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SUBMISSION TO THE NATIONAL TREASURY:
THE DRAFT REGULATIONS PUBLISHED FOR PUBLIC COMMENT IN TERMS OF THE SHORT-TERM INSURANCE ACT NO. 53 OF 1998, (GOVERNMENT GAZETTE 35114), DATED 2 MARCH 2012 (COLLECTIVELY REFERRED TO AS THE *"DRAFT DEMARCATION REGULATIONS"*)
BY THE SOUTH AFRICAN INSURANCE ASSOCIATION (SAIA)

Date of submitting:	**2 May 2012**
Entity submitting:	**Submission by the South African Insurance Association (SAIA) on behalf of the short-term industry**
Contact person/s:	**Suzette Strydom**
Contact details:	
Type of stakeholder:	**Industry representative body**

SAIA Submission

The SAIA has considered the proposed draft Demarcation Regulations published by the Minister of Finance on 2 March 2012 and hereby submits comments for consideration.

In preparing the commentary cognisance was taken of the following legislation:

- The Short-term Insurance Act, 1998 ("STIA") including the regulations promulgated thereunder;
- The Long-term Insurance Act, 1998 ("LTIA") including the regulations promulgated thereunder;
- The Medical Schemes Act, 2008 ("MSA") including the regulation promulgated thereunder;
- The Promotion of Administrative Justice Act, 2000 ("PAJA");
- Financial Services Laws General Amendment Bill, 2012;
- The Constitution of the Republic of South Africa, 1996 ("the Constitution"); and

In this regard, kindly note that due to the similarities of the wording used in both the LTIA draft regulations and STIA draft regulations, our comments are to be applied equally, unless otherwise stated to the contrary and the text, to both the LTIA draft regulations and STIA draft regulations. The STIA draft regulations and the LTIA draft regulations shall, where appropriate in this submission, be referred to collectively as "*the draft regulations*".

This submission is to be read together with statements dealing with matters referred to in documents accompanying the publication of the STIA draft regulations and LTIA draft regulations, being –

- the media statement entitled "*Minister of Finance releases draft regulations on the demarcation between health insurance policies and medical schemes", dated 2 March 2012 ("the media statement");*
- the document entitled "*Frequently Asked Questions: Demarcation between Health Insurance Policies and Medical Schemes" ("the FAQ document*");
- the article published by the Council for Medical Schemes entitled "*A victory of the medical schemes regulator*", a copy of which is attached marked "A";
- Notice 195 of 2012 entitled "*Invitation for Public Comment on the Draft Financial Services Laws General Amendment Bill, 2012*" ("the Bill"), published in *Government Gazette* 35132, dated 9 March 2012 ("the Notice"), more particularly, the amendments to the definition of "*business of a medical scheme"* in section 1(1) of the MSA;
- The National Treasury Policy document "A Safer Financial Sector to Serve South Africa Better" published in February 2012;
- The Treating Customers Fairly ("TCF") Roadmap published by the Financial Services Board ("FSB") in 2011; and
- The Joint Explanatory Press Statement by the National Treasury and the Department of Health on Draft Health Insurance Products and Medical Scheme Demarcation Regulations, dated 16 April 2012.

1. **Introduction and background**:

1.1 Consultation process

The SAIA confirms that the process of addressing the legislative framework relating to the demarcation between insurance business and medical schemes business commenced in or about 24 October 2008 when the SAIA were invited to join the National Treasury Demarcation Working Group.

The members of the Working Group were subject to confidentiality agreements and the SAIA representatives were therefore not in a position to consult in a meaningful way within their respective constituencies.

Whilst the SAIA expresses its appreciation for the willingness of the National Treasury to consult, it is submitted that the confidentiality agreements, referred to above, precluded productive dialogue with industry and limited input from the major players in the industry. The consultation process was thus compromised through this approach and therefore the submission in the Explanatory Memorandum, namely that the draft Demarcation Regulations had been published as a result of *"robust and inclusive consultation with interested and affected stakeholders*", is not an accurate reflection of the history of the clipped and limited dialogue around and in connection with the Demarcation Regulations.

It is furthermore suggested that the consultation approach in the Working Group was furthermore hampered during 2010 to 2011 when all Working Group meetings came to a standstill up to August 2011 at which time a first draft of the Regulations was unilaterally produced and submitted to the Working Group.

The members of the Working Group did not have sight of the draft prior to this distribution and had not been adequately consulted during the drafting of the proposed draft Regulations. The SAIA confirms that the draft Regulations were circulated on Thursday afternoon, 18 August 2011, to the members of the Working Group with a reminder that the draft Regulations should be treated as confidential for discussion in a Working Group meeting scheduled for Monday, 22 August 2011. The late circulation afforded the members of the Working Group one and a half working days to review the draft prior to any discussion. The SAIA requested a postponement of the meeting to allow the members of the Working Group a reasonable and proper opportunity to prepare but the request was not granted by the National Treasury. No reasons for this position by the National Treasury were provided.

Furthermore the members of the Working Group were afforded only 4 working days, from 22 August 2011 to 26 August 2011, to submit written comments on the first draft. The members of the Working Group submitted comments on 26 August 2011 and no substantive reply or feedback on the submission has been received to date.

The SAIA continued to seek feedback on the Demarcation Regulations in several forums and has been informed that the proposed Demarcation Regulations would be published for public comment only due to pressing deadlines to finalise these Regulations. It is submitted that 7 months after the last Working Group meeting, the publication of the Draft occurred. No reasons for the adoption of this process have been provided and no explanation given for the time periods that have been followed in respect of the Demarcation Regulations.

As a result of the very limited and inadequate consultation that has taken place and the potential impact of the proposed Regulations the SAIA submitted a written request to the National Treasury on 10 April 2012 for an extension to submit comments a copy of which is attached marked "B".

On 16 April 2012 the SAIA received notification that the National Treasury discussed the request internally and is comfortable with SAIA submitting its comments on the Demarcation Regulations by 2 May 2012. Again, no substantive reasons for comments were provided in response to SAIA's application for extension.

The SAIA, will as result of the deadline, not be in a position to consider an independent qualitative market research study as part of the submission. Consequently, SAIA is of the considered view that SAIA has not been afforded a reasonable time to deal meaningfully with the Demarcation Regulations and its rights to procedurally fair administrative justice have been unfairly limited. In this regard, SAIA's rights remain reserved including the rights of the members which it represents. In addition, no comment has been provided to SAIA since the process referred to above commenced in 2008 that allows SAIA to assess the attitude of the National Treasury to

comments historically provided by SAIA on the demarcation between insurance and medical scheme products.

The Working Group's previous comments, dated 26 August 2011, are attached marked "C" and are to be read as if specifically incorporated into this document. In so far as a substantive reply is required to these comments, such a reply is also to address the contents of annexure "C".

We specifically draw attention to the product typology therein addressed. It is proposed that the said typology should be reconsidered. It is a moot point that many of the products have no impact or link to medical scheme business

1.2 Impact on industry and consumers

In the short period available to extract and submit comments from its members, the SAIA has attempted to assess the impact of the draft Regulations on existing policyholders, the insurance industry and the economy as a whole.

