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**Analysis of proposed Demarcation Regulations**

## 1 Background

1.1 The Insurance Laws Amendment Act 2008 introduced changes to the definition of "accident and health policy" under the Short-term Insurance Act and to the definition of "health policy" under the Long-term Insurance Act with a view to allowing health policies only if they are aligned with health cover provided under the Medical Schemes Act.

1.2 This is a summary of the regulations with some comments. It is not a detailed analysis nor a comment on the legality or discriminatory effect of the regulations.

1.3 The new definitions of "accident and health policy" and "health policy" have yet to be brought into force. This will happen when the final demarcation regulations are ready.

1.4 Despite taking six years of negotiation between the insurance and health authorities and the government departments involved, the regulations are not well drafted. They also draw a line through the rights of hundreds of thousands of policyholders.

## 2 Short-term accident and health policy defined

2.1 An accident and health policy will be a contract providing benefits if a disability, health or death event occurs. The definitions of "disability event" "health event" and "death event" have not been changed and are sufficiently wide to cover any health event and death on account of accident or illness.

2.2 The definition specifically excludes an insurance policy that provides for the conduct of the business of a medical scheme under the Medical Schemes Act unless it is authorised by regulation.

2.3 It includes any category of contract identified by regulation under section 70(2A) as an accident and health policy and a policy taken out by a medical scheme to cover its liability to its members.

2.4 The Medical Schemes Act will have a new definition of the "business of a medical scheme". The intention is to prevent insurers from selling policies that undertake liability:

(1) to make provision for obtaining a relevant health service (for instance by guaranteeing payment of medical expenses prior to the health service being incurred); and/or

(2) to grant assistance in defraying expenses for a relevant health service (in other words paying actually incurred medical expenses); and/or

(3) to render the health service or make provision for rendering the health service.

2.5 It is no longer necessary that the policy provides all three. If any one or more of the three applies it will be enough to trigger the prohibition unless the demarcation regulations allow the insurance.

2.6 A "relevant health service" is any healthcare treatment aimed at the examination, diagnosis, treatment or prevention of a defect, illness or deficiency, giving advice in relation to pregnancy and termination of pregnancy, prescribing or supplying medicines, appliances or apparatus in that regard, and nursing or midwifery includes an ambulance service and hospitalisation.

2.7 An insurer can only provide the equivalent of medical scheme business if the policy complies with the demarcation regulations.

2.8 The demarcation regulations, according to section 70(2A) have as their overall objective:

(1) Community rating: Everyone insured on similar terms pays a similar premium.

(2) Open enrolment (no-one should be turned away because they have a higher risk than someone else e.g. because of medical history or age i.e. there should be no underwriting).

(3) Cross-subsidisation (lower risk policyholders will subsidise those with higher risks). For instance the young and fit will pay and benefit the same as the old and infirm).

## 3 Long-term health policy defined

3.1 A health policy is now defined so as to exclude a policy that conducts the business of a medical scheme unless authorised by regulations under s 72(2A).

## 4 Maximum broker's commission

4.1 It is proposed that the commission for selling health policies will be equivalent to the remuneration for introducing members to a medical scheme.

4.2 There are two problems with this. The remuneration under the Medical Schemes Act is the lesser of R50 (plus VAT) per month or 3% (plus VAT) of the contributions.

4.3 The first problem is that the figure of R50 has not been increased for years. Secondly, compensation of 3% of the monthly contribution may be rational in relation to the sort of contributions paid for medical aid. It does not make much sense as a percentage of the lower premiums paid for health policies.

## 5 Types of policies allowed

5.1 Regulation 7.2 contains a proposed table of the categories of policies that will be allowed. The table sets out specific policy benefits that are permissible and the criteria for the policies.

5.2 An interesting inclusion is short-term gap cover, presumably because there are a number of such products without competing with medical schemes on the market which many people use to top up their medical schemes benefits.

5.3 There are eight categories of **short-term cover**.

**Gap cover**

(1) Short-term Category 1 is medical expense shortfall cover sold only to insured persons who are also members of medical schemes.

