30 June 2014

The Healthcare Inquiry Panel

Email: health@compcom.co.za

Dear Sirs/Madam

RE: COMMENTS FROM DISCOVERY HEALTH MEDICAL SCHEME ON THE DRAFT GUIDELINES FOR PARTICIPATION IN THE MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR AND THE DRAFT STATEMENT OF ISSUES: MARKET INQUIRY INTO THE PRIVATE HEALTHCARE SECTOR

1. Set out below are Discovery Health Medical Scheme's ("**DHMS**") comments on the Draft Guidelines for Participation in the Market Inquiry (the "**Guidelines**") and the Draft Statement of Issues (the "**Statement of Issues**") which were published on 30 May 2014. These observations are sent pursuant to a call for public comment made by the Healthcare Inquiry Panel (the "**Panel**"). As a stakeholder with an interest in the outcome of the Healthcare Inquiry, DHMS is grateful for the opportunity to submit these comments.

2. Having regard to the Statement of Issues, DHMS is of the view that there are certain key areas within the healthcare sector which should be more closely examined by the Panel. In this regard –

    2.1. we note that the Panel intends to assess "*the market for medical technology and devices*" in terms of the broader consumables market. In this regard, DHMS is of the view that the Panel should focus on, *inter alia*, (i) the unregulated nature of devices; (ii) the impact of the cost of developing technologies for new and / or better procedures on the broader healthcare industry (including consumers); (iii) the impact of the cost of devices on the broader healthcare industry (including consumers) (iv) the role of device manufacturers in the healthcare sector; and (v) the role of medical technology developers in the healthcare sector;

    2.2. it is not clear whether the Panel intends to include radiologists, pathologists and / or allied therapists under the broad "specialists" category identified in its Statement of Issues. In this regard, it bears mention that –

        2.2.1. as a result of significant barriers to entry, pathology services are provided by only three large corporate entities in South Africa. Furthermore, pathologists generally operate on a limited regional basis as national expansion is very difficult;

2.2.2. insofar as radiologists are concerned, practices within private hospitals tend to have a monopoly over radiology services in a specific area / location. This negatively impacts on competition dynamics and has a direct impact on healthcare costs; and

2.2.3. there are a significant number of allied therapists (including, but not limited to, anaesthesia technicians, audiologists, clinical psychologists, dental hygienists, dieticians, biokineticists, laboratory scientists, occupational therapists, orthotists / prosthetists, paramedics, physical therapists, rehabilitation counsellors and speech therapists) operating in South Africa. These medical professionals play a significant role in treating consumers and, as such, their services have a direct impact on the cost of private healthcare. Accordingly, DHMS is of the view that the role of allied therapists should be examined in further detail – especially in light of the fact that no tariffs and / or coding systems apply to these services.

2.3. we note that the Panel intends to evaluate "*the role and impact of competition and sustainability of the sector of health insurance products of financial service providers that are not medical schemes*". In this regard, DHMS is of the view that the Panel should specifically assess the issue of "gap cover insurance" and "hospital cash plans" in South Africa. It bears mention that –

2.3.1. "gap cover insurance" is an insurance product which provides top-up cover for in-hospital and out-patient treatment costs which are not fully covered by medical aids;

2.3.2. "gap cover insurance" products are currently regulated by the insurance industry and not by the healthcare industry. As a result, these products are not governed by medical scheme legislation notwithstanding that the policies provide a form of health insurance to consumers;

2.3.3. by way of example, in terms of the Council for Medical Schemes Act (the "**CMS Act**"), medical aid schemes are required to have a 25% solvency ratio. Such a requirement is not imposed on insurance providers;

2.3.4. for completeness, it bears mention that the National Treasury has recently published amended guidelines regarding the regulation of "gap cover insurance". For ease of reference, a copy of the Explanatory Memorandum to these Draft Regulations has been attached hereto.

2.3.5. in summary, DHMS is of the view that the Panel should consider and investigate the impact of "gap cover insurance" and other related healthcare insurance policies on healthcare providers and / or consumers. By way of example, the Panel should assess whether governance of "gap cover" insurance products through insurance legislation, as opposed to medical scheme legislation, has a negative impact on consumers, healthcare providers or the costs of healthcare.

3. Insofar as the Guidelines are concerned, DHMS does not have any material comments in relation thereto, save for the following –

3.1. DHMS suggests that the Panel makes provision for a period in which interested parties may comment on its provisional findings;

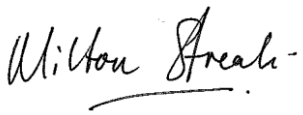
3.2. although the opportunity for public comment is reflected in paragraph 31 of the Guidelines, DHMS recommends that a specific period of time is allocated for this exercise;

3.3. in this regard, DHMS notes that the UK Healthcare Inquiry provided for a two month period in which parties could comment on its provisional findings followed by a further two month period in which parties could comment on its proposed remedies.

4. Once again, we thank the Panel for the opportunity to comment on its Statement of Issues and Guidelines. We trust that our comments have been of assistance.

5. Please do not hesitate to contact us if you have any comments or queries.

Yours sincerely



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FSB

EXPLANATORY MEMORANDUM

To the Second Draft Demarcation Regulations made under section 72(2b) of Long-Term Insurance Act, No. 52 of 1998

1. INTRODUCTION

The National Treasury ("NT") releases, for further public comment, the Second Draft Demarcation Regulations. The Demarcation Regulations specify which types of health insurance policies are permissible under the Long-term Insurance Act, No. 52 of 1998 (and accordingly excluded from regulation under the Medical Schemes Act, No. 131 of 1998) despite meeting the definition of the business of a medical scheme.