Initial indications are that 887 000 policies affecting 1 873 000 beneficiaries may be compromised if current products, from contested categories, are discontinued. Over the past year, these beneficiaries received claim payments totalling approximately R262 000 000 from our member companies, and this protection will be lost to policyholders and the economy in future. It is also estimated that roughly 160 jobs in the insurance industry will be directly affected by the disappearance of these products, and this does not include the effect on independent financial advisors who receive commission through the sale and support of these products.

2. General comments in respect of proposed amendments to the definition of "*business of a medical scheme*" in the FSLGAB Bill.

2.1 In relation to the Bill, the SAIA will submit comments concerning the definition of "*business of a medical scheme*" as it appear in the Laws Amended Schedule on page 279 of the Bill. In this regard, we advise that -

2.1.1 the second item in the Laws Amended Schedule deals with the amendments of section 1 of the MSA "*as amended by section 1 of Act 55 of 2001, section 1 of Act 62 of 2002, section 40 of Act 65 of 2002 and section 25 of Act 52 of 2003*";

2.1.2 the second item endeavours to amend the definition of "*business of a medical scheme*" as it currently appears in section 1(1) of the MSA in the manner suggested in the Laws Amended Schedule;

2.1.3 the Bill is entirely silent about any aspect of or provision concerning or relating to the MSA. In fact, nowhere in the Bill is any reference made to

the provisions of the MSA, more particularly, to the definition of "*business of a medical scheme*";

2.1.4 in so far as the Laws Amended Schedule to a Bill is to be utilised for purposes of amending, consequently, legislation where a cross reference occurs in that legislation to a term that is amended in the main part of a Bill in a primary piece of legislation, then the secondary piece of legislation is amended in the Laws Amended Schedule. This state of affairs does not apply in circumstances where there is no secondary piece of legislation in light of the fact that neither the primary piece of legislation nor the secondary piece of legislation relies on terminology that is amended in the Bill, which is endeavouring to amend the primary piece of legislation;

2.1.5 consequently, the reference to the MSA or any amendment to the provisions of the MSA in the Laws Amended Schedule to the Bill is *ultra vires* the powers of the National Treasury, alternatively, the Minister of Finance, further alternatively, any regulatory authority referred to in any one or more of the primary pieces of legislation referred to in the Bill in respect of any amendment to the MSA. Accordingly, the amendment contained in the Laws Amended Schedule to the Bill is susceptible to challenge pursuant to the provisions of section 33 of the Constitution read together with section 3 of the PAJA and should be removed;

2.1.6 in so far as it is the intention of the legislature to amend the definition of "*business of a medical scheme*", then such an amendment should be proposed pursuant to an Amendment Act in terms of the MSA and in accordance with the powers afforded to the Minister of Health to deal with the MSA as the Minister within the National Cabinet identified in terms of the MSA and who is charged with overseeing the implementation of the MSA in law;

2.1.7 the proposed amendments to the definition result in making it too broad in so far as it will apply to any person rendering a health service in return for the payment of a premium and not merely a person intentionally undertaking the specific liability of a medical scheme;

2.1.8 the basis for the amendment is not explained in the Bill. The legal status of the existing definition was discussed by the Supreme Court of Appeal ("the SCA") the decision of *Guardrisk Insurance Co Ltd v Registrar of Medical Schemes and Another* 2008 (4) SA 620 (SCA). In this decision, the SCA –

- recognised that the definition is drafted deliberately to take into account the definition of "*accident and health policy*" in the STIA and to allow both definitions to co-exist harmoniously – see paragraphs 10, 16 and 18 of the judgment;
- held that the undertaking of a liability to defray expenditure, related to a relevant health service, is "*quite different*" to making provision for the obtaining of a relevant health service – see paragraph 16;
- stated that no evidence was produced at the time of the hearing of the matter before the SCA that motivated the contention that the definition, if not amended, allowed or encouraged "*younger and healthier members of a medical scheme to choose to subscribe only minimum benefits of the scheme and supplement their benefits by subscribing to the appellant's cheaper policy.*" – see paragraph 19;
- refused to accept that short-term insurance products undermine medical schemes. There is therefore no need, based on the fact that the circumstances that prevailed at the time of the judgment continue to prevail, to amend the definition to change the situation at present – the comments in the judgment remain apposite;
- stated that *"[p]ractical reality has shown that there exists a need for this type of insurance and there seems to be no reason why it should not be permitted."* (emphasis added) – see paragraph 23;

2.1.9 without proper motivation and factual and empirical evidence justifying the amendments to the definition, there is no basis upon which to accept that the proposed amendments are justified. The amendments are thus contested;

2.1.10 in light of the importance of the proposed amendments to the "*business of a medical scheme"* to SAIA's members, not only in respect of the provisions of the Bill, but also the proposed draft regulations pursuant to the STIA, we would be grateful if you would continue to keep us advised of the status of the reference to the MSA in the Bill and steps to be taken to accept these comments and the reason/s why, if at all, the comments are to be rejected by your offices;

2.1.11 a further effect of the proposed amendment is that the subsections of the definition of "*business of a medical scheme*" will be read separately, instead of conjunctively:

2.1.11.1 a separate reading of the subsections means that any business granting assistance in defraying expenditure (in connection with the rendering of a relevant health service), will constitute the "*business of a medical scheme*", without the additional requirement that subsections (a) and (c) have to be met;

2.1.11.2 if implemented, the definition has the effect of rendering a reinsurance contract between a medical scheme and an insurer susceptible to a declaration of invalidity, as it falls within the definition of "*business of a medical scheme*", irrespective of the provisions in section 20 of the MSA;

2.1.12 medical schemes that fall under Schedule 2, more particularly, section 4(3) of the Transitional Arrangements of the MSA, which were registered in terms of section 28(g) of the Labour Relations Act, will be directly affected:

2.1.12.1 there are no transitional requirements for sick funds registered in terms of the Labour Relations Act,. The Department of Labour is of the view that such schemes, which are now continued in terms of a bargaining council collective agreements or which were established prior to 1 February 1999 under section 43(1) C of the 1995 Labour Relations Act, are not subject to the MSA;

2.1.12.2 the effect of the proposed amendment is that it also renders any reinsurance contract between a sick fund and an insurer susceptible to a declaration of invalidity;

2.1.12.3 Another example of the consequences of the amendment would be where consumers pay a monthly contribution/rent to an old age home for accommodation, food AND health services and the potential impact may be that the old age home will be doing the business of a medical scheme.

2.2 Demarcation Regulations: Proposed categories inhibits design of new products

2.2.1 It is submitted that the proposed seven categories and associated criteria, will severely hamper the new design of products as only seven categories of health and accident policies will be allowed. In addition, it remains unclear as to the extent to which products falling outside the predefined categories will be impacted by the Draft Regulations. Such clarity is required in order to determine the reasonableness of the amendments proposed.

2.2.2 It is proposed that the suggested categories will result in severely limiting consumer choice and are susceptible to a constitutional challenge.