(a) It covers the costs and expenses of health services which are not prescribed minimum benefits under the Medical Schemes Act or are minimum benefits that are not paid in full by the medical scheme.

(b) The policy benefits must be lump sum amounts stated in Rand terms in the policy.

(c) The policy benefits may not exceed R3 000 plus CPI per month.

(d) The contract must be an annual contract with monthly premiums.

(2) Short-term Category 2 is lump sum cover. Lump sum or income replacement is lump sum or income replacement cover and:

(a) The policy benefits must be one or more lump sum amounts stated in Rand terms. Bands are still possible.

(b) It pays policy benefits on the happening of a health event.

(c) It covers loss of income and "contingency expenses" associated with the health event (the word "contingency" does not seem to add anything except to reaffirm the principle of risk 2).

(d) The aggregate of policy benefits under all policies issued by the insurer and related persons (holding, subsidiary or fellow-subsidiary companies or companies under similar control) - (see section 2 of the Companies Act 2008) must not exceed R50 000 plus CPI per day per person. (This figure of R50 000 must be a mistake and it should be per event).

(e) Seeing it insures expenses "associated with" an insured person experiencing a specific health event, loss of income suffered by a family member who takes time off to nurse the ill or injured person could be covered, for instance.

(f) The policy must be an annual contract with monthly premiums.

(g) A waiting period before coming on risk is permitted.

(h) There is no reason why benefits should not be paid on a prefunded basis (for instance in order to get someone admitted to hospital).

**Motor: Third party liability**

(3) Short-term Category 3 covers third party liability motor policies.

(a) It covers insured persons who will be person insured agent liability for a third party's medical expenses.

(b) It covers insured persons against a third party's cost of health services following injury to a third party and is intended to be a form of liability cover.

(c) The injury must result from an accident which presumably intends to refer to a motor accident or some accident related to the use of a motor vehicle. It is not clear why there is this limitation.

(d) The policy can pay the actual costs or expenses of the health service provided to the third party.

(e) This means that the driver can, for instance, cover his or her liability to anybody injured in a motor vehicle accident including passengers.

(f) This category will extend the nature of third party liability insurance to cover costs rather than liability.

(g) It is not clear what the difference between "costs" and "expenses" is.

**Property: Third party liability**

(4) Short-term Category 4 is property third party liability which is similar to motor third party liability cover:

(a) It covers insured persons against the costs of a third party's medical expenses.

(b) It pays the actual costs of the relevant health service (actual costs or expenses may be paid).

(c) The loss must result from an injury to a third party.

(d) The injury must take place "while at the property of the insured person". Property is not defined. A property policy relates to "the use, ownership, loss of or damage to movable or immovable property" so the scope for cover is wide. Cover would for instance be permitted for almost any accident occurring at the insured person's property, movable or immovable.

**HIV and AIDS**

(5) Short-term Category 5 deals with HIV and AIDS cover:

(a) It covers expenses for HIV-related testing and HIV and AIDS treatment.

(b) Expenses must be covered on an employee group basis for employees and their dependents. This is highly discriminatory in favour of those lucky enough to be employed by large employers. These are the employees most likely to have medical aid.

(c) Benefits may be linked to actual medical costs and expenses.

(d) Cover is offered on either a prefunded or an immediate need basis, which is therefore unrestricted.

(e) A waiting period (elimination or deferred period) before benefits are paid is permitted.

**International travel insurance**

(6) Short-term Category 6 is international travel insurance:

(a) It covers costs associated with a health service incurred while travelling outside South Africa; and

(b) The health service must relate to a health, disability or death event that occurs while not in South Africa (even if there is a contributory pre-existing adverse state of health). Therefore medical tourism is not covered.

(c) Benefits that may be payable in kind (making provision for the health service or providing medicines for instance).

(d) Benefits may be paid directly to the health service provider.

(e) Benefits may be linked to actual costs and expenses.

(f) Cost and expenses may be offered on a prefunded or immediate needs basis.

