CC

Long-Term Insurance Act, 1998: Publication of Proposed Amendment of Regulations made under Section 72 for Public Comment

MMI (Momentum, Metropolitan) Holdings appreciates the opportunity given to provide comments to the proposed amendments.

We understand that the aim of the Draft Regulations is to find a better balance between Medical Schemes and Health Insurance Products, with the aim of protecting Medical Schemes from anti-selection based on age and health profiles.

MMI is in agreement with the spirit of the proposed amendment but requires further clarification and guidance on some of the sections.

Kindly see below our comments.

Categories of contracts identified as health policies under paragraph (b) of the definition of health policy (7.2.1(a)

Income Protection Policies

Clarification is sought in respect of whether the definition of Category 1 policies extends to Income Protection policies.

With regard to the definition of Category 1 policies, is it the intention of the Minister to include Income Protection products under the definition of disability product under the Long Term Insurance Act or under the definition of Category 1 policies in terms of the draft regulations.

It is our opinion that Income Protection policies conform to the definition of disability policy in terms of the Long Term Insurance Act despite the inclusion of some health event criteria evident in the product.

Income replacement policies usually provide benefits based on the policyholder's ability to perform his job, without having specific regard for the reason(s) behind the inability to work. There are some products where benefit payments are linked to the occurrence of a specific health event. The reason for this alternative approach is to provide a more objective criterion for the payment of benefits. Assessing whether an individual can still do his/her job is often perceived as a subjective exercise.

It is however important to note that the benefit is still intended to deal with the consequence of the health event, namely the policyholder's inability to work.

In our opinion it therefore that it does not make sense to include this benefit in the legislation. Should it remain included we would suggest that the proposed benefit limit be removed or at least be increased to cover 100% of a policyholder's gross income

Critical Illness Policies

With regard to Critical Illness contracts, they have traditionally been sold to address certain needs associated with the occurrence of specified health events.

The main needs that these policies cater for are:

1. Providing for temporary loss of income following a policyholder's inability to work after the occurrence of a critical illness event.

2. Providing for the cost of any lifestyle adjustments that may be required following the occurrence of a critical illness event.

3. Providing for any excess medical expenses that the policyholder may have following the occurrence of a critical illness event.

Critical illness policies are primarily intended to deal with the consequences of the specified health events, rather than the health event (or its associated costs) itself. Given the severity of most of the critical illness benefits, it is however not uncommon for policyholders to have residual medical expenses (either directly related to medical procedures or related to effective rehabilitation and recovery) not covered by their medical scheme.

It would therefore make sense for these residual expenses (where they may exist) to be covered by a Critical Illness policy. It has never been positioned as an alternative to medical schemes and most policyholders who select this benefit also have medical aid. We accept that a part of the benefit could relate to medical expenses and therefore understand and agree with the inclusion of this benefit in the draft legislation. However, given that the benefit primarily deals with the consequences of the critical illness events and is not sold or positioned as an alternative to medical aid, it is our opinion that the general provisions under 7.2 (2) (d) should be sufficient to ensure that these benefits do not encroach on the work of a medical scheme.

7.2(1) Criteria relating to Category 1: Benefit Limitation

Further clarification is required in respect of the benefit limitation of 70% of the policyholder's net income per day. It is not clear if this limit only applies to income replacement benefits or is intended to apply to lump sum benefits as well. If it is intended to include lump sum benefits, it is not clear how the given benefit limit should be applied.

7.2(2)(b)Underwriting practices at claims stage

If the exclusion in respect of underwriting practices is only at claims stage

We would like to obtain clarification on the stipulations under 7.2 (2) (b). It is not clear if this imposes any limitation on the insurer's ability to underwrite risks and, depending on the results of the underwriting process, to impose specific sanctions / limits, such as exclusions related to pre-existing conditions, premium loadings or declinations.

7.2 (2) (c) Criteria relating to Category 1: Cancellation, variation or non-renewal of contract as a result of health or claims experience

Clarification is required under this section. It would appear that the stipulation could potentially limit the insurer's actions in the event of adverse claims experience. Typically an insurer needs to be able to review and adjust price if necessitated by experience. For retail business this would normally be a general change and would apply to all policyholders of similar profile. For group business it is common practice to charge larger schemes a price that reflects their specific experience.

7.2(2)(d) Cessions or payments to health providers

Clarification is required in respect of the reasoning behind the restriction of cessions to health providers. Ownership is a real right that entitles the person holding that right to specific entitlements. One of the entitlements to ownership is the ability to alienate or transfer the right by way of outright cession. Whilst it is acknowledged that the right of ownership is not absolute and must consequently be exercised within the social function of the law, in the interests of the community, the balance between the exercise of entitlements of ownership (supra) and the obligation of the owner to the community must be maintained. In this instance it is established law that the infringement on the right of ownership must be reasonable and equitable. It is therefore our submission that the restriction on cession of benefits to health providers be scrutinised against a constitutional disposition.

7.3(a) Marketing and disclosures

It is submitted that not using the terms "medical" or "hospital" or any "derivative" thereof poses a practical difficulty in terms of adequate disclosures as it pertains to the product. It is submitted that the use of the word "derivative" be either removed or explicitly defined to provide clarity.

7.3. (d) Marketing and Disclosures

Specifically in relation to Critical Illness benefits, we propose that the compulsory wording be modified to reflect the fact that medical expenses could be part of the contingencies covered. For example: "The intention of the policy is primarily to cover contingencies other than medical expenses. ..."

7.5Transitional arrangements

The transitional arrangements relate to existing health policies introduced or launched on or after the 15 December 2008. What is the position in respect of health polices introduced or launched prior to this

date? Furthermore, what is the position in respect to products launched prior to this date but an alteration is effected to an existing policy to add a health policy after 15 December 2008? Would this policy then be subject to this paragraph?

7.5(3) Transitional arrangements

The Registrar may instruct the insurer to terminate any health policy or to amend any of the terms and conditions, benefits of a health policy. In the event that a determination is made to the effect that such health policies be terminated, what is the Minister's view on policyholder expectations in this regard? Furthermore, should the Minister determine that terms and conditions be amended, this would amount to a unilateral change by the insurer.

What is the Minister's view on the apparent conflict between contractual principles and the proposed regulations?

Categories 2-4

As mentioned in the Explanatory Memorandum that accompanied the draft legislation, categories 2,3 and 4 relate to contracts that provide for policy benefits relating to actual medical expenses associated with the health events identified in those categories. It is further stated that these categories were excluded from the definition of the business of a medical scheme as they are not harmful to the medical schemes environment.

It is our opinion that more benefit categories could have been included here, whilst still meeting the criteria of not being harmful to the medical schemes environment. Specifically:

- Allowing insurers to provide for benefits that fall outside the requirements of the Prescribed Minimum Benefits should not have any adverse effect on medical schemes' ability to provide the Prescribed Minimum Benefits in a cost effective way; and

- Allowing insurers to provide benefits to low income earners should also have limited (if any) affect on the wellbeing of medical schemes. Many low income earners cannot afford even the most basic medical scheme option. Allowing health insurance policies to be provided would at least provide them with some benefit;

- It may actually be in the medical scheme's interest to limit the benefits payable in respect of certain high cost events / conditions. Also, most medical schemes have upper limits in terms of the benefits that they provide. There is potentially a place for insurance to provide for certain high cost events or to provide medical scheme members with coverage should they exceed the medical scheme benefit limits.