2.2.3 It is submitted that as other products that fall outside the allowed categories cannot be designed and that this prejudices consumers that are unfairly denied access to policies that may provide essential cover. The reality is that the consumer will be out of pocket for costs over and above that covered by medical schemes. This will have the effect of denying consumers access to healthcare services of their choice and thus infringing on the consumers' rights in terms of section 27 of the Constitution.

2.2.4 There is a view that the Draft Demarcation Regulations may very well be in conflict with the Competition Act but that this issue has not been fully ventilated given the time constraints.

2.3 Demarcation Regulations: Increase in the cost of regulatory compliance, which will lead to increase costs to the consumer

2.3.1 It is submitted that the proposed regulations will result in an increase in costs to insurers, specifically due to the reporting requirements in regulations 7.4 and 7.5 namely the requirement to report to both the Registrar and the Registrar of Medical Schemes. The reporting includes a summary of the benefits, terms and conditions and marketing material. It is submitted that the increase in regulatory compliance will inevitably lead to the costs being passed on to the consumer.

2.3.2 The introduction of caps, in category 1, will furthermore add to the costs at the underwriting stage. Currently, these products are introduced into the market without any underwriting relating to the determination of income.

2.3.3 The creation of the categories of accident and health policies must not entitle the insurer to refuse any claim for policy benefits on the grounds that the policyholder or insured person experienced a health event prior to the commencement of the applicable cover, unless a material misrepresentation or non-disclosure in regard to such health event has occurred. The result of this amendment will be an increase in costs in respect of driving the products to an individual underwriting basis.

2.4 Demarcation Regulations: Perceived discrimination at disease and other levels

2.4.1 It is proposed that the identification of AIDS/HIV as the only disease for which one may provide cover is insensitive and unfair and contravenes the provisions of, at least, section 9 of the Constitution read together with the provisions of the Promotion of Equality and Prevention of Unfair Discrimination Act No. 4 of 2000, ("the Equality Act").

2.4.2 It is submitted that that the Draft Demarcation Regulations could lead to a further challenge as a result of indirect discrimination against employment and/or income as a result of the criteria namely "*covered offered to employers in respect of employees*" in the AIDS/HIV category.

2.5 Demarcation Regulations: The definitions and substantive provisions

2.5.1 The introduction of amendments to substitute part 7 in the existing regulations under the LTIA and the STIA, respectively, introduces a number of definitions and substantive provisions into the existing regulations under both the LTIA and STIA, respectively.

2.5.2 The most obvious difficulty with the proposed amendments, in the LTIA draft regulations and STIA draft regulations, occurs in proposed regulation 7.2. This proposed regulation purports to introduce a further definition of the term

"*health policy*". The introduction of a definition is apparent from the express wording used in proposed regulation 7.2: *"[a] contract is a **health policy** under paragraph (b) of the definition..."* (emphasis added). It is accepted and is trite in South African law that regulations may not purport to apply or be applied to amend statutes. In both the LTIA and STIA there are existing definitions of the term "*health policy*" (in the LTIA) and "*accident and health policy*" (in the STIA). In this regard, we record that –

- the term "*health policy*" in the LTIA is recognised by and its definition is set out expressly in the explanatory memorandum to the draft LTIA regulations at page 15, being Annexure 1 to Schedule B;
- the term "*accident in health policy*" is recognised by and its definition is set out expressly in the explanatory memorandum to the draft STIA regulations at page 16, being Annexure 1 to Schedule B.

2.5.3 There are therefore competing definitions between the existing definitions referred to above and those now presented in proposed regulation 7.2. To introduce such definitions in the proposed regulations causes a conflict between the proposed regulations and the prevailing legislation. Accordingly, it is not competent for definitions to be imposed in the proposed regulations that are different to the existing definitions in the primary pieces of legislation, being the LTIA and the STIA. The definitions therefore in proposed regulation 7.2 are susceptible to legal challenge.

2.5.4 The provisions of proposed regulation 7.2 also rely on information contained in tables in the draft regulations. The tables identify the information provided into three columns: dealing with the identification of certain policies, in a category format, policy benefits and criteria.

2.5.5 Whilst the intention behind the using such tabulated regulation is not clear from the draft regulations, it appears that one is required to use the table to ascertain whether or not one's policies are capable of being classified into one or more of the categories identified. In this regard, we refer you to the various statements in the explanatory memorandum – page 11 in respect of the draft LTIA regulations and page 12 in respect of the draft STIA regulations.

2.5.6 The application of the criteria in the tables appears to be exhaustive in respect of the type of policy identified in the first column. However, in so far as the express criteria are to be applied to determine whether or not a particular policy falls within a particular category, the criteria are unusually restrictive and thus exclusive. Therefore, the application of the criteria, for example to a "*lump sum of income replacement policy*" may lead to certain of these policies falling outside of the scope of particular category due to the slight alteration of the policy's terms and conditions, i.e. the policy benefits are limited to 75% "*of the policyholder's net income per day.*" The potential for the draft regulations to be applied in this manner-

2.5.6.1 creates artificial distinctions between policies; and

2.5.6.2 differentiates unfairly between fundamentally identical policies. This type of differentiation is without reasonable and justifiable grounds and renders the draft regulations susceptible to challenge in terms of, at least, the provisions of sections 7, 9, 18, 33, 195 and 237 of the Constitution and the Equality Act.

Further clarity is required around the policies intended to be covered in each category.

2.5.7 The legislative rationale for imposing the criteria is not apparent from the draft regulations, as the explanatory memoranda simply state that "*a contract is a health policy only if that contract* ***matches*** *any one of these categories of contracts.*" (emphasis added). In its current form, the provision could lend itself to the interpretation that policies falling outside the prescribed parameters are thus excluded and not subject to the application of the Draft Regulations. Accordingly, the lack of explanation for the criteria used in the tables in the draft regulations undermines the rationality of the draft regulations and renders the draft regulations susceptible to challenge pursuant to the provisions of section 33 of the Constitution read together with section 3 of the PAJA.

2.6 Demarcation Regulations: GAP Cover products

2.6.1 The Demarcation Regulations have a catastrophic effect on an estimated 300,000 consumers representing almost 750,000 beneficiaries who have purchased a policy that augments medical scheme cover, such as Gap cover and Major Medical expense cover.

2.6.2 We are of the considered view that the consumer will be unfairly denied access to policies that provide essential cover and that the policy principals that inform the Demarcation Regulations are unsubstantiated and not supported by statistical or any other independent evidence.

2.6.3 There is no evidence to show that Gap policies result in younger and healthier members limiting or reducing their medical scheme cover, which results in a negative impact on the life cycle protection offered by medical schemes. Similarly, there is no evidence showing that medical schemes are reducing their cover due to the existence of such policies.

2.6.4 The reality is that the individual consumer selects a medical scheme benefit option based primarily on affordability, the effect of the medical scheme rules regarding the use of designated service providers (DSPs), and the rules-based diagnosis and treatment pairs (DTPs), particularly for medicine formularies for on-going chronic medication benefits.