This Explanatory Memorandum ("Memo") is an update to the previous Memo released with the First Draft Demarcation Regulations.

Background

The enhancement of the legislative framework relating to demarcation between health insurance policies and medical schemes commenced with the enactment of the Insurance Laws Amendment Act No. 27 of 2008. This Act introduced provisions in the Long-term Insurance Act No. 52 of 1998 ("LTIA") and the Short-term Insurance Act No. 53 of 1998 ("STIA"), to facilitate a clear demarcation between what constitutes insurance business (namely, "health policies" and "accident and health policies", in the respective Acts), and what constitutes the business of a medical scheme, in instances where there appears to be uncertainty and ambiguity in the legislative framework.

These provisions afford the Minister of Finance legislative authority to make regulations that identify certain categories of contracts as health policies or accident and health policies despite the fact that those contracts may be interpreted as doing the business of a medical scheme. These identified categories of contracts will be excluded from the medical schemes regulatory environment, and will be regulated under the LTIA and STIA, respectively.

The First Draft Demarcation Regulations released in 2012

The First Draft Demarcation Regulations were published for public comment on 2 March 2012. Two particular proposals in the First Draft Demarcation Regulations elicited considerable public comment – namely a prohibition on Gap Cover products and restrictions on Hospital Cash Plan insurance policies. On 15 October 2013 the NT released a summary of the 343 comments received during the initial consultation process. (The public comments are available at www.treasury.gov.za).

The scope of the Second Draft Demarcation Regulations

The Second Draft Demarcation Regulations take into account the diverse comments received on the first draft. The revised draft recognises the role that appropriately designed and marketed health insurance policies can play in meeting the need for protection against unanticipated health events; however these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical scheme cover. The Second Draft Demarcation Regulations therefore provide for the continued sale of Gap Cover and Hospital Cash Plan insurance within defined product parameters.

The proposed conditions on health insurance products, as outlined below, seek to ensure that the design and marketing of health insurance policies does not undermine a sustainable medical scheme industry, while at the same time serving the needs of those who require additional protection against health-related risks:

- prohibition on health insurance policies from discriminating against any person on the grounds of age, gender and other criteria;
- enhanced product disclosure/marketing requirements;
- alignment of broker commission between health insurance and medical scheme products;
- enhanced regulatory reporting and monitoring;
- product standards which limit policy benefits; and
- limitations on bundled type health insurance products which replicate medical schemes.

The amendment to the definition of a "business of a medical scheme"

The publication of the Second Draft Demarcation Regulations follows the enactment of the Financial Services Laws General Amendment Act, No. 45 of 2013 ("the Act"). The Act, which was passed by Parliament on 12 November 2013, assented to by the President on 14 January 2014, and published in *Government Gazette* No. 37237 of 16 January 2014, amends the definition of a *"business of a medical scheme"* to support the Second Draft Demarcation Regulations and address recent court case judgments which widen the interpretation of this definition.

The Act came into operation on 28 February 2014. The amendment to the definition of a "*business of a medical scheme*" was deferred to come into effect at the same time as the Demarcation Regulations are finalised.

Health insurance products that fall within the ambit of this amended definition will be prohibited, unless they are explicitly exempted through the Second Draft Demarcation Regulations.

Comment process and implementation timelines

Comments on the revised Demarcation Regulations are invited from all interested stakeholders. Written comments should be sent to Reshma Sheoraj at LTdemarcation@treasury.gov.za or faxed to 012 315 5206 on or before **7 July 2014**.

The final Demarcation Regulations are then expected to be published by September 2014, after taking into account public comments. It is the intention that the effective date of implementation of the Demarcation Regulations will be soon after the final Demarcation Regulations are published.

2. POLICY PRINCIPLES THAT INFORM THE DRAFT DEMARCATION REGULATIONS

Basic principles of a health insurance policy

A health insurance policy[1] is a binding contract issued by an insurance company to an individual. The policy can be sold by an insurance company in terms of the LTIA or STIA and is subject to regulatory oversight by the Financial Services Board ("FSB"). The policy promises to pay for certain stated benefits when the individual is ill or injured. The individual pays a certain premium which is directly related to the age, health status or income of the individual. Specific type of exclusions may also be built into a policy, which can have the effect of limiting who the policy can be sold to.

[1] Referred to as health policies under the LTIA and accident and health policies under the STIA.

Basic principles of medical schemes

Medical schemes are regulated in terms of the Medical Schemes Act and are subject to regulatory oversight by the Council of Medical Schemes ("CMS"). They are non-profit organisations and belong to their members. Medical schemes operate through the collective pooling of good and bad risks, and may not discriminate between individuals based on age or health status.

Contributions apply universally to all members who are enrolled and may only vary in respect of the cover provided. Different benefits options are priced differently depending on the level of cover afforded and are determined by the rules of the scheme. The effect is that there are equal premium contributions for high and low risk members, which promotes greater equity in the scheme.

The current market challenge

One of the concerns which the draft Demarcation Regulations seek to address relate to contentions that certain health insurance products (which provide similar benefits to medical schemes) in the long-term and short-term insurance market cause harm to the medical schemes environment by attracting younger and generally healthy members out of medical schemes. This practise if left unchecked could result in increasing costs for the older and less healthy who remain dependent on medical schemes for their cover. Pooling healthier and sicker individuals facilitates a form of cross-subsidisation whereby sicker people do not pay contributions according to their health status; this improves the affordability of medical schemes.

