health and other expenses that may in the opinion of the insurer allow the claimant to return to work or recover fully or partially. These payments are often referred to as rehabilitation benefits and are used by the insurance industry to aid claimants to return to work earlier than otherwise and also save the industry some costs.

An example may be that the employer cannot accommodate the disabled person due to lack of access facilities such as a ramp. The insurer could then pay for the cost of the ramp which allows the beneficiary to return to work. In some cases specific medical devices and/or treatments may also aid the return to work.

It is our opinion that this legislation provides an opportunity to allow such benefits to be made by insurers of disability claimants. These benefits are not specifically charged to the policyholder but present a mutually beneficial (to insurer and beneficiary) cost management technique to manage ongoing disability claims cost.

These benefits are therefore not funded by premiums but by savings in claims costs. They do not compete with medical schemes as they are only available to disability claimants.

This could be included as a further category under the table.

8 Section 7.2(2)

a) Under some circumstances providing that a life insured be a member of a medical scheme may in effect ensure that the policy is not impacting the business of a medical scheme (provided that the benefits do not overlap with that provided under a medical scheme). It is understood that abuse of this may occur.
b) This implies that insurers should underwrite these policies but not just use pre-existing exclusions.
c) Some policies may terminate after paying out the sum assured as a matter of course (and as stipulated in the policy terms up-front). Wording could be improved to make sure that such automatic termination is allowed.
d) No comments.

9 Section 7.3

Under (a), not being able to identify hospital daily cash benefits using the word hospital may be very confusing to buyers of this policy. The policies pay a daily benefit for every day in hospital. Thus the name does clearly state what the intention of the policy is. Changing the name to something else would lose a lot of clarity in the policy name. Such an approach also contradicts the aims of the treating customers fairly initiative.

10 Section 7.4(1)

Reporting of product information is complex and time consuming, and is not common in the South African insurance landscape. It significantly increases the costs of doing business and introduces uncertainty into the product and marketing processes. This may lead to a shrinkage in the market of the products on offer. Product reporting also results in little or no innovation in the provision of products or services. This innovation has made the South African insurance market one of the leaders in the world in the provision of insurance services. Further such innovation will be required to ensure that we achieve a broad based expansion of insurance services. Reporting of product should be removed.

There is also a lack of clarity in what information is required. Where the reporting of product information is considered essential, the onus rests on the various Registrars to ensure that these processes do not unduly restrict or close down business practices. Regulations need to be clear what exact information is required in the summary, terms and conditions and marketing material, for example by use of a form. It is preferable that the information is submitted only to the Registrar, by a certain date. The Registrar may then communicate with other interested parties.

11 Section 7.4(2)

Lack of a time-frame in response from the Registrar for Medical Schemes results in significant uncertainty to the insurer. It is not clear what purpose this reporting serves, since the draft

regulations establish a framework within the Long Term Insurance Act. In any event the Registrar for Medical Schemes is at liberty to approach the Registrar at any time on any matter. As an interested party it may also take any decision of the Registrar on judicial review. It is our opinions that no reporting should occur to the Registrar for Medical Schemes.

12 Section 7.4(3)

There needs to be a specific time-frame on this response. Lack of a time frame means that an insurance company may incur significant unforeseen costs should a product be terminated which it thought was valid. For an insurance company only doing this kind of business or a large portion of this type of business this may mean insolvency to the detriment of policyholders, since significant development costs are incurred at the launch of a new product. It is likely that the threat of termination of a product class would significantly reduce the launch of new products.

There also needs to be a transparent response framework and a method to challenge the decisions of the registrar. It should be incumbent on the Registrar to:-

- Provide reasons for its decision
- Provide an opportunity for the product provider to appeal the decision of the Registrar
- Respond within a set timeframe. If the Registrar does not respond, then the product should be deemed to comply with the regulations.

13 Section 7.5

As mentioned above lack of clarity on information required as well as time frame to the Registrars responses are problematic.

The transitional date (December 2008) is too far back and retrospective in nature. There are significant volumes of hospital cash business which may be in breach of the regulations and therefore be affected. This would lead to expenses and be to the ultimate detriment of policyholders.