2.6 5 It is also submitted that it is not only the young and healthy that elect Gap cover policies, but that –

2.6.5.1 Gap cover policies are generally available to all South Africans;,

2.6.5.2 premiums are mostly community based; and

2.6.5.3 underwriting and premium penalties are generally provided in a similar manner to regulation 11 to the MSA in which the term "*late Joiners*" is defined.

2.6.6 The effect of the Demarcation Regulations in omitting Gap Cover in the definition of a Health and Accident Policy will be that the individual consumer will be out of pocket for charges over and above the medical scheme tariff. This is so as the majority of medical scheme members, who have purchased a Gap Cover policy, do not have the option to buy up or select medical scheme benefit options that will provide for the benefits otherwise provided by Gap Cover policies. The reality is also that the majority of medical schemes' most comprehensive option plans still do not cover these exposures of the individual consumer.

2.7 Category 1: "*Lump sum or income replacement policy benefits payable on a health event"*

2.7.1 The policy principles that informed the draft regulations refer to policies "*providing similar benefits as medical schemes*", but then include in Category 1 policies that clearly do not provide a similar benefit to that of a medical scheme.

2.7.2 It is submitted that there is a disjunct between the name of the policy in the table and the benefits that are to be provided. This occurs most notably in the first category dealing with "*lump sum or income replacement policy benefits payable on a health event*". The "*policy benefits"* portion of the tables describe only the second of the type of insurance contract described in the first column, being the income replacement policy benefit, and does not address or set out any criteria applicable a lump sum-type contract. The income replacement policy benefit does not set out any criteria in respect of the payment of a lump sum. The reason for this disjunction or omission is not apparent from the draft regulations but renders the Demarcation Regulations vague.

2.7.3 Accordingly, the lack of particularity in the tables in proposed regulation 7.2 renders the provisions of proposed regulation 7.2 susceptible to challenge in respect of the provisions of sections 7, 9, 18, 33, 195 and 237 of the

Constitution, the Equality Act and the PAJA. This is especially important in relation to the application of proposed regulation 7.2(2)(d)(i) in so far as this proposed regulation singles out the contracts that fall into category one of the table stipulated in proposed regulation 7.2.

2.8 "*Introducing*" or "*launching*" terms remains undefined

2.8.1 The terms "*introducing*" and "*launching*" are not defined in the draft regulations but much turns on these terms in so far as proposed regulation 7.5 is concerned. The draft regulations are therefore entirely vague on what is meant by these terms and the distinction that is intended by the use of these terms in the proposed regulations.

2.8.2 Due to the vagaries imported into the proposed regulations by the abovementioned terms, the draft regulations are so vague as to be unenforceable and susceptible to challenge pursuant to the provisions of the Constitution and the applicable provisions of South African administrative law concerning the legality of legislation that is vague and unenforceable as set out in the decisions of *Minister of Health and Another v New Clicks SA (Pty) Ltd and Others (Treatment Action Campaign and Innovative Medicines SA as* Amici Curiae) 2006 (1) BCLR 1 (CC) and *Hospital Association of SA Ltd v Minister of Health and Another; ER24 EMS (Pty) Ltd and Another v Minister of Health and Another; SA Private Practitioners Forum and Others v Director-General of Health and Others* 2010 (10) BCLR 1047 (GNP).

2.8.3 The use of the abovementioned terms, being "*introducing*", "*launching*", "*introduced*" and "*launched*" occurs in primarily proposed regulations 7.4 and 7.5. The importance of meaning of these terms is pronounced in so far as the provisions of proposed regulation 7.5(1) are concerned, which creates the transitional provisions for the draft regulations.

2.8.4 The use of these undefined terms makes it impossible to determine whether or not one has to comply with the provisions of proposed regulation 7.5(1) in relation to policies that are being sold or entered into, to use terminology already in use within the LTIA and STIA, respectively, before and after 15 December 2008. We reiterate the comments made about the vagaries of legislation and the susceptibility of such legislation to review pursuant to the Constitution and applicable principles of South African administrative law.

2.9 Demarcation Regulations: Perceived unlawful exclusions and exemptions

2.9.1 In relation to the identification of policies in proposed regulation 7.2, certain statements are made in the explanatory memoranda to the LTIA draft regulations and STIA draft regulations, respectively.

2.9.2 Of concern in these explanatory memoranda, more particularly, in relation to the STIA draft regulations, is an assumption that certain of the contracts referred to in the draft regulations constitute the business of a medical scheme but will not be considered to fall within the scope and ambit of the MSA and will be treated as exempt for this purpose:

"*Contracts that relate to [Categories 2, 3, 4, 5, 6 and 7]* ***unambiguously*** *constitute the business of a medical scheme as defined in the [MSA]. These categories of contracts, however, are excluded from the definition of the business of a medical scheme as they are deemed not to be harmful to the medical schemes environment.*" (at page 12) (emphasis added) We submit that there is no evidence or substantiation for this view (the deeming of what is harmful and what is not) and wish to again reiterate our view that the regulations are susceptible to legal challenge.

2.9.3 It is not competent for the STIA draft regulations or the LTIA draft regulations to create and impose exemptions or exclusions for contracts or products that otherwise fall into the scope and ambit of the MSA. In so far as such contracts or products are to be treated as exempt from the MSA, then an exemption in terms of section 8 of the MSA must be sought and obtained in respect of each of the contracts or products concerned. It is therefore ultra vires the provisions of section 70(2A)(a) of the STIA and section 72(2A)(a) of the LTIA, respectively, to assume such exemptions or exclusions may be brought into existence in the draft regulations.

2.9.4 The *ultra vires* character of the draft regulations renders both the LTIA draft regulations and the STIA draft regulation susceptible to review in terms of the Constitution, the PAJA and the applicable provisions of South African administrative law relating to the required element of legality in legislation.

2.10 Demarcation Regulations: Transitional arrangements

2.10.1 In so far as the application of the transitional arrangements is concerned, the draft regulations fail and/or neglect to deal with policies in existence prior to 15 December 2008.

2.10.2 In so far as a policy was "*introduced or launched*", as the case may be, prior to the date specified in proposed regulation 7.5(1), the draft regulations do not explain what is to happen to such a policy. The failure of the draft regulations to deal with these policies creates a regime in terms of which there are now two categories of policies differentiated on the basis of the date in the proposed transitional provisions. The draft regulations do not justify the differentiation, which renders the differentiation susceptible to review pursuant to sections 9 and 33 of the Constitution read together with the applicable provisions of the PAJA and the Equality Act.

2.10.3 In relation to the powers afforded to the Registrar of Medical Schemes ("the Registrar") by proposed regulations 7.4(2) and 7.5(2), the creation of such powers to the MSA is *ultra vires* and renders the allocation of such powers to

the Registrar susceptible to review in terms of section 33 of the Constitution read together with section 3 of the PAJA and the applicable principles of administrative law.