A clear demarcation between health policies and medical schemes is therefore necessary to support and enhance the objectives and purpose of the Medical Schemes Act, No. 131 of 1998, which entrenches the principles of community rating, open enrolment and cross-subsidisation within medical schemes. These principles are briefly explained in **Box 1** below.

Health insurance policies (providing similar benefits as medical schemes) may result in –

- younger and healthier persons terminating, limiting or reducing their medical scheme cover;
- a negative impact on the life-cycle protection offered by medical schemes; and
- medical schemes reducing benefits.

Section 72(2A) of the LTIA specifically requires the Minister of Finance when making regulations to have regard to the objectives and purpose of the Medical Schemes Act, including the principles of community rating, open enrolment and cross-subsidisation within medical schemes.

A clear demarcation between 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 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.

Box 1: Principles of Medical Schemes

The principles referred to above may be briefly explained as follows:

Open enrolment is a social security principle that requires every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme. Put differently, the principle of open enrolment ensures non-discriminatory access to private healthcare financing. Every person who applies for membership, as well as any member who applies for the membership of a dependant, is guaranteed membership of an open medical scheme. Applicants must be accepted into the scheme regardless of factors such as their age or past and present medical history.

Community rating refers to the practice of charging a contribution to all members on a specific benefit option within a medical scheme that does not discriminate against them unfairly. In other words, all members on a particular option pay the same contribution, regardless of their age or health status or any other arbitrary ground. Community rating is the opposite of individual risk-rating, where the latter describes the practice of distinguishing between "high risk" and "low risk" individuals and charging an individual more if he/she is more likely to claim a benefit and therefore poses a high insurance risk. The benefits of community rating include:

- Considerable **cross-subsidisation** between low-risk and high-risk individuals. All members on a specific medical scheme benefit option pay the same contribution for the same benefits but access benefits based on what they need;
- The most vulnerable members enjoy affordable access to healthcare and are protected against the potentially catastrophic effects of an illness and/or medical expenditure; and
- Price discrimination against people with high risk medical condition(s) is prevented (they would have been excluded in a risk-rated market).

The requirement to include prescribed minimum benefits (PMB) in medical schemes extends the social security net to vulnerable groups, ensuring access to healthcare and providing protection from catastrophic out-of-pocket expenditure. By compelling the funding of the PMB package from the common risk pool of a medical scheme, the principle of community rating is achieved across all medical schemes so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join.

3. SCOPE OF THE DRAFT REGULATIONS

The draft Regulations relate only to contracts referred to in paragraph (b) of the definition of accident and health policy in section 1 of the STIA. That is policies identified by the Minister of Finance as accident and health policies, despite the fact that providing the policy benefits under those policies may constitute conducting the business of a medical scheme under the Medical Schemes Act. It does not refer to accident and health policies in general.

4. DIFFERENCE BETWEEN THE FIRST AND SECOND DRAFT DEMARCATION REGULATIONS

4.1 The First Draft Demarcation Regulations aimed to achieve the policy principles referred to in paragraph 2 by –

- identifying those categories of as health policies that 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;
- prescribing the policy benefits that may be provided under these categories of health policies, to further protect the business of medical schemes from being undermined;
- prescribing clear criteria that must be met by contracts under these categories of health policies, which criteria relate to the purposes for which policy benefits may be paid and to whom such policy benefits may be paid;
- prescribing matters relating to the marketing of these categories of heath policies;
- prescribing matters relating to disclosures that must be made by insurers and intermediaries relating to these categories of health policies;

- prescribing requirements for reporting product details of these categories of health policies to the Registrar of Long-term Insurance (the Registrar) and the Registrar of Medical Schemes, so as to facilitate adequate supervisory oversight; and
- prescribing transitional provisions for regularising existing health policies that are inconsistent with the draft regulations.

4.2 The Second Draft Demarcation Regulations enhances the achievement of the policy principles by –

4.2.1 limiting the commission payable in respect of contracts identified as accident and health policies in the Demarcation Regulations to the maximum compensation and other requirements prescribed under regulation 28 of the Regulations made under the Medical Schemes Act, 1998 (Act No. 131of 1998) pursuant to section 65(2) of that Act, 1998 (Act No. 131 of 1998);

4.2.2 clarifying the scope of the category 1 contracts that provide for lump sum or income replacement policy benefits payable on a health event by -

- limiting policy benefits payable under these contracts to one or more sums assured stated in the contract in Rand terms;
- limiting the aggregate of the policy benefits payable under *all policies issued by an insurer and its related parties to a specific person* to R 3 000,00 (three thousand Rand)[2];
- requiring that these contract must provide for an annual term and monthly premiums;

4.2.3 allowing category 2 contracts that covers custodial care (assistance with activities of daily living) for insured persons and category 3 contracts that covers expenses for HIV-related testing and HIV and Aids treatment on an employee group basis to include waiting periods;

4.2.4 extending the scope of category 3 contracts that cover expenses for HIV-related testing and HIV and Aids treatment on an employee group basis to dependents of employees;

4.2.5 prohibiting contracts identified as accident and health policies in the Demarcation Regulations from unfairly discriminating directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health; and

4.2.6 prohibiting the development or offering of contracts identified as health policies in the Demarcation Regulations by an insurer together with a related party of that insurer if the policies collectively may result in the aggregate of the policy benefits under those policies being contrary to the objectives and purpose of the MS Act .

