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Unpacking new Insurance Regulations, PPR & Demarcation

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16 February 2017

Proposed short-term insurance regulations from 1 May 2017

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Transitional arrangements

- Remuneration clauses in agreements must be:
  - Amended by 31 July 2017 if entered into after 23 December 2016
  - Otherwise by 31 December 2017

- Other amendments to agreements must be made by 31 December 2017
  - Not that easy – includes specifying all incidental binder activities and standards of service for each of them ("Incidental" is activity "necessary or expedient" to perform binder functions);
  - Include exchange of comprehensive and reliable data every 24 hours with IT systems to match;
  - Must set up new profit share arrangements

Some important definitions

"Associate" far wider and includes:

- Sharing a director
- Have the same or associated company significant owner (15% of shares, votes or director appointments)
- Trusts are equally wide
- "Premiums" are irrationally for fee purposes "premiums payable by policyholders"
- "Enter into" is no longer "as a result of which" but "directed towards" another person entering into, varying or renewing a policy

Some important definitions

- “Policy data administration services” means:
  - Managing, recording and updating policy and policyholder data
  - To ensure complete integration between IT systems
  - Enabling insurer to have continuous access to accurate, up-to-date, complete and secure data

- “Personal lines” are natural persons and “commercial lines” are legal persons as insured

Limitation on fees

The limitations relate to:

- Intermediary services
- Policy data administration services
- Binder functions and incidental activities
- Other outsourcing arrangements
- Policyholder fees (s 8(5))

Limitation on fees

General principles for all fees:

- Must be reasonably commensurate with the actual service, function or activity (not cost)
- Not result in anything being remunerated again
- Not structured to “increase the risk of unfair outcomes for policyholders”
- Not linked to claims rejected, paid or not paid

Limitation on fees

- Fees for rendering services as intermediary are unchanged except "directed towards" instead of "as a result of which" policy entered into

- 12.5% and 20% are still maximums and the general principles apply (namely "reasonably commensurate" with service function or activity).

- For accident and health policies a sliding scale of 5% (premium above R2 000 per month) to 20% (premium less than R300 per month)

- Fees for policy data administration services are:
  - Only payable if person has operational capability and necessary IT system
  - Must not exceed 2% of total premium for the policies administered
  - Not payable to a natural person nor to a binder holder who enters into policies (presumably considered incidental)

Binder functions and incidental activities

- If the binder holder is FAIS registered for ‘advice’, maximum fees (without exemption) are:
  - 2% for entering into, varying or renewing policies
  - 2% for determining wordings, premiums and limits
  - 2% for settling claims

  But
  - No commercial lines binder allowed
  - No personal lines binder fees for determining wording, premiums or limits (see below)
  - Therefore only if exempted

- If binder holder is a “not advice” intermediary:
  - Fees are not capped
  - General principles apply (commensurate/not duplicated/ fair outcomes/unrelated to claims)

Binder functions and incidental activities

Registrar may grant approval to insurer (not intermediary) for higher fees if:

- Appropriate to nature, scale and complexity of binder function
- Does not impede fair treatment of policyholders
- No conflict of interest or conflict mitigated

All binder fees must be disclosed to policyholders

Profit shares

- Profit shares are only allowed to a non-mandated intermediary that is a binder holder with an insurer cell entitling it to dividends
- A cell structure is an equity participation in the shares of the insurer (not necessarily a cell insurer) entitling the shareholder to profits and liable for the share of the losses linked to the ring-fenced insurance business placed with the insurer
- There are no longer special dispensations for underwriting managers. An NMI can get a profit share without being an underwriting manager
- Where to now for underwriter managers?
- By 31 December 2017 cell structures will have to be put in place by insurers with approval

Other outsourcing arrangement fees

- Other outsourcing is not specifically regulated
- Because fee cannot be regulated (e.g. investment managers, actuarial services, IT services and a myriad of others)
- The general principles, namely (namely reasonably commensurate with service, function or activity/not duplicated/ fair outcomes/not linked to claims)

Policyholder fees

- This is the old s 8(5) policy fee
- The amount and purpose of the fee must be agreed by the policyholder in writing
- The fee must:
  - Relate to the actual services provided
  - Be a service other than an intermediary service
  - Not be a fee for which the intermediary is already remunerated
  - Be reasonable and commensurate with the service

Binder agreement changes

- No commercial lines (juristic persons) binder agreements for NMIs who render “advice” (rationale? rational? Constitutional – s 22 freedom of trade)

- Personal lines (natural persons) binders with NMIs rendering advice may not earn a fee for determining wordings, premiums limits. Who can?