2.10.4 Accordingly, the powers afforded to the Registrar in the draft regulations should be removed. In addition, the proposed powers afforded to the Registrar to make representations to the Registrar of Long-term Insurance and the Registrar of Short-term Insurance, is also *ultra vires* the provisions of the STIA and the LTIA, more particularly, those provisions of the STIA and the LTIA, respectively: which permit Minister of Finance to create only regulations contemplated and dealt with in the applicable sections of STIA and LTIA, respectively, concerning "*regulations identifying a **kind, type or category** of contract as a health policy*" (emphasis added).

2.11 Demarcation Regulations: The explanatory memoranda

2.11.1 As stated above there is an explanatory memorandum attached to each of the STIA draft regulations and LTIA draft regulations, respectively, which purports to detail the purpose of the draft regulations. The explanation at page 9 of the STIA draft regulations, dealing with "*Policy Principles that Informed the Draft Regulations*", states unequivocally that:

"*A clear demarcation between accident and health policies (providing benefits that appear similar to that of medical schemes) and medical schemes is further necessary to protect consumers / policyholders. The absence of a clear demarcation **may** result in consumers **believing** that –*

- *that health policies offer the same protection as a medical scheme, when in fact the protection is partial and conditional; and/or*
- *that health policies are medical schemes.*" (emphasis added)

2.11.2 No evidence is proffered, either in the draft regulations or the explanatory memoranda, to support the statements quoted above, more particularly, in so far as the use of the word "*may*" within the statement quoted indicates clearly that the results identified in the two bullet points, quoted above, have not yet occurred and are not intended to occur.

2.11.3 The National Treasury published a policy document "*A Safer Financial Sector to Serve South Africa Better*" on 23 February 2011, which confirms consumer protection as one of its policy priorities.

2.11.4 The Treating Customers Fairly (TCF) initiative was also published in March 2011 requiring the financial sector to incorporate the fair treatment of customers at all stages of the product life-cycle. The initiative was developed to lead to more optimal outcomes from the perspective of the regulators, consumers and the financial sector.

2.11.5 It is proposed that the Demarcation Regulations do not compliment the TCF initiatives and should be reviewed from a TCF perspective. Neither are they aligned with the principles of the document "*A Safer Financial Sector to Serve*

South Africa Better" as far as protection and fair treatment of consumers of financial products are concerned.

2.11.6 It is submitted that consumers that cannot afford to purchase medical scheme products, which are projected in the Policy Paper on National Health published by the Department of Health in 2011 as 83.8% of the population, have limited financial products to choose from that may assist them with defraying medical expenditure and policy benefits that are in line with the contingent expenses of illness or hospitalisation or both.

2.11.7 There is therefore no need to legislate in the LTIA or the STIA, in the manner contemplated in the explanatory memorandum, for what is perceived or deemed to be a problem when there is no evidence that such a problem exists.

2.11.8 In particular, the aim of the draft regulations would be to remove any subjectivity of interpretation as to what features of a product could be harmful in this regard.

2.11.9 The process of having to submit all accident and health policies to the Registrar of Short-Term Insurance ("the STIA Registrar") and the Registrar for approval does not appear to assist with the objectives of the draft regulations and does not give the insurance industry the confidence needed to invest time and capital in the development of insurance products for the South African public.

2.11.10 We are also concerned that an assumption of what is "*harmful*" is being applied in a discriminatory manner, as is evidenced from the fact that whilst a particular product type has been allowed, other very similar product types have been disallowed such as cover for Tuberculosis

2.11.11 It is our understanding that the intention of the draft regulations is to exclude products that undermine the risk pool of medical schemes. However, this assumption remains unsubstantiated:, no evidence has ever been provided by the Council for Medical Schemes, the Department of Health or National Treasury to show that any of the excluded products undermine the medical scheme environment. During the Working Group sessions between 2008 and 2011, both industry bodies (SAIA and ASISA) requested the National Treasury to agree to conduct a qualitative study that addresses these concerns, but this was rejected without reason or explanation. It was submitted that no simple statistical analysis alone (as attempted by the Council for Medical Schemes) answers questions of causality, and the absence of correlation (or its presence) cannot be used to draw conclusions in this regard.

2.11.12 Furthermore, any sample of existing policies and the purchasing patterns of the corresponding policyholders that refute the assertions will be labeled as biased and unrepresentative in the event that the National Treasury is not involved in setting up the study. We therefore, once again, urge the National Treasury to oversee such an independent qualitative survey

so that the allegations of undermining may be shown to be either well-founded or not valid. SAIA members affected by the draft regulations will be pleased to fund such a qualitative survey, jointly participate in setting the terms of reference and participate.

2.11.13 In addition to what is set out above, the current provisions of the MSA in sections 7(a), (c), (g) and (h) afford adequate powers to the Council for Medical Schemes to ensure that members of and prospective members of medical schemes are protected. This objective is achieved by the Council of Medical Schemes by ensuring –

- that the rules of medical schemes are clear – see sections 29 and 31 of the MSA;
- that medical schemes and their products are marketed in a particular manner – see sections 20, 21 and 21A; and
- the enforcement of the prohibition, in terms of sections 20(1), 26, 27 and 43 of the MSA, on persons from conducting the "*business of a medical scheme*" as this term is currently defined in the MSA.

2.11.14 The explanatory memoranda also set out how the draft regulations will apparently "*achieve the policy principles*". In this regard, at pages 10 and 11 of the STIA draft regulations, it is stated that:

"*The policy principles referred to in paragraph 3 above are achieved by –*

4.1 identifying those categories of health policies ***as may be interpreted*** *as doing the business of a medical scheme,* ***but will not undermine the principles of open enrolment, community rating and cross-subsidisation;***

4.2 prescribing the policy benefits that may be provided under these categories of health policies, to further protect the business of medical schemes ***of being undermined****;*

4.3 prescribing clear criteria that must be met by contracts under these categories of health policies, which criteria relate to the purpose for which policy benefits may be paid and to whom such policy benefits may be paid;

4.4 prescribing matters relating to the marketing of these categories of health policies;

4.5 prescribing matters relating to the disclosures that must be made by insurers and intermediaries relating to these categories of health policies;

4.6 prescribing requirements for reporting product details of these categories of health policies to the Registrar of Short-term Insurance ... and the Registrar of Medical Schemes, so as to facilitate the adequate supervisory oversight; and

4.7 prescribing transitional provisions for regulating existing health policies that are inconsistent with the draft regulations" (emphasis added).

2.11.15 Once again, in relation to the quote set out in the immediately preceding paragraph, no evidence is offered that supports or remotely indicates that any one or more of the consequences set in paragraphs 4.1 and 4.2 quoted above, respectively, have occurred or will occur. There is therefore no basis to accept that paragraphs 4.1 to 4.7 quoted above, reflect accurately or at all current market conditions. Consequently, there is no basis on which to accept that the aforementioned paragraphs form a rational basis in law for the existence of the draft regulations. On this basis alone, the draft regulations are vulnerable to challenge in terms of the Constitution read together with the PAJA.

2.11.16 Open enrolment and community rating principles guarantee acceptance for any citizen applying for membership and disallow any form of risk rating or price differentiation other than for family size and/or income is entrenched in the MSA. The National Treasury statement confirms that the process to allow categories included identified *"health policies that will not undermine open enrolment and community rating"*. It is entirely impossible for any insurance policy of any nature to undermine these components of the MSA since these are legal requirements common only to medical schemes. It is submitted that insurance policies can not undermine the principles of community rating and open enrolment.