4.2.7 The Second Draft Demarcation Regulations to be made under the Short-term Insurance Act identifies an additional category of contracts as accident and health policies, which category provides for cover against medical expense shortfalls. This category is not accommodated in the Second Draft Demarcation Regulations to be made under the Long-term Insurance Act. This is so because a contract of short-term insurance is a contract of indemnity. A contract of long-term insurance is a contract of non-indemnity insurance (or capital insurance).

[2] This amount will escalate annually from the effective date of the Demarcation Regulations by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999))

5. IMPLICATIONS OF THE DRAFT REGULATIONS

An insurer that offers policies to the public that are consistent with regulation 7.2 of the draft regulations and complies with regulation 7.3 to 7.6 of the draft regulations is, in respect of such policies, subject to regulation under the Act and not the MS Act, despite the fact that those policies may constitute or appear to constitute the business of a medical scheme[3] as defined in the MS Act.

6. TRANSITION AND IMPLEMENTATION

The Final Demarcation Regulations are then expected to be published by September 2014, after taking into account public comments. It is the intention that the effective date of implementation of the Demarcation Regulations will be on or soon after the Final Demarcation Regulations are published.

All new health insurance policies written after the Final Demarcation Regulations come into operation must be aligned with the requirements set out in the Final Demarcation Regulations. Existing health insurance policies will be expected to align to the Final Demarcation Regulations requirements upon renewal of the health insurance contract.

It is expected that the marketing and sale of the health insurance products covered by the Demarcation Regulations between now and the effective date of the Demarcation Regulations should be accompanied by disclosure with respect to the planned regulatory changes. The Financial Services Board will be requested to monitor any potential mis-selling or abuse during the transition period and take appropriate action where this is necessary.

7. CONSEQUENCES OF NOT COMPLYING WITH THE ACT AND THE DRAFT REGULATIONS

An insurer that offers policies to the public that are inconsistent with regulation 7.2 of the draft regulations read with the definition of health policy in section 1 of the Act and the definition of the business of a medical scheme[4] in section 1 of the MS Act, will be contravening the MS Act, unless an exemption for such policies was granted under that Act. The Registrar of Long-term Insurance, under section 6A of the Financial Institutions (Protection of Funds) Act No. 28 of 2001, may refer any non-compliance with regulation 7.3 to 7.6 of the draft regulations to the enforcement committee established under section 10 of the Financial Services Board Act No. 97 of 1990.

[3] See footnote 2.
[4] See footnote 2.

ANNEXURE 1

EXTRACT FROM THE LONG-TERM INSURANCE ACT

SECTION 1

'health policy' means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits upon a health event, and includes a reinsurance policy in respect of such a contract—

(a) excluding any contract—

(i) that provides for the conducting of the business of a medical scheme referred to in section 1(1) of the Medical Schemes Act;

(ii) of which the policyholder is a medical scheme registered under the Medical Schemes Act, and which contract—

(aa) relates to a particular member of the scheme or to the beneficiaries of that member; and

(bb) is entered into by the medical scheme to fund in whole or in part its liability to the member or the beneficiaries of the member referred to in subparagraph *(aa)* in terms of its rules; but

(b) specifically including, notwithstanding paragraph *(a)(i),* any contracts identified by the Minister by regulation under section 72(2A) as a health policy;

"health event" means an event relating to the health of the mind or body of a person or an unborn;

SECTION 48(1)

48. Summary, inspection and copy of policy.-(1) A person who enters into or varies a long-term policy, other than a fund policy and a reinsurance policy, shall be provided in writing or in another form prescribed by the Registrar, by the long-term insurer concerned, with information, in the form of a summary, relating to at least the following matters, namely—

(*a*) those of the representations made by or on behalf of that person to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy;

(*b*) the premiums payable and the policy benefits to be provided under the policy; and

(*c*) 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,

SECTION 72

(2A)(a) The Minister, despite the definition of 'business of a medical scheme' in section 9(1) of the Medical Schemes Act, may make regulations identifying a kind, type or category of contract as a health policy.

(b) Regulations under paragraph *(a)*—

(i) must be made only—

(aa) in consultation with the Minister of Health;

(bb) after consultation between the National Treasury, the Registrar and the Registrar of Medical Schemes established under the Medical Schemes Act; and

(cc) after having regard to the objectives and purpose of the Medical Schemes Act, including the following principles entrenched therein—

(A) community rating:

(B) open enrolment; and

(C) cross-subsidisation within medical schemes; and

(ii) must provide for a long-term insurer to submit specified information on any product within a kind, type or category of contract referred to in paragraph *(a)* to the Registrar and the Registrar of Medical Schemes within any specified timeframes;

(iii) may provide for matters relating to the design and marketing of any product within a kind, type or category of contract referred to in paragraph *(a).*

(c) Where the Minister has made regulations referred to in paragraph *(a),* the kind, type or category of contract identified as a health policy in the regulations, is subject to this Act and not the Medical Schemes Act.

EXTRACT FROM THE MEDICAL SCHEMES ACT

1. Section 1 of Act 131 of 1998 is hereby amended by the substitution for the definition of ‘‘business of a medical
scheme’’ of the following definition:[5]

‘‘business of a medical scheme’’ means the business of undertaking, **[liability]** in return for a premium or
contribution **[-]**, the liability associated with one or more of the following
activities:
(a) **[to make provision]** Providing for the obtaining of any relevant health service;
(b) **[to grant]** granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; **[and]** or
(c) **[where applicable, to render]** rendering a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.’