**Domestic travel insurance**

(7) Short-term Category 7 is domestic travel insurance. Domestic travel insurance is similar to international travel insurance except that:

(a) The health, disability or death event must occur inside South Africa.

(b) The event must occur in a province other than the province in which the insured person or dependant is ordinarily resident. This is a strange provision. It means someone living in Vereeniging is covered whilst fishing on the south bank but not the north bank of the Vaal River.

**Emergency evacuation or transport**

(8) Short-term Category 8 covers:

(a) Guaranteed access to or the use of specialised medical transportation and/or guaranteed hospital admission to ensure admission to an emergency treatment facility and stabilisation. It is not at all clear why it should only relate to the costs at an emergency treatment facility or exactly what that means. Any hospital with an emergency section qualifies.

(b) Benefits paid in kind or directly to the provider of the medical transport or health service.

(c) Benefits that may be linked to actual costs and expenses of the health service.

5.4 There are four categories of **long-term cover**:

**Lump sum cover**

(1) Except for some inexplicable wording differences ("linked to" instead of "related to" and "as a result of" instead of "in respect of") the wording is similar except that the R50 000 limit is not included in the long-term regulations (is this the same mistake or can long-term insurers give unlimited cover?).

**Frail care**

(2) Frail care cover is permitted only to long-term insurers. It covers "custodial care (assistance with activities of daily living)" for the insured persons. The word "custodial" is rather unfortunate but it implies admission to the frail care centre.

(3) Policy benefits can be stated in the policy or ascertainable on a predetermined basis. It is not clear why this provision is in the regulations because benefits may be paid on a prefunded or immediate needs basis and may be linked to the actual costs or expenses incurred. That surely is all the policy need say.

(4) Benefits may be paid in kind (so that the long-term insurer makes provision for the frail care which seems unlikely) or, more likely by payment to the provider of the frail care service.

(5) An elimination or deferred (waiting) period may apply before policy benefits are payable.

**HIV and AIDS**

(6) HIV-related testing and HIV and AIDS treatment may be covered.

(7) For some reason it can only be covered "on an employee group basis for employees and their dependents". There seems to be no justification for this discrimination against employees who cannot insure on a group basis or people who are not employees.

(8) For the rest, the provisions are the same as with frail care above and the comments are the same.

**Emergency transport**

(9) Emergency evacuation or transport cover insures guaranteed access to and utilisation of specialised medical transport (e.g. ambulances and air ambulances) and/or guaranteed hospital admission (by paying deposits or prefunding hospital expenses)

to ensure admission to an "emergency treatment facility and stabilisation". Presumably any hospital with an emergency room qualifies.

(10) These policy benefits must be ancillary to main policy benefits covered under some other policy and standalone emergency evacuation or transport is not allowed.

(11) Policy benefits may be payable in kind (which implies the long-term insurer provides the ambulance which is unlikely) or by paying it directly to the provider of the service (more likely).

(12) The policy benefits may be linked to the actual costs or expenses of the emergency service.

(13) Inexplicably the long-term cover is for "the insured person" whereas the short-term equivalent is for "the policyholder or insured persons". There is no justification for this distinction between long-term and short-term insurers. A health policy under the Long-term Insurance Act covers a "health event" which is an event relating to the health of the mind or body of "a person". It is not restricted to insured persons as opposed to policyholders nor does the definition of "health policy" make such a distinction.

## 5.5 Specific requirements

Regulation 7.2(2) sets out a number of specific requirements deal with the insistence on non-discriminatory community rating, non-discriminatory open enrolment and cross-subsidisation between low-risk and high-risk individuals in the same benefit options. The requirements bear comment:

### (1) All cover – Short-term only

There is no logical reason why long-term insurers should not provide gap cover seeing they can provide health policies and disability.

### (2) All cover - Unfair discrimination

(a) A policy may not discriminate unfairly against anyone on the constitutionally protected grounds of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy and disability. Interestingly it excludes sex, colour, religion, conscience, belief, culture, language and birth presumably on the grounds they are not seen to be directly relevant to health cover which is doubtful.

(b) The unfair discrimination provision specifically includes a new ground of "state of health". This prevents any unfair discrimination on the grounds, for instance, of a pre-existing medical condition.