2.11.17 The draft regulations are entirely silent on the existence of a particular problem with which the draft regulations will deal by the introduction of the amendments. Accordingly, the proposed draft regulations have an ulterior purpose in relation to the attainment of the objectives for which they are supposedly designed and the objectives that they, in fact, achieve. This purpose is to subject certain policies into the scope and ambit of the MSA, being those policies in existence before 15 December 2008 and which fall outside of the draft regulations, under the direct power of the Registrar. This ulterior purpose is evident when one takes into account what is set out above, more particularly, the statements in the explanatory memoranda and the proposed amendments to the term "*business of medical scheme*", which appears at page 17 of the explanatory memorandum to the STIA draft regulations and page 16 of the explanatory memorandum to the LTIA draft regulations. In this regard, we also refer you to the following statements in the documents referred to above in paragraph 4 above, which are also made without any evidence or substantiation –

2.11.17.1 the reference to "*the risk of possible harm*" caused by health insurance products" in line 4 of the media statement;

2.11.17.2 the reference to "*consideration will be given to its impact on medical schemes*" in lines 27 to 28 of the media statement;

2.11.17.3 the reference to "*the current or potential harm that a health insurance policy may cause to medical schemes environment*" in lines 29 to 31 of the media statement;

2.11.17.4 the reference to "*critical to prevent regulatory arbitrage between health insurance and medical scheme products in South Africa*" in lines 35 to 36 of the media statement;

2.11.17.5 the references to "*cause harm*" in paragraph 3 of the FAQ document and "*if left unchecked could result in increasing costs*";

2.11.17.6 the references to "*current or potential harm that a health insurance policy may cause to [the] medical schemes environment*" in section 4 of the FAQ document;

2.11.17.7 the reference to "*anti-selective behaviour*" in paragraph 5 of the FAQ document. In this regard it is submitted that cross-subsidisation is undermined within the medical schemes industry as a result of the fact that the MSA does not impose any form of mandatory cover. In fact the open enrolment and community rating provisions enhance anti-selective behaviour since they remove any barriers to entry for a consumer who makes the conscious decision to remain uninsured while young/healthy and then to join a medical scheme once they are old/sick, especially since acceptance is guaranteed. This subsequently further undermines cross-subsidisation within medical schemes;

2.11.17.8 the references to "*directly linked to costs of medical care must not cause harm to the medical schemes environment*" in paragraph 6 of the FAQ document read together with the statement that *"[t]he net effect is that costs begin to rise for older/sicker individuals as the cross subsidisation principle is undermined.*" Also in paragraph 6;

2.11.17.9 the references to "*exceptions*" in paragraph 7 of the FAQ document;

2.11.17.10 the contents of paragraph 12 of the FAQ document read together with the provisions of paragraph 13 of the FAQ document dealing with transitional arrangements.

2.11.18 The statements referred to above are enhanced by statements that appear in the explanatory memoranda as follows:

STATEMENT	**REFERENCE IN THE EXPLANATORY MEMORANDUM TO THE STIA DRAFT REGULATIONS**	**REFERENCE IN THE EXPLANATORY MEMORANDUM TO THE LTIA DRAFT REGULATIONS**
Paragraph 3 in relation to the benefits provided by health policies and their alleged impact on medical schemes.	At the foot of page 9	At the foot of page 8
The intended scope of the draft regulations.	Paragraph 5 on page 11	Paragraph 5 on page 10
The reference to so-called "*interpretational*	The second paragraph under the heading	The second paragraph under the

difficulties" in relation to Category 1 policies.	referring to draft regulation 7.2 on page 12	heading referring to draft regulation 7.2 on page 11

2.11.19 Without proper substantiation in respect of the matters referred to above, the introduction of the draft regulations is entirely without merit or rational grounds. Therefore, the draft regulations lack the elements of rationality and reasonableness required by the Constitution and the South African common law in relation to the introduction for proposed legislation. For this reason alone, the draft regulations are susceptible to legal attack.

3 Consolidation of specific industry feedback:

Notwithstanding the fact that the draft Demarcation Regulations in its current form are regarded as unacceptable the table is below is presented as a discussion document for further consultation and the comments in this table should, in no way whatsoever, be construed as an acceptance of the draft Demarcation Regulations whether in whole or in part.

TABLE A - Categories of contracts recognised as "accident and health policies" for the purposes of the Short-term Insurance Act and as contemplated in terms of Regulation 7. 2(1) read with Regulation 7.2(1)

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
1.	Lump sum or income replacement policy benefits payable on a healthy event	Covers loss of income and contingency expenses associated with an insured person experiencing a specified health event	In addition kindly review section 2.5.7 of this submission.	• Policy benefits are on one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined	The restriction on policy benefits ignores the contingent expense component of the cover. In addition, for the Lump Sum benefit is entirely unsuitable as it presupposes a daily benefit. Sum assured is not adequately	It is not appropriate to group Lump Sum and Income Replacement Benefits in the same category, and with the same limitations. It is proposed that the National Treasury should

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
				basis set out in the contract.	defined, and it is not clear whether this is also capped by reference to income at an undefined time. Clarity Is required on whether the criteria are inclusive or whether standalone lump sum policies are also allowed. It is submitted that the category could be renamed "*contingent expenses.*" Hospital Cash policies do not typically require a person to be working or event to have no continuance of income if policyholders are incapacitated from working.	provide clarity in the Regulations on what is regarded as a "pre-determined basis."

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
					It is submitted that neither the term *"income"* nor the term *"net income"* is clear. The measurement of income per day is equally unclear. By linking the benefit to income, the unemployed, retired and stay-at-home parents are unfairly denied cover, which constitutes indirect unfair discrimination.	
				• Policy benefits are limited to 70% of the policyholder's net income per day.	The benefit restriction ignores the contingency basis of cover, as there is no link between expenses and income. The restriction also	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
					prevents individuals from protecting 100% of their income as is currently the case, and no substantiation is presented for the proposed 70%. This capping of benefits to income unfairly discriminates against low income consumers. No indication is offered relating to when the income is to be determined, namely whether or not it should be determined at the application stage, at any time in the life of the policy or at the time of a claim. As most of these policies are sold free of	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
					underwriting, the introduction of this cap will dramatically increase costs to the consumer if underwriting is now required. Claims underwriting would be prejudiced, particularly if an individual's income has dropped over the life time of the policy and the policyholder benefit is now inequitably reduced to comply with legislation. It is submitted that an elimination or deferred period has a similar meaning.	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
				• Policy benefits may be differentiated for different health events. • Policy benefits may be differentiated in	The draft regulations are silent in respect of the differentiation between elimination periods and waiting or eligibility period. As a result section 2(b) may be contradictory.	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
				accordance with the severity of different health events and expressed as percentage of the sum assured, up to a maximum of 10 severity levels. • An elimination or deferred period may apply before policy benefits are paid.		