“medical scheme” means any medical scheme registered under section 24(1);

“member” means a person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the rules of a medical scheme, is a member of such medical scheme;

“relevant health service” means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object -

(a) the physical or mental examination of that person;

(b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

(c) the giving of advice in relation to any such defect, illness or deficiency;

(d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

(e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or

(f) nursing or midwifery,

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[5] **Section 1 of the Medical Schemes Act, 1998 was amended by Financial Services Laws General Amendment Act No. 45 of 2013**

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;

SECTION 65

(1) A medical scheme may compensate any person, in cash or otherwise, in accordance with its rules, for the introduction or admission of a member to that medical scheme.

(2) The Minister may prescribe the amount of the compensation which, the category of persons to whom, the conditions upon which, and any other circumstances under which, a medical scheme may compensate any person in terms of subsection (1).

(3) No person shall be compensated for providing services relating to the introduction or admission of a member to a medical scheme in terms of subsection (1) unless the Council has, in a particular case or in general, granted accreditation to such a person.

(4) An application for accreditation shall be made to the Council in the manner and be accompanied by such information as may be prescribed, and any other information as the Council may require.

EXTRACT FROM THE REGULATIONS MADE UNDER THE MEDICAL SCHEMES ACT

REGULATION 28: CONDITIONS TO BE COMPLIED WITH BY BROKERS

(1) No person may be compensated by a medical scheme in terms of section 65 for acting as a broker unless such person enters into a prior written agreement with the medical scheme concerned.

(2) Subject to subregulation (3), the maximum amount payable to a broker by a medical scheme in respect of the introduction of a member to a medical scheme by that broker and the provision of ongoing service or advice to that member, shall not exceed -

(a) R50, plus value added tax (VAT), per month, or such other monthly amount as the Minister shall determine annually in the Government Gazette, taking into consideration the rate of normal inflation; or

(b) 3% plus value added tax (VAT) of the contributions payable in respect of that member, whichever is the lesser.

(3) A medical scheme may not differentiate the amount of compensation offered to brokers for the introduction of members to the scheme based upon the anticipated claims experience, age, health status or employment status of the members being introduced;

(4) Subregulation (2) must not be construed to restrict a medical scheme from applying a sliding scale based on the size of the group being introduced provided that -

(a) the maximum amount in respect of any member introduced as specified in subregulation (2) is not exceeded; and

(b) a medical scheme may not pay a lesser amount for the introduction of individual members than the per capita amount payable in respect of introduction of members who form part of a group.

(5) Payment by a medical scheme to a broker in terms of subregulation (2) shall be made on a monthly basis and upon receipt by the scheme of the relevant monthly contribution in respect of that member.

(6) The ongoing payment by a medical scheme to a broker in terms of this regulation is conditional upon the broker -

(a) continuing to meet service levels agreed to between the broker and the medical scheme in terms of the written agreement between them; and

(b) receiving no other direct or indirect compensation in respect of broker services from any source, other than a possible direct payment to the broker of a negotiated professional fee from the member himself or herself (or the relevant employer, in the case of an employer group);

(7) A medical scheme shall immediately discontinue payment to a broker in respect of services rendered to a particular member if the medical scheme receives notice from that member (or the relevant employer, in the case of an employer group), that the member or employer no longer requires the services of that broker.

(8) A medical scheme may not compensate more than one broker at any time for broker services provided to a particular member.

(9) Any person who has paid a broker compensation where there has been a material misrepresentation, or where the payment is made consequent to unlawful conduct by the broker, is entitled to the full return of all the money paid in consequence of such material misrepresentation or unlawful conduct.

national treasury

Department:
National Treasury
REPUBLIC OF SOUTH AFRICA

FSB

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1. INTRODUCTION

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- limitations on bundled type health insurance products which replicate medical schemes.

The amendment to the definition of a "business of a medical scheme"

The publication of the Second Draft Demarcation Regulations follows the enactment of the Financial Services Laws General Amendment Act, No. 45 of 2013 ("the Act"). The Act, which was passed by Parliament on 12 November 2013, assented to by the President on 14 January 2014, and published in *Government Gazette* No. 37237 of 16 January 2014, amends the definition of a "*business of a medical scheme*" to support the Second Draft Demarcation Regulations and address recent court case judgments which widen the interpretation of this definition.

The Act came into operation on 28 February 2014. The amendment to the definition of a "*business of a medical scheme*" was deferred to come into effect at the same time as the Demarcation Regulations are finalised.

Health insurance products that fall within the ambit of this amended definition will be prohibited, unless they are explicitly exempted through the second draft Demarcation Regulations.

Comment process and implementation timelines

Comments on the revised Regulations are invited from all interested stakeholders. Written comments should be sent to Reshma Sheoraj at STdemarcation@treasury.gov.za (for the Short-term Insurance Regulations) or faxed to 012 315 5206 on or before **7 July 2014**.

The final Demarcation Regulations are then expected to be published by September 2014, after taking into account public comments.

2. POLICY PRINCIPLES THAT INFORM THE DRAFT DEMARCATION REGULATIONS

Basic principles of a health insurance policy

A health insurance policy[1] is a binding contract issued by an insurance company to an individual. The policy can be sold by an insurance company in terms of the LTIA or STIA and is subject to regulatory oversight by the Financial Services Board ("FSB"). The policy promises to pay for certain stated benefits when the individual is ill or injured. The individual pays a certain premium which is directly related to the age, health status or income of the individual. Specific type of exclusions may also be built into a policy, which can have the effect of limiting who the policy can be sold to.

[1] Referred to as health policies under the LTIA and accident and health policies under the STIA.

Basic principles of medical schemes

Medical schemes are regulated in terms of the Medical Schemes Act and are subject to regulatory oversight by the Council of Medical Schemes ("CMS"). They are non-profit organisations and belong to their members. Medical schemes operate through the collective pooling of good and bad risks, and may not discriminate between individuals based on age or health status.