- Within a group of entities separate advice and non-advice NMIs can be set up:
  - The advice intermediary’s fees will be capped at 4% (personal lines)
  - The non-advice binder fees will not be capped for commercial lines services but no advice may be given
  - A personal lines binder holder determining wording, premiums and limits must not be registered for advice but fees uncapped

Amendments to agreements

- Incidental activities must be specified with levels and standards of service
- Incidental functions may be outsourced under an outsourcing arrangement for commensurate remuneration
- The insurers must require the binder holder to be “fit and proper” and regularly assess that status
- Governance, risk management, internal controls, ability to comply with laws and agreement, operational and financial capability must all be regularly assessed and promptly rectified
- Timely, comprehensive and reliable data to enable the insurer to comply with regulatory data management requirements must be provided at least every 24 hours and IT systems must be in place to do so

Other exemptions

The Registrar may exempt an insurer conditionally from the commercial lines prohibition, personal lines prohibition, business between NMI and MI, and UMA not dealing with NMI and MI that is an associate if:

- No conflict of interest; or
- Conflict is mitigated without unfair treatment of policyholders; and
- The person exempted has operational and financial capability to perform function or business
- As always, subject to who-knows-what conditions


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Proposed replacement of Policyholder Protection Rules

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Commencement

- The rules will repeal the 2010 PPR
- 1 May 2017
- FSB have asked for comments on implementation date
- Registrar may set different dates for different provisions of PPR to come into operation

Application

- The rules will apply to all new and existing policies
- Apply to all policies regardless of the method or medium used to market or enter into policies
- Insurer remains responsible for meeting the requirements set out in PPR

Definitions

- “Policy” now includes policies with juristic persons under R2 million asset value or annual turnover threshold- same as the CPA
  - Direct selling?

- “Potential policyholder” gives you obligations eg to someone you have solicited or someone who receives a brochure on an insurance policy
  - How can this be properly regulated?

Rule 1: TCF

- Insurers must act with due skill, care and diligence and “with due regard to the convenience of the policyholder”

- TCF outcomes listed. Outcome are now rules.

Rule 2: Product line design

- It is an offence not to “make use of adequate information on the needs of identified customer groups”
- You must apply “necessary skills” to limit access by customer groups for whom a product line is inappropriate. What does this mean in practice?
- White labelling- insurers must undertake a DD
- Managing executive of the insurer must sign off on the product
  - D&O cover

Rule 3: Consumer credit insurance

- Insurers must comply with the consumer credit regulations made by the Minister of Trade and Industry

- If the insurer is or should reasonably be aware that the policyholder has substituted one CCI policy with a policy issued by the insurer – must confirm this in writing if requested by the credit provider

Rule 4: Cooling-off rights

- Applicable where the policy is longer than 30 days

- The policyholder has a 14 day cooling-off period:
  - After the date of receipt of the policy which means you need proof of delivery; or
  - From a reasonable date on which it can be deemed the policyholder received the contract. This is too open-ended. The CPA equivalent is the date on which the transaction or agreement was concluded

Rule 5: Negative option selection of policy terms

- If there is more than one option in a policy, negative option selection is not permissible

- Insurers will have to be careful how they frame policy contracts and schedules so that it is not in a two-option form

- For instance, in a multiperil policy, a section may not apply unless the policyholder elects to pay a premium. Wordings must be carefully looked at to avoid negative option choice

Rule 6: Determining premiums

- The premium “must reasonably balance the interests of the insurer and the reasonable benefit expectations of policyholders based on realistic assumptions that the insurer reasonably believes are likely to be met

- Fits into Rule 1

- No fees are payable in addition to premiums. For personal lines policies administration charges are no longer allowed (which implies for other policies they are). This increases the fees to intermediaries

Rule 10: Consent required to insure a life

- An insurer may only insure a person's life with their written consent
- E.g. travel policy where cover is available to the ticket holder who happens to be a spouse child

Rule 11: Advertising

- The rules on advertising, brochures and similar communications are long and complicated and will require additional compliance staff

- Advertisement includes “any direct or indirect visual or oral communications transmitted by any medium” advertising insurance or trying to induce the public to purchase the insurance. This includes billboards and similar displays.