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
2.	Motor: Third Party Liability	Covers policyholders and insured persons for the costs associated with damages incurred during a theft or accident of a vehicle, including the cost of a relevant health service following the injury to occupants of the vehicle or a third party as a result of an accident.	It is submitted that this category is not a health and accident policy. The category name namely "*Motor: Third Party Liability*" is also a concern as the name of this category does not clearly identify it as an accident and health policy. Accordingly it will lead to uncertainty relating to the information that must be submitted to the Registrars.	• Policy benefits may be linked to actual costs or expenses of a relevant health service.	It is submitted that the intention of this provision is unclear. In the event that this category is regarded as an accident and health policy it may lead to further unintended consequences such as capital requirements. It is submitted that alternative categories may not be introduced in legislation but should be provided for in legislation such as the Insurance Laws Amendment Bill or proposed insurance legislation.	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
3.	Property: Third Party Liability	Covers policyholders and insured persons for all damages or theft from property, including any costs of a relevant health service following the injury of third parties while on that property and/or compensation for bodily injury of the policyholder or insured person as a result of violent and external means.	See comments above	• Policy benefits may be linked to actual costs or expenses of a relevant health service.	See comments above	
4.	HIV & AIDS	Covers expenses for	Kindly refer to the comments	• Cover offered to	It is submitted that the cover	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
		HIV-related testing and HIV & Aids treatment on an employee group basis.	in section 7 of this submission.	employers in respect of employees. • Policy benefits may be paid in kind or to a provider of a relevant health service. • Policy benefits may be linked to actual costs or expenses of a relevant health service. • Cover may be offered on a pre-funded or	should not be restricted to employer groups but should also be extended to individual consumers alternatively should be extended to other groups such as infinity groups, church groups, bargaining councils, unions.	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
				immediate needs basis.		
5.	International travel insurance	Covers costs associated with a relevant health service incurred while travelling outside of the Republic of South Africa, as a result of a health, disability or death event that occurs while not in the Republic.	It is submitted that the introduction of the category leads to the introduction of a class in itself, disability/death brought into the policy benefit, It is submitted that international travel insurance can be clearly demarcated from the medical schemes environment due to the provisions in the MSA, namely that the Council for Medical Schemes must approve the practice code number and the	• Policy benefits may be payable in kind or to a provider of a relevant health service. • Policy benefits may be linked to actual costs or expenses of a relevant health service. • Cover may be offered on a pre-funded or immediate needs	Clarification regarding the terminology "*payable in kind*" is needed.	

Category	Name	Policy Benefits	If you do not agree with the proposed benefits, what should be excluded or what other benefits should be added and why.	Criteria	If you do not agree with criteria, what other criteria should be considered and why.	Additional Comments
			Council has no jurisdiction to approve practice code numbers in other countries.	basis.		
6.	Domestic travel insurance	Covers costs associated with a relevant health service incurred while travelling inside South Africa, as a result of health, disability or death event that occurs while in South Africa.	The inclusion of death as a policy benefit remains unclear as it does not relate to the providing of the "business of a medical scheme." Accordingly, all policy benefits allowing for cover as a result of death should, by default, not fall within the provisions of these regulations.	• Policy benefits may be payable in kind or to a provider of a relevant health service. • Policy benefits may be linked to actual costs or expenses of a relevant health service.		

TABLE B - Contractual limitations on accident and health products

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
7.2(2) (a)	The contracts listed above must not provide that the policyholder or insured be a member of a medical scheme.	The word *"specific"* before medical scheme is missing.	It is unclear how this provision furthers the aim of medical scheme membership.	The proposed regulation should include that a policyholder may not a member of a **registered** medical scheme and insurance premiums may not be linked to a specific medical scheme benefit option or that insurance benefits may not be dependent on a specific medical scheme benefit option.
7.2(2)(b)	The contract listed above must not entitle the insurer to refuse any claim for policy benefits on the grounds that the policyholder or insured person had experienced a health event prior to the commencement of the applicable cover, unless material misrepresentation or non-disclosure in regard to such health event has occurred.	The challenge lies in the fact that the categories allegedly include acceptable products. These products are essentially allowed due to the fact that it may be regarded as a medical scheme. It is submitted that this provision should not be a condition for category 1 policies which are prevented by 7.2(2)(d) from in any way indemnifying medical	This provision will lead to limiting the ability to underwrite accident and health policies. Furthermore, local insurers will not be able to compete with international competitors. The result of this provision will be that accident and health policies will be compelled onto fully underwriting basis and lead to an increase in costs such as administration costs that will	Allow a limited eligibility or waiting period of a maximum of 24 months; and add *"or unless individually excluded under section 3(b)(i) and (iii)"* and allow for medical underwriting (if required).

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
		expenses and accordingly acting like a medical scheme.	impact on the affordability of products to consumer.	
7.2(2)(c)	The contract must not provide for the cancellation, variation or non-renewal of the contract by the insurer as a result of the health or claims experience of a policyholder or insured person, unless material misrepresentation or non-disclosure in regard to the insured person's health or claims experience has occurred. and	Defines acceptable products and yet those products have to then "behave" like a medical scheme. What component of the policy benefits are they referring to? This is a general condition. Why should this apply to category 1 products which are prevented by 7.2(2)(d) from in any way indemnifying medical expenses and hence acting like a medical scheme?		
7.2(2)(d)	In respect of "lump sum or income replacement policy benefits payable on a health event", the contract must not provide for policy benefits that are fully or partially related to indemnifying the policyholder against	It is unclear what the intention of the words "*fully or partially*" is. It is proposed that a		

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
	medical expenses incurred in respect of .a relevant health service; or	differentiation between the intent of a policy versus the actual use of benefits by an insured should be identified?		
7.2(2)(e)	In respect of "lump sum or income replacement policy benefits payable on a health event", "Motor: Third Party Liability" or "Property: Third Party Liability", the contract should not allow for cession or payment of any policy benefits payable under the contract to a provider of a relevant health service.			
7.2(3)(a)	"Accident and health policies" must provide for a 90-day notice of termination period to a policyholder if an insurer will no longer be offering such policies or contracts that relate to the same or similar policy benefits, or the same event as part of its short-term insurance business.	It is suggested that category 1 should be excluded from this provision due to the fact that category 1 does not deal with medical expenses. This provision should apply to categories 2 to 7 only.		
7.2(3)(b)	"Accident and health policy" contracts must be in	This provision implies that		

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
	clear and easily understood language identifying those representations made by or on behalf of the policyholder or insured person to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy; state the premiums payable and policy benefits under to be provided under the policy; and state the events in respect of which the policy benefits are to be provided and the circumstances (if any) in which those benefits are not to be provided.	specifically named exclusions are allowed and thus contradicts 7.2(2)(b). The *"representations"* need to be defined otherwise age, gender etc may need to be listed.		