Contributions apply universally to all members who are enrolled and may only vary in respect of the cover provided. Different benefits options are priced differently depending on the level of cover afforded and are determined by the rules of the scheme. The effect is that there are equal premium contributions for high and low risk members, which promotes greater equity in the scheme.

The current market challenge

One of the concerns which the draft Demarcation Regulations seek to address relate to contentions that certain health insurance products (which provide similar benefits to medical schemes) in the long-term and short-term insurance market cause harm to the medical schemes environment by attracting younger and generally healthy members out of medical schemes. This practise if left unchecked could result in increasing costs for the older and less healthy who remain dependent on medical schemes for their cover. Pooling healthier and sicker individuals facilitates a form of cross-subsidisation whereby sicker people do not pay contributions according to their health status; this improves the affordability of medical schemes.

A clear demarcation between health policies and medical schemes is therefore necessary to support and enhance the objectives and purpose of the Medical Schemes Act, No. 131 of 1998, which entrenches the principles of community rating, open enrolment and cross-subsidisation within medical schemes. These principles are briefly explained in **Box 1** below.

Health insurance policies (providing similar benefits as medical schemes) may result in –

- younger and healthier persons terminating, limiting or reducing their medical scheme cover;
- a negative impact on the life-cycle protection offered by medical schemes; and
- medical schemes reducing benefits.

Section 70(2B) of the STIA specifically requires the Minister of Finance when making regulations to have regard to the objectives and purpose of the Medical Schemes Act, including the principles of community rating, open enrolment and cross-subsidisation within medical schemes.

A clear demarcation between 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 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.

Box 1: Principles of Medical Schemes

The principles referred to above may be briefly explained as follows:

Open enrolment is a social security principle that requires every open medical scheme registered in South Africa to accept as a member or dependant any and every person who wishes to join that medical scheme. Put differently, the principle of open enrolment ensures non-discriminatory access to private healthcare financing. Every person who applies for membership, as well as any member who applies for the membership of a dependant, is guaranteed membership of an open medical scheme. Applicants must be accepted into the scheme regardless of factors such as their age or past and present medical history.

Community rating refers to the practice of charging a contribution to all members on a specific benefit option within a medical scheme that does not discriminate against them unfairly. In other words, all members on a particular option pay the same contribution, regardless of their age or health status or any other arbitrary ground. Community rating is the opposite of individual risk-rating, where the latter describes the practice of distinguishing between "high risk" and "low risk" individuals and charging an individual more if he/she is more likely to claim a benefit and therefore poses a high insurance risk. The benefits of community rating include:

- Considerable **cross-subsidisation** between low-risk and high-risk individuals. All members on a specific medical scheme benefit option pay the same contribution for the same benefits but access benefits based on what they need;
- The most vulnerable members enjoy affordable access to healthcare and are protected against the potentially catastrophic effects of an illness and/or medical expenditure; and
- Price discrimination against people with high risk medical condition(s) is prevented (they would have been excluded in a risk-rated market).

The requirement to include prescribed minimum benefits (PMB) in medical schemes extends the social security net to vulnerable groups, ensuring access to healthcare and providing protection from catastrophic out-of-pocket expenditure. By compelling the funding of the PMB package from the common risk pool of a medical scheme, the principle of community rating is achieved across all medical schemes so that everyone is charged the same standard rate for the common PMB package, regardless of the option or scheme they choose to join.

3. SCOPE OF THE DRAFT REGULATIONS

The draft regulations relate only to contracts referred to in paragraph (b) of the definition of accident and health policy in section 1 of the STIA. That is policies identified by the Minister of Finance as accident and health policies, despite the fact that providing the policy benefits under those policies may constitute conducting the business of a medical scheme under the Medical Schemes Act. It does not refer to accident and health policies in general.

4. DIFFERENCE BETWEEN THE FIRST AND SECOND DRAFT DEMARCATION REGULATIONS

4.1 The first draft of the Demarcation Regulations aimed to achieve the policy principles referred to in paragraph 3 above by –

- identifying those categories of accident and health policies that 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;
- prescribing the policy benefits that may be provided under these categories of accident and health policies, to further protect the business of medical schemes from being undermined;
- prescribing clear criteria that must be met by contracts under these categories of accident and health policies, which criteria relate to the purposes for which policy benefits may be paid and to whom such policy benefits may be paid;
- prescribing matters relating to the marketing of these categories of accident and health policies;

- prescribing matters relating to disclosures that must be made by insurers and intermediaries relating to these categories of accident and health policies;
- prescribing requirements for reporting product details of these categories of accident and health policies to the Registrar of Short-term Insurance (the Registrar) and the Registrar of Medical Schemes, so as to facilitate adequate supervisory oversight; and
- prescribing transitional provisions for regularising existing accident and health policies that are inconsistent with the draft regulations.