(c) This raises interesting questions. The Promotion of Equality and Prevention of Unfair Discrimination Act 2000 allows an insurer to prove that its discrimination is not unfair if it can show that "the discrimination reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned" (section 14(2)(c)). It is intrinsic to insurance that insurers are entitled to underwrite risks according to their particular risk assessment and it is part of their prudential responsibility to do so. Putting in exclusions for ethnic groups who have a higher predisposition to certain illnesses is unlikely to be upheld. But is it fair to discriminate by imposing a longer waiting period for someone with a terminal disease likely to die soon after benefits incept? The prudential requirements for medical schemes and insurers are entirely different and it does not seem to fit into the concept of insurance under the common law or the Short-term Insurance Act or the Long-term Insurance Act to label actuarially sound of discrimination as unfair.

(3) **All cover - Waiting period**

The waiting period may not exceed six months (as in the case of medical schemes).

(4) **All cover - Pre-existing health event**

(a) Once the insurer has taken on a policyholder or insured person, subject to the waiting period the insurer cannot refuse to pay a claim because the person experienced a health event prior to the commencement of the cover.

(b) This is a clear indication that there can be no discrimination in underwriting the policy irrespective of the state of health of the insured person.

(5) **All cover - Cancellation, variation or non-renewal**

(a) A policy cannot be cancelled, varied or not renewed because of the health or claims experience of the policyholder or insured person.

(b) Although the policies are annual policies they involve a long-term commitment that changes the nature of short-term insurance.

(c) **Lump sum cover - No indemnity for medical expenses under lump sum cover**

Category 2 lump sum or income replacement benefits cannot be paid on the basis of indemnifying the policyholder for actual medical expenses incurred.

(6) **Gap, lump sum, motor, property cover - No direct payment or cession to health service provider**

(a) Policies that give gap cover, lump sum cover, and motor or property third party liability cover (categories 1, 2, 3 or 4) may not allow for a cession of the benefits or payment to the health service provider.

(b) Gap cover and lump sum/income replacement payments must therefore be made to the policyholder or insured person (not a healthcare cessionary).

(c) Third party liability claims may be paid to the third party or the policyholder or to the insured person but not the healthcare provider as cessionary.

(d) As always, an instruction by the insured person at claims stage to pay the healthcare provider directly is permitted.

(7) **Membership of medical scheme**

(a) Except for gap cover, none of the categories of policies may require the policyholder or insured person to be a member of a medical scheme in order to get cover.

(b) That does not mean there cannot be a provision deducting from the indemnified amount any payment received from the insured person's medical scheme so that there is no double compensation or contribution. This may however put the policy in conflict with the medical scheme and some form of contribution or precedence should be provided for.

5.6 **Compulsory requirements – all cover**

Regulation 7.2(3) sets out some provisions that must be in the policy.

(1) This does not prohibit termination for other reasons provided they are not unfairly discriminatory.

(2) If the insurer no longer offers the policy cover or policy benefits, the policy or benefits can be cancelled on 90 days' notice to policyholders. Otherwise it may be a long-term commitment by short-term insurers.

(3) Gap cover insurers can terminate cover for any health service that subsequently becomes a prescribed minimum benefit under the Medical Schemes Act on 90 days' notice.

(4) **Plain language**

(a) The policy must be "in clear and easily understood language" that:

(i) Identifies the representations made by the policyholder that are regarded as material to the assessment of the risk. This is an indication that misrepresentation is still a possible defence, if it is not unfairly discriminatory.

(ii) States the premiums payable.

(iii) Describes the policy benefits provided.

(iv) States the risks and events that are covered and the circumstances under which those benefits are not provided (e.g. the limitations and exclusions).

5.7 **Marketing and disclosure**

Regulation 7.3 deals with marketing activities or marketing materials relating to a health policy.

(1) The policy may not be identified by the term "medical" or "hospital" or any derivative of those terms. Anyone already using those terms will have to change the policy name or description.