- Descriptions in adverts must include key limitations, exclusions, risks and charges. How do you do that on a billboard or TV ad?

Rule 11: Advertising

- Sign off of ads by the managing executive. If feasible provide for independent review
- Records of adverts to be kept for a period of 3 years after being made available
- The rules incorporate the code of advertising practice issued by the Advertising Standard Authority.
- White labelled policies also affected
- Can these be rationally complied with?

Rule 12: Disclosure and record-keeping

- Information must be given to policyholders in good time to make an informed decision considering the policyholders "decision-making process and point at which the information may be most useful"

- The insurer must provide the policyholder with a long list of information at the point of entering into a policy

- You need to tell policyholders what their obligations are, conditions they can claim for, during the life of the policy continue making disclosures

- You need a system, process and procedures to "record all verbal and written communications with a policyholder

Rule13: Intermediation

- Intermediary agreements must be in writing
- The insurer may only enter into an intermediary agreement with an intermediary who “meets any competency requirements prescribed under the FAIS Act” for the policies offered
- Insurers will have to examine every intermediary before contracting with them and you can’t rely on the mere fact of FAIS authorisation and monitor them regularly

Rule 14: Data management

- This is also contained in the Proposed Binder Regulations
- Continuous access data -24 hour benchmark

Rule 17: Claims management

- Fits into TCF principles
- The board of directors is expected to “oversee the implementation of the claims management framework”
- There is a six month minimum period for instituting action after rejecting a claim which is reasonable
- The insurer must ensure that its “claims processes and procedures are transparent, visible and accessible through channels that are appropriate” to the insurer’s policyholders and claimants

Rule 17: Claim management

- Communications with a claimant must be in “plain and simple language”
- You have to give a claimant “contact details of the person who will be processing the claim”
- You are only entitled to “essential” information for a claim
- Rule 17 is likely going to increase claims costs

Rule 18: Complaints

- Increases costs of compliance
- Dedicated team to deal with complaints
- The board of directors are responsible
- Complaints need to be categorised
- Keep and maintain data
- Are these feasible?

Rule 19: Termination of policies

- “Termination” means cancellation or lapsing of a policy.
- Thirty days’ notice of a policy lapsing has to be given which is absurd
- You have to give notice of non-renewal where the policyholder “has a legitimate expectation that the policy will be renewed”

Rule 19: Termination of policies

- The insurer remains liable for a period of 30 days after the date on which the insurer receives proof that the policyholder is made aware of the intended termination of the policy or for the period until the insurer receives proof that the policyholder has entered into another policy
  - Free cover?
  - You need to find ways to ensure that policyholder knows that the policy has been terminated


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Demarcation regulations

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Demarcation regulations

- The demarcation regulations were gazetted on 23 December 2016 and come into force on 1 April 2017 – policies must comply by 1 January 2018

- Simultaneously the definition of “business as a medical scheme” under the Medical Schemes Act will come into force substituting “or” for “and” so that defraying of medical expenses will be the business of a medical scheme unless exempted by the demarcation regulations or outside the framework

- Accident and health policies covering medical and hospital expenses of various healthcare service providers have been substituted by specific, limited accident and health policies

Overbroad and unconstitutional

- National Treasury and the FSB suggest that you cannot provide any medical expenses, for instance, on a motor policy or a stated benefits policy.

- This is not correct. This is not the business of a medical scheme

- The regulations are unconstitutional because they take away the right to basic healthcare by denying hospital cash plans and low level medical insurance for people who cannot afford medical schemes

- No discrimination is allowed on the grounds of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability, state of health or similar grounds (not religion, conscience, belief, language & birth)

Short-term insurance

- Gap cover is allowed of up to R150 000 per year (escalating annually at CPI) above the limits of an insured's medical aid scheme for a health event.