TABLE C - Marketing and disclosures

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
7.3	Marketing material or activity in respect of "*accident and health policies*" must:			
(a)	Not be identified by the term "medical", "hospital" or any derivative thereof.	This provision may mislead the public if the word "hospital" is used as a gatekeeper for determining absence from the workplace, but the term is then not allowed in any explanation of the policy description, particularly if it is used in the definition of a claim in the contract wording. For existing policies "hospital" cannot be retrospectively barred from use. Also, for future policies there is no clash no		

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
		linkage between use of "hospital cash" and individuals being confused, particularly with the use of "this is not a medical scheme" scripts. It is suggested that a review of complaints for all members to see how many and what percentage of Hospital Cash plans related complaints are due to an individual "believing they had purchased a medical aid".		
(b)	Not in any manner create the perception that the contract indemnifies a policyholder against medical expenses incurred as a result of a relevant health service; or is a substitute for medical scheme membership.			
(c)	Display the following statement in clear legible print in a			

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
	prominent position: "*This is not a medical scheme and the cover is not equivalent to that of a medical scheme. This policy is not a substitute for medical scheme membership*"			
(d)	Clearly disclose and explain in easily understood language the matters referred to in 7.3(b) above.			

TABLE D - Reporting of product information

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
7.4(1)	An insurer must, at **least one month <u>prior</u>** to the introduction or launch of a new accident and health policy, submit a summary of benefits, terms and conditions and marketing material of that accident and health policy to the Registrar of Short-term Insurance and the Registrar of Medical Schemes.		If a policy meets all the requirements of these regulations, it is proposed that submission of the products should NOT follow. This provision will lead to a change to the manner in which the industry is regulated. The cost implications in the way that the industry is intended to be regulated will have implications for policy holders and the public in terms of limiting innovation,	Remove this requirement – pre-filing is not common practice; it increases costs and premium to the consumer alternatively, any submission should only be to the Registrar of Short-term Insurance. The Registrar: STIA may consult with the Registrar.

			choice of products in the market place, the price of products, speed of development and response to market needs. The word "*New*" is not defined and it is unclear if a "change of price/benefit" might be regarded as a new policy. Furthermore the submitting of a summary is also not defined. It is suggested that the full policy and the marketing material should be submitted, as a "summary" is open to misinterpretation.	If our proposal that no submission is rejected, then it is proposed that the consideration should be allowed for electronic submission of documents.
7.4(2)	The Registrar of Medical Schemes may, within one month referred to in 7.4(1) above or at any time thereafter, advise the Registrar of Short-term Insurance		Suggested that "must" rather than "may" should be used, and that the words "*at any*	

	that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act and must provide reasons for such opinion.		*time thereafter*" be deleted. There should be no submission of any policy that adheres to the provisions of these regulations and clearly fits into any of the categories outlined in 7(2)(1). The words "*at any time thereafter*" are unacceptable as they give no business certainty to an insurer. If the policy adheres to the conditions of these regulations, it is submitted that cannot be regarded contrary to the objectives and purpose of the MSA. It is submitted that "reasons for such opinion" is subjective. The request should rather be against an	

			objective set of criteria. The purpose and objectives of the MSA are not defined for the purposes of the draft regulations.	
7.4(3)	The Registrar of Short-term Insurance may within the one month period referred to in 7.4(1) above or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to 7.4(2) above, by notice to the insurer object to any of the benefits, terms and conditions and marketing material of an accident and health policy submitted. The Registrar can, pursuant to this decision, either: - (a) Prohibit the insurer from introducing or launching the accident and health policy; or (b) Instruct the insurer to stop offering or renewing the policy and within 90 days of the date determined by the Registrar, terminate any accident and health policy; or		The words "or at any time thereafter" do not allow for certainty in the business environment and lead to large losses to the insurance industry. It is recommended that the word "ought" should be replaced with *the word "must"*. It is submitted that the following words must be added after the phrase "*by notice to the insurer*", the words "*either approve or object with stated reasons*". In the event that the phrase	

	(c) Require the insurer to amend any of the benefits, terms and conditions and marketing material of an accident and health policy in accordance with the requirements of the Registrar of Short-term Insurance.		*"at any time thereafter"* is retained, then it is proposed that in relation to items (a), (b) and (c) that the Regulator will indemnify the insurer with any costs associated with ombudsman complaints, legal and/or regulatory proceedings and associated costs arising therefrom. It is submitted that part (a) assumes that feedback will be submitted within 1 month. It is submitted that part (c) should occur with effect from the next annual renewal.	

TABLE E - Transitional arrangements

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
7.5(1)	An insurer must, **3 months after** the coming into effect of these Regulations, submit a summary of the benefits, terms and conditions and marketing material of all existing accident and health policies referred to in these Regulations introduced or launched on or after 15 December 2008 to the Registrar of Short-term Insurance and Registrar of Medical Schemes.	It is submitted that Regulations should be clear regarding policies prior to 15/12/2008. The provision does not include reference to renewed policies.	Refer to comments regarding summary (above). It is submitted that 3 months is too short a period of time, taking into consideration the potential and practical impact on the consumer as well as well as the product providers and the registrars. It is proposed that the period be set at 12 months. It is submitted that a clear distinction be made between *"policies"* and "products" throughout the draft regulations.	

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
			Clarity should be provided for products that *"were first made available to the market"* prior to 15 December 2008.	
7.5(2)	The Registrar of Medical Schemes may, within the 3 months referred to under 7.5(1), or at any time thereafter, advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, the terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act and the reasons for this opinion.		The words *"at any time thereafter"* are unacceptable as they give no business certainty to an insurer. It is submitted that the no insurance products in terms of the draft regulations would pass the test as proposed under this sub-regulation. The purpose and objectives of the MSA are not defined for the purposes of the draft regulations	

Relevant Regulation	Description	Issues to consider	Commentary	Alternative proposal
7.5(3)	The Registrar may within the 3 months period referred to under 7.5(1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to in 7.5(2) above, by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of an accident and health policy submitted under 7.5(1) and: - Instruct the insurer to stop offering or renewing those accident and health policies to the public and within 90 days of the date determined by the Registrar, terminate any accident and health policy; or - Instruct the insurer, by date determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of an accident and health policy in accordance with the requirements of the Registrar before offering those health policies or renewing any existing accident and health policies to the public.		The words *"at any time thereafter"* are unacceptable as they give no business certainty to an insurer. It is proposed that the wording *"within the 3 months period"* be changed to "the registrar must within a 3 month period following the receipt of the information submitted under R7(5)(1), of the Registrar...". It is proposed that the Registrar must submit reasons in the notice to the insurer.	Instruct the insurer to stop offering or renewing those accident and health policies to the public within 90 days of such instruction. Instruct the insurer, by a date to be determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of an accident and health policy in accordance with the requirements of the Registrar in respect of any product renewing after that date.

4 Conclusion

The SAIA confirms its availability to enter into further consultations with the National Treasury on the Demarcation Regulations.

The SAIA reserves the right to amend its submission to the extent that changes to legislation or any proposed survey or study may impact on its members' views.

For all of the reasons set out above, substantial revisions of the draft regulations and an abandonment of the amendments to the definition of "*business of a medical scheme*" are required in order to align the draft regulations, in so far as this is possible, with the requirements of Constitution and South African law concerning the contents of proposed legislation.

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