(2) The marketing may not "create the perception" that the contract indemnifies medical expenses incurred as a result of a health service. This is a strange provision because indemnifying medical expenses is specifically allowed in some categories of policies and it will be deceiving if policyholders are not told in plain language what they are getting.

(3) The policy may not create the perception that it is a substitute for medical scheme membership. This is a poorly drafted provision because "perception" is subjective and who knows what perception will be created in the minds of a potential policyholder when reading some marketing material.

(4) The marketing must "display" the following in "clear, legible print" in a prominent position:

(a) "This is not a medical scheme and the cover is not equivalent to that of a medical scheme. This policy is not a substitute for medical scheme membership."

(b) Seeing it uses the words "display" in "legible print" this would not relate to, for instance, radio or television advertising. It also relates to marketing activities and marketing material and not to the policy itself although TCF would require such a provision in the policy itself.

(5) The marketing activity and marketing material also has to clearly disclose and explain in easily understood language the representations relied on that are material, the premiums payable, the policy benefits provided and the insured and accepted events. This puts impossible demands on marketing material. It is impossible to do that in every radio or TV ad or SMS promotion.

5.8 **Limitation on combination of policies**

(1) The insurer may not itself or with related parties (holding companies, subsidiaries and fellow subsidiaries or companies controlled by the same person) offer a number of health policies that collectively result in the aggregate policy benefits collectively exceeding benefits contrary to the objectives and purposes of the Medical Schemes Act relating to community rating, open enrolment and cross-subsidisation.

(2) In other words, an insurer may not offer a number of policies to a single policyholder or insured person who can afford it so that they are entitled to much better benefits than, for instance, a lower income purchaser of a single policy.

(3) It will be very difficult to see where the line is crossed to defeat the objectives and purposes of the Medical Schemes Act which itself allows better cover for extra contributions by those who can afford it.

5.9 **Reporting existing and new products**

(1) Within one month of the regulations coming in force, a summary of any new policy to be "introduced or launched" must be submitted to the Registrar of Insurance and the Registrar of Medical Schemes.

(2) The summary must be a summary of the benefits, terms and conditions and marketing material of the health policy together with a summary of the benefits, terms & conditions and marketing material of other health policies offered by that insurer or a related party insurer.

(3) The Registrar of Medical Schemes may respond within a month or "at any time thereafter" to the Registrar of Insurance if the Registrar of Medical Schemes believes that the policies or marketing material are contrary to the objectives and purposes of the Medical Schemes Act, giving reasons for that opinion.

(4) The Registrar of Insurance must then after a further month or at any time thereafter object, by notice to the insurer, to any benefits, terms or conditions or marketing material and:

(a) Prohibit the insurer from introducing or launching the policy; or

(b) Instruct the insurer to stop offering or renewing the policies and to terminate existing policies within 90 days; or

(c) To amend the benefits, terms, conditions or marketing material.

Any such instruction by the Registrar will be subject to review by the courts on the usual grounds of administrative decision review. The Registrar can be required to provide reasons for the decision.

5.10 **Arrangements for existing policies**

(1) Three months after the demarcation regulations come into operation, insurers must submit a summary of the benefits, terms & conditions and marketing material for existence health products introduced or launched since 15 December 2008. The summary must be sent to the Registrar of Insurance and the Registrar of Medical Schemes.

(2) The Registrar of Medical Schemes may within three months or at any time thereafter advise the Registrar of Insurance of any opinion that the benefits, terms & conditions

or marketing material are contrary to the objectives and purposes of the Medical Schemes Act.

(3) The Registrar of Insurance may thereafter:

(a) Instruct the insurer to stop offering or renewing those policies and terminate any policy on 90 days' notice; or

(b) Instruct the insurer to amend the policies to comply with the Registrar of Insurance's requirements.

(4) Any such instruction by the Registrar will be subject to review by the courts on the usual grounds of administrative decision review. The Registrar can be required to provide reasons for the decision.

(5) Save for those provisions, the Act and regulations are not retrospective. Indefinite period policies introduced or launched before 15 December 2008 may continue in force.

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**26 June 2014**