CG2

Via E-mail: LTDemarcation@treasury.gov.za

2 May 2012

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

ASISA COMMENTS 2.05.2012

DRAFT DEMARCATION REGULATIONS-SECTION 72 OF THE LONG TERM INSURANCE ACT

SECTION OF THE REGULATION	COMMENT	RECOMMENDATION
PART 7-CONTRACTS IDENTIFIED AS HEALTH POLICIES UNDER PARAGRAPH (B) OF THE DEFINITION OF HEALTH POLICY		
Categories of contracts identified as health policies under paragraph (b) of the definition of health policy		
Table - Category 1 Lump sum or income replacement policy benefits payable on a health event	Whilst the other categories are very clear and specific as to the type of contract it covers, it is not clear what the ambit of this category is e.g. it is not clear whether the requirement pertaining to 70% of income (which is not defined) also applies to lump sum benefits. We submit that it is necessary to separate lump sum and other benefits and that "periodic payments" replaces the term "income replacement". The proposed criteria to limit policy benefits to 70% of the policyholder's net income per day raises a number of problems such as: • How will this be applied and calculated for lump sum payments or in those instances where people are remunerated by way of commission? • It will largely restrict meaningful cover; non-medical out of pocket and contingency expenses from a hospital stay can rise to several times one's net daily income • It will penalise low income consumers who are often unable to afford a medical scheme e.g. a domestic worker earning R2 500 per month would only be able to obtain less than R90 per day • It excludes consumers who don't have an income e.g. unemployed, students, housewives and pensioners • The cost of getting information on income will increase the cost of the products as this is currently not usually collected for these policies We submit that this criterion should be removed. In the event that this submission is not accepted we have put forward, as an alternative, that a limit should only apply for periodic payments.	Split category 1 into; • Lump sum policy benefits payable on a health event -remove link to net income in the criteria • Periodic payments payable on a health event -remove link to net income in the benefit. If this proposal is not accepted then an alternative is to limit the benefit to the greater of Rx (e.g. R5 000) per day or % of net income per day (in which event net income needs a clear definition (such as taxable remuneration less tax).

ASISA COMMENTS 2.05.2012

DRAFT DEMARCATION REGULATIONS-SECTION 72 OF THE LONG TERM INSURANCE ACT

SECTION OF THE REGULATION	COMMENT	RECOMMENDATION
Table - Category 3 HIV/AIDS cover	Limiting the provision of benefits to employee groups only would exclude self employed and unemployed people and probably those employed in the informal sector. This would be inconsistent with government's agenda to make these treatments available to the entire population and tantamount to unfair discrimination. We submit that market forces should determine whether these products are offered on an individual basis or to groups other than employers, rather than a regulatory restriction.	The first bullet point under criteria should be removed. It is also suggested that provision be made to add other diseases in future if they meet the same policy objectives.
Table- Additional category Rehabilitation benefit	Rehabilitation benefits to claimants of disability benefits are used by insurers to aid claimants to return to work e.g. payment for disability access facilities and for physiotherapy. These are considered as a risk management tool **provided at the discretion of the insurer** and are not a policy benefit. It is suggested that a new category 5 be created so that should an insurer wish to provide these as a policy benefit they are able to do so, in the same manner that they would be able to provide frail care benefits.	We propose that a Category 5 for rehabilitation benefits be added with the same criteria as Category 4.
7.2(2)(a)	Our members do not object to this requirement except in the case of products which provide for payment of medical scheme contributions (on disability or death of the principal member), which is something not provided by Medical Schemes. This would mean that the policyholder would only benefit if he/she is a member of a medical scheme. We submit that an exception should be made for these products.	Add at the end "..except for purposes of payment of medical scheme contributions".
7.2(2)(b)	Pre-existing condition clauses are included in many of the applicable products in order to limit the costs of underwriting and the risk to the insurer, thereby keeping the premium affordable. Removing these clauses will push up costs and make many of these products unaffordable to those income groups that can benefit most. This is because it will provide an opportunity for anti-selection. Costs will increase as it will either compel insurers to underwrite at application stage, or to increase premiums to factor in the risks. In order to achieve a proportional balance between the interests of policyholders and insurers it is proposed that a time limit of 24 months is included.	Amend to include the underlined words "... to refuse any claim for policy benefits <u>after the first 24 months of cover</u> on the grounds that....has occurred, <u>except in terms of conditions imposed on and disclosed to the policyholder at the inception of the policy</u>".

