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ASISA

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DRAFT REGULATIONS UNDER SECTION 72: CALL FOR COMMENTS

ASISA appreciates the opportunity to submit our comments on the draft regulations made under Section 72 of the Long Term Insurance Act ("the Act"), and the extension granted until 2 May 2012 to do so. We do however point out that the time afforded for commentary was very limited and that our comments are therefore not exhaustive of all the potentially problematic issues.

We do have some major concerns with the regulations, which are set out below, and these should be read together with the attached table of comments per section.

Scope of the Regulations

As set out in the explanatory memorandum (pg. 8), Section 72 of the Act "affords the Minister of Finance legislative authority to make regulations that identify certain categories of contracts as health policies. Despite the fact that those contracts may be interpreted as doing the business of a medical scheme". Whilst Categories 2-4 in the regulations are clear as to what is included, Category 1 is not clear.

Our submissions are premised on our understanding, derived from feedback from the ASISA representatives on the National Treasury Demarcation Work Group, that the regulations will only have application to health policies which constitute the business of a medical scheme and that health policies which provide benefits not catered for by medical schemes, such as critical illness benefits, are not subject thereto.

We also point out that the regulations will have to be aligned with the definition of "the business of a medical scheme" in the Medical Schemes Act, which may be amended in terms of the Financial Services Laws General Amendment Bill. Depending on whether the definition is amended as proposed or otherwise, the proposed Regulations may well have to be amended in which event we shall require an opportunity to again comment on the amended regulations.

Purpose of the Regulations

Although the reasons why certain health policies are being targeted are given (page 8, in the Explanatory Memorandum), we have never been provided with any evidence in support of the apparent conclusion that certain health policies erode the risk pool of medical schemes. It is therefore not clear on what facts such conclusion is based. Although the FSB sent out an information request on health policies to insurers in the latter part of 2011, we don't know whether the results of this have been considered and if they will be made public.

The regulations in their current form are very far reaching and may very well deprive the public of valuable and necessary benefits. As such we strongly submit that the "mischief" needs to be properly identified before regulations are passed which may have unintended consequences.

Whilst we support the principles of medical scheme coverage as set out in the explanatory memorandum (pg. 9), we submit that a large gap in the application of social solidarity principles to the medical scheme environment is that of compulsory membership and risk equalisation. A high cost medical scheme environment will naturally lead to younger and healthier lives exiting, with or without health insurance. The introduction of open enrolment and community rating, in the absence of compulsory membership and risk equalisation, is dangerous, and international literature would support that all these elements go hand-in-hand.

We raise these points in order to emphasise the importance of the regulations identifying the correct categories of contracts, if any, which should be "disallowed". It is a reality that medical schemes, even at the maximum benefits provided, do not always cover the medical and hospital costs incurred and that members may very well suffer severe financial hardship if not permitted to insure against this contingency, nor do they provide for other, non-medical expenses that may arise as a result of the occurrence of a health event.

Proposed restrictions in the draft regulations

- Limitation of policy benefits to 70% of the policyholders net income (which has not been defined) per day for Category 1- this limitation does not make sense for products paying lump sum benefits and for benefits such as a daily amount under a hospital cash plan. This limitation would largely restrict meaningful cover, particularly for lower income earners, and exclude those with no income. For example in order to qualify for a daily benefit of R1 000 under a hospital cash plan, one would need to have a salary (income) of R300k per annum.
  it will furthermore increase costs if insurers need to obtain information on income which is often not currently required.

- Underwriting-Section 7(2)(b) of the regulations prevents the insurer from underwriting at claims stage. It furthermore prevents an insurer from providing a policy to a person with an existing medical condition, subject to an exclusionary clause related only to that condition. This will mean that people with existing medical conditions may not be able to obtain cover at all.

  Pre-existing condition clauses are used on certain simple health products, such as hospital cash plans, which have small premiums, to sensibly manage the insurer's risks without complicating the acquisition and underwriting processes for the client. It is not viable to conduct initial underwriting on these products. It is recognised by our members that pre-existing condition clauses must be used in a fair and responsible way so that the consumer can understand the extent of their cover and this can be achieved by limiting their application to say 24 months after the cover commences.

- Use of the word "medical", "hospital" or derivatives thereof (Section 7.3(a))- While certain marketing restrictions and disclosures are justified, insurers should be able to ensure that their customers understand exactly what they are covered for. For example, not being able to identify hospital daily cash benefits using the word hospital will be very confusing to buyers of this policy as the policies pay a daily benefit for every day in hospital. Thus the name clearly states what the intention of the policy is.

Reporting requirements

It is our submission that the regulations go much further than provided for in the Act, as the only purpose of the reporting requirements should be to check that they comply with the Regulations, and if they do not, to give the insurer an opportunity to remedy any defects. Only if this is not done, should action such as prohibiting the product be taken. The launch of a new product is expensive and will be severely inhibited by the regulations as they stand because of the possibility that either of the Registrars may decide at any point in future to intervene or stop an already launched product/benefit.

This reporting requirement is already a departure from the framework for all other insurance policies where no such reporting is necessary and under the Act the statutory actuary signs off any new products or product changes.

As presently formulated, the audi alteram principle is also negated and as such the proposed regulations offend against fair administrative justice. It is essential that the regulations provide that the insurer be afforded sufficient opportunity to challenge the decisions of the Registrar prior to any binding notification. This is absent in the regulations as presently formulated and in our view they may therefore be in violation of the Constitutional right to fair administrative justice.

Transitional Arrangements

In the case of existing policies, we submit that vested rights of policyholders may not be removed and that the regulations cannot be made retrospective.

Although existing products which do not comply with the regulations can be closed in respect of new business, our comments as regards fair administrative justice processes being adhered to, has equal application.

In conclusion, ASISA is in support of regulations which will achieve certainty and support the legislation and is keen to work with National Treasury in amending the regulations to achieve this effect.

Yours sincerely

Addendum:

- Table of ASISA's specific comments on the regulations