4.2 The second draft of the Demarcation Regulations enhances the achievement of the policy principles by –

4.2.1 limiting the commission payable in respect of contracts identified as accident and health policies in the Demarcation Regulations to the maximum compensation and other requirements prescribed under regulation 28 of the Regulations made under the Medical Schemes Act, 1998 (Act No. 131of 1998) pursuant to section 65(2) of that Act, 1998 (Act No. 131 of 1998);

4.2.2 allowing for an additional category of contracts as accident and health policies as category 1, which category provides for cover against medical expense shortfalls; i.e. it covers the costs or expenses of a relevant health service that in respect of the minimum benefits provided for under Regulation 8 of the Regulations made under section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998) as published in GN R1262 of 1999, as amended from time to time, does not constitute a minimum benefit or constitutes a minimum benefit not paid in full by a medical scheme, provided that these contracts –

- limit policy benefits payable under these contracts to one or more sums assured stated in the contract in Rand terms;
- limit the aggregate of the policy benefits payable under all policies issued by an insurer and its related parties to a specific person to R 50 000,00 (fifty thousand Rand)[2];
- provide for an annual term and monthly premiums;

4.2.3 clarifying the scope of the category 2 contracts that provide for lump sum or income replacement policy benefits payable on a health event by -

- limiting policy benefits payable under these contracts to one or more sums assured stated in the contract in Rand terms;
- limiting the aggregate of the policy benefits payable under all policies issued by an insurer and its related parties to a specific person to R 3 000,00 (three thousand Rand)[3];
- requiring that these contract must provide for an annual term and monthly premiums;

4.2.4 limiting category 3 (Motor: Third Party Liability) cover to the costs of a relevant health service following the injury of a third party (other than the insured persons) as a result of an accident and category 4 (Property: Third Party Liability) cover to the costs of a relevant health service following the injury of third parties (other than the insured persons) while on the property of the insured persons;

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[2] This amount will be escalated annually from the effective date of the Demarcation Regulations by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999))

[3] See footnote 4.

4.2.5 extending the scope of category 5 contracts that cover expenses for HIV-related testing and HIV and Aids treatment on an employee group basis to dependents of employees and allowing for waiting periods;

4.2.6 limiting category 7 (Domestic travel insurance) to costs associated with a relevant health service incurred as a result of a health, disability or death event (excluding life events) that occur while travelling inside the Republic of South Africa and in a province other than the province in which the insured persons and their dependants are not ordinarily resident, as a result of a health, disability or death event that occurs while in South Africa;

4.2.7 removing the limitation that category 8 (Emergency Evacuation or Transport) policy benefits must be ancillary to the main policy benefits provided under the policy;

4.2.8 prohibiting contracts identified as accident and health policies in the Demarcation Regulations to unfairly discriminating directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health;

4.2.9 provide for waiting periods exceeding 6 months;

4.2.10 provide that the policyholder or insured person must be a member of a medical scheme; and

4.2.11 prohibiting the development or offering of contracts identified as health policies in the Demarcation Regulations by an insurer together with a related party of that insurer if the policies collectively may result in the aggregate of the policy benefits under those policies being contrary to the objectives and purpose of the MS Act.

5. IMPLICATIONS OF THE DRAFT REGULATIONS

An insurer that offers policies to the public that are consistent with regulation 7.2 of the draft regulations and complies with regulation 7.3 to 7.6 of the draft regulations is, in respect of such policies, subject to regulation under the Act and not the MS Act, despite the fact that those policies may constitute or appear to constitute the business of a medical scheme[4] as defined in the MS Act.

6. TRANSITION AND IMPLEMENTATION

The Final Demarcation Regulations are expected to be published by September 2014, after taking into account public comments. It is the intention that the effective date of implementation of the Demarcation Regulations will be on or soon after the Final Demarcation Regulations are published.

All new health insurance policies written after the Final Demarcation Regulations come into operation must be aligned with the requirements set out in the Final Demarcation Regulations. Existing health insurance policies must align to the Final Demarcation Regulations requirements upon renewal of the health insurance contract. It is expected that the marketing and sale of the health insurance products covered by the Demarcation Regulations between now and the effective date of the Demarcation Regulations should be accompanied by disclosure with respect to the planned regulatory changes. The Financial Services Board will be requested to monitor any potential mis-selling or abuse during the transition period and take appropriate action.

[4] See footnote 2.

7. CONSEQUENCES OF NOT COMPLYING WITH THE ACT AND THE DRAFT REGULATIONS

An insurer that offers policies to the public that are inconsistent with regulation 7.2 of the draft regulations read with the definition of accident and health policy in section 1 of the Act and the definition of the business of a medical scheme[5] in section 1 of the MS Act, will be contravening the MS Act, unless an exemption for such policies was granted under that Act.

The Registrar of Short-term Insurance, under section 6A of the Financial Institutions (Protection of Funds) Act No. 28 of 2001, may refer any non-compliance with regulation 7.3 to 7.6 of the draft regulations to the enforcement committee established under section 10 of the Financial Services Board Act No. 97 of 1990.

[5] See footnote 2.

ANNEXURE 1

EXTRACT FROM THE SHORT-TERM INSURANCE ACT

SECTION 1

'accident and health policy' means a contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a disability, health or death event contemplated in the contract as a risk event occurs, and includes a reinsurance policy in respect of such a contract -

(a) excluding any contract -

(i) that provides for the conduct of the business of a medical scheme referred to in section 1(1) of the Medical Schemes Act; or

(ii) of which the policyholder is a medical scheme registered under the Medical Schemes Act and which contract -

(aa) relates to a particular member of the scheme or to the beneficiaries of such member; and

(bb) is entered into by the medical scheme to fund in whole or in part its liability to the member or the beneficiaries of the member referred to in subparagraph *(aa)* in terms of its rules; but

(b) specifically including, despite paragraph *(a)(i),* any category of contracts identified by the Minister by regulation under section 70(2A) as an accident and health policy;

"death event" means the event of the life of a person or an unborn having ended;

"disability event" means the event of the functional ability of the mind or body of a person or an unborn becoming impaired;

"health event" means an event relating to the health of the mind or body of a person or an unborn;

SECTION 70

(2A)(a) The Minister, despite the definition of 'business of a medical scheme' in section 9(1) of the Medical Schemes Act, may make regulations identifying a kind, type or category of contract as an accident and health policy.