ASISA COMMENTS 2.05.2012

DRAFT DEMARCATION REGULATIONS-SECTION 72 OF THE LONG TERM INSURANCE ACT

SECTION OF THE REGULATION	COMMENT	RECOMMENDATION
	As it stands this sub section will also not allow an exclusion for a specific condition to be used, so if for example a person with a heart condition applies for a policy the insurer cannot manage their risk by using an exclusion clause for this condition and will probably then decline the policy application. This may very well result in people suffering from any health condition not being able to obtain any cover at all.	
7.2.2.(d)(ii)	An insurer is not a party to a cession of a policy so is not able to ensure that this provision is adhered to.	Wording to be amended to reflect this.
Marketing and Disclosures		
7.3 (a)	We have interpreted "be identified by" as referring to the name of the product. It is submitted that this provision is too wide and that it would be sufficient to demonstrate to consumers that the product is not a medical scheme if the word "medical" is not used in the name of the product. We are concerned that preventing the use of the word "hospital" could increase the risk of policyholders with hospital cash plan products not understanding that their cover applies when they are hospitalised. This is contrary to "plain and simple" language requirements in the Consumer Protection Act and the Treating Customers Fairly project which is underway. It is also not clear what words would be considered a derivative of these words.	Delete and replace with "not use the word "medical" in the name of the contract."
"7.3 (b)(i)	This applies only for Category 1 policies	Add in "for Category 1 contracts".
7.3 (e)(i)	Section 48 disclosures are not made in marketing material but in the policy summary to the policyholder because the material representations by the policyholder are made at application stage. Therefore the content of these disclosures, which include terms and conditions and the premium payable, can't be included in marketing material for individual policies as they are not yet known.	Delete subsection (e)(i) and renumber accordingly.

ASISA COMMENTS 2.05.2012

DRAFT DEMARCATION REGULATIONS-SECTION 72 OF THE LONG TERM INSURANCE ACT

SECTION OF THE REGULATION	COMMENT	RECOMMENDATION
Reporting of Product Information		
7.4(1)	As a practical measure it is requested that a prescribed form for the submission of product information is included in the regulations.	Include a prescribed form for the submission of the product information
7.4(2)	The legal basis for this process is not clear. Read within the context of the Act and the regulations the only 'test' to be applied by the respective Registrars should be whether the information submitted meets the requirements of the regulations. There also needs to be a transparent response framework and a method to challenge the decisions of the Registrar. The open ended timeframe ("at any time thereafter)and the subjective discretion given to the Registrar of Medical Schemes ("..is of the opinion.."),conflicts with the right to both substantive and procedural fair, just and reasonable administrative action.	Amend this subsection to require the Registrar of Medical Schemes to respond within the 3 month period referred to in 7.4(1), provide for a transparent response framework and a method to challenge the decisions of the Registrar.
7.4 (3)	As for 7.4(2). In addition the proposed sub-regulation entitles the Registrar of Insurance to prohibit an Insurer from launching or from continuing to market a policy at any time, without affording the relevant insurer an opportunity to submit its opinion on the matter. This is a clear negation of the audi altarem partem principle and conflicts with the right to fair administrative justice.	The subsection should be amended to provide for a proper consultative process and to allow an insurer sufficient time to respond to any proposed suspension of marketing and sales.
Transitional Arrangements		
7.5(1)	As Section 72 does not provide that the Minister may issue regulations with retrospective effect, the regulations may not have retrospective effect. Furthermore doing so will violate clients existing rights.	Change the December 2008 date to the effective date of the regulations.
7.5(2)	We have the same concerns as raised under 7.4(2) about the need for a fair administrative justice process.	

ASISA COMMENTS 2.05.2012

DRAFT DEMARCATION REGULATIONS-SECTION 72 OF THE LONG TERM INSURANCE ACT

SECTION OF THE REGULATION	COMMENT	RECOMMENDATION
7.5(3)	We have the same concerns as raised under 7.4(2) about the need for a fair administrative justice process. Existing products which do not comply with the regulations can be closed in respect of new business, but the Regulations cannot provide that existing policies must be terminated, as this will effectively result in the Regulations having retrospective effect.	Include a provision for a consultative process with the insurer and amend as follows: (a) Instruct the insurer to stop offering or renewing those health policies to the public within 90 days of the date determined by the Registrar. Delete (b)