(b) Regulations under paragraph *(a)*—

(i) must be made only—

(aa) in consultation with the Minister of Health;

(bb) after consultation between the National Treasury, the Registrar and the Registrar of Medical Schemes established under the Medical Schemes Act; and

(cc) after having regard to the objectives and purpose of the Medical Schemes Act, including the following principles entrenched therein—

(A) community rating:

(B) open enrolment; and

(C) cross-subsidisation within medical schemes; and

(ii) must provide for a short-term insurer or Lloyd's underwriter to submit specified information on any product within a kind, type or category of contract referred to in paragraph *(a)* to the Registrar and the Registrar of Medical Schemes within any specified timeframes;

(iii) may provide for matters relating to the design and marketing of any product within a kind, type or category of contract referred to in paragraph *(a).*

(c) Where the Minister has made regulations referred to in paragraph *(a),* the kind, type or category of contract identified as an accident and health policy in the regulations, is subject to this Act and not the Medical Schemes Act.

EXTRACT FROM THE MEDICAL SCHEMES ACT

EXTRACT FROM THE MEDICAL SCHEMES ACT

1. Section 1 of Act 131 of 1998 is hereby amended by the substitution for the definition of ‘‘business of a medical scheme’’ of the following definition:[6]

‘‘business of a medical scheme’’ means the business of undertaking, **[liability]** in return for a premium or contribution **[-]**, the liability associated with one or more of the following activities:

(a) **[to make provision]** Providing for the obtaining of any relevant health service;
(b) **[to grant]** granting assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; **[and]** or
(c) **[where applicable, to render]** rendering a relevant health service, either by the medical scheme itself, or by any supplier or group of suppliers of a relevant health service or by any person, in association with or in terms of an agreement with a medical scheme.’

“medical scheme” means any medical scheme registered under section 24(1);

“member” means a person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the rules of a medical scheme, is a member of such medical scheme;

“relevant health service” means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object -

(a) the physical or mental examination of that person;

(b) the diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;

(c) the giving of advice in relation to any such defect, illness or deficiency;

(d) the giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;

(e) the prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or

(f) nursing or midwifery,

and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practised, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy;

SECTION 65

(1) A medical scheme may compensate any person, in cash or otherwise, in accordance with its

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6 **Section 1 of the Medical Schemes Act, 1998 was amended by Financial Services Laws General Amendment Act No. 45 of 2013**

rules, for the introduction or admission of a member to that medical scheme.

(2) The Minister may prescribe the amount of the compensation which, the category of persons to whom, the conditions upon which, and any other circumstances under which, a medical scheme may compensate any person in terms of subsection (1).

(3) No person shall be compensated for providing services relating to the introduction or admission of a member to a medical scheme in terms of subsection (1) unless the Council has, in a particular case or in general, granted accreditation to such a person.

(4) An application for accreditation shall be made to the Council in the manner and be accompanied by such information as may be prescribed, and any other information as the Council may require.

EXTRACT FROM THE REGULATIONS MADE UNDER THE MEDICAL SCHEMES ACT

REGULATION 28: CONDITIONS TO BE COMPLIED WITH BY BROKERS

(1) No person may be compensated by a medical scheme in terms of section 65 for acting as a broker unless such person enters into a prior written agreement with the medical scheme concerned.

(2) Subject to subregulation (3), the maximum amount payable to a broker by a medical scheme in respect of the introduction of a member to a medical scheme by that broker and the provision of ongoing service or advice to that member, shall not exceed -

(a) R50, plus value added tax (VAT), per month, or such other monthly amount as the Minister shall determine annually in the Government Gazette, taking into consideration the rate of normal inflation; or

(b) 3% plus value added tax (VAT) of the contributions payable in respect of that member, whichever is the lesser.

(3) A medical scheme may not differentiate the amount of compensation offered to brokers for the introduction of members to the scheme based upon the anticipated claims experience, age, health status or employment status of the members being introduced;

(4) Subregulation (2) must not be construed to restrict a medical scheme from applying a sliding scale based on the size of the group being introduced provided that -

(a) the maximum amount in respect of any member introduced as specified in subregulation (2) is not exceeded; and

(b) a medical scheme may not pay a lesser amount for the introduction of individual members than the per capita amount payable in respect of introduction of members who form part of a group.

(5) Payment by a medical scheme to a broker in terms of subregulation (2) shall be made on a monthly basis and upon receipt by the scheme of the relevant monthly contribution in respect of that member.

(6) The ongoing payment by a medical scheme to a broker in terms of this regulation is conditional upon the broker -

(a) continuing to meet service levels agreed to between the broker and the medical scheme in terms of the written agreement between them; and

(b) receiving no other direct or indirect compensation in respect of broker services from any source, other than a possible direct payment to the broker of a negotiated professional fee from the member himself or herself (or the relevant employer, in the case of an employer group);

(7) A medical scheme shall immediately discontinue payment to a broker in respect of services rendered to a particular member if the medical scheme receives notice from that member (or the relevant employer, in the case of an employer group), that the member or employer no longer requires the services of that broker.

(8) A medical scheme may not compensate more than one broker at any time for broker services provided to a particular member.

(9) Any person who has paid a broker compensation where there has been a material misrepresentation, or where the payment is made consequent to unlawful conduct by the broker, is entitled to the full return of all the money paid in consequence of such material misrepresentation or unlawful conduct.