- R20 000 or R3 000 per day (escalating annually at CPI) is paid to cover non-medical expenses as a result of hospitalisation from day one, subject to at least three days in hospital. Collusion to keep people in hospital is likely. Indemnity can't relate to payment for health services.

- Cover can be provided without limitation for policy benefits for HIV, AIDS, tuberculosis or malaria testing and treatment. Why only these diseases? High blood pressure and diabetes are at least as serious and frequent as malaria?

- The above can only be underwritten on a group basis although written individually and may not discriminate

Short-term insurance (cont/…)

- International travel insurance is allowed for policy benefits for a health event covering costs “associated with” the service whilst travelling “in a country in which the insured persons are not ordinarily resident”. “Associated with” means you can get expenses once you return home to South Africa if resident here. Foreigners can get cover in South Africa

- Medical emergency can cover the unlimited cost of emergency evacuation or transport and emergency medical treatment

Long-term insurance

Long-term insurers can cover the following:

- Non-medical expense cover for hospitalisation. This is the same as the short-term provision. Group basis only
- Cover for HIV, AIDS, tuberculosis or malaria testing and treatment is allowed but only as a rider benefit which is an additional ancillary insurance obligation under a long-term policy. Group basis only
- Frail care “to cover the cost or expenses of assistance for activities of daily living”. This is open-ended and would allow you to cover any material costs of home nursing or home assistance
- Medical emergency transport (same as short-term insurance) but rider benefit only

Demarcation regulations

- In both long-term and short-term regulations policyholders may not be refused cover unless they previously committed a fraudulent act relating to insurance

- Higher premiums can be charged after a specific age provided the same higher premium is paid by all policyholders entering into the product line after that age

- General waiting periods of three months and condition specific waiting periods of up to 12 months can be applied to short-term gap, non-medical and HIV etc. cover

Demarcation regulations

- Condition specific waiting periods are limited if the policyholder previously had a similar policy with waiting periods

- Policies (including premiums) can be amended on the basis of health or claims experience as long as it is done across the board

- Accident and health policies can only be terminated or not renewed if the policyholder fails to pay the required premium, submits fraudulent claims or commits a fraudulent act or the insurer no longer offers the specific product line eg No termination for aging insured

Demarcation regulations

- Policies may not be described as “medical”, “hospital” or their derivatives except gap cover or hospitalisation for the non-medical expense hospital cover. The policy must not be a substitute for a medical scheme and must state that it is not a substitute for medical scheme membership

- New products must be submitted for approval

- The Registrar may take action to amend policies or to forbid policies being offered


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Credit Life regulations

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Credit life regulations

- The credit life regulations came out on 9 February 2017 which will apply after six months from 9 August 2017

- These are regulations under the National Credit Act relating to credit providers but the PPR requires insurers to comply with them

- The caps are:
  - Mortgage agreement for mortgage bond over R450 000: R2 per R1 000 of deferred amount;
  - Mortgage agreements for deferred amounts under R450 000: R2 per R1 000 under 55 and R2.50 per R1 000 for over 55 (which is impermissible age discrimination)
  - Credit facilities (eg credit cards): R4.50 per R1 000 of average utilisation in the billing cycle which is fluctuating amount difficult to administer
  - Other credit agreements: R4.50 per R1 000
  - If temporary disability gives full payment of the balance the premium may be an additional R1.00 per R1 000.

Credit life regulations

- These premium limits are only for compulsory credit life insurance. Not voluntary additional insurance (for instance insurance of the property sold)

- Irrationally, the cover “must provide for at least” on death or permanent disability to pay the total obligations without any definition of what “permanent disability” is but it can be physically or mentally impaired, totally or partially permanently which means for a minimum disability consumers can get the full debt paid

- If temporary disability is longer than 12 months you get 12 months indemnity. If it is less you get the remaining repayment period or till the temporary disability is over

Credit life regulations

- If the consumer becomes unemployed or unable to earn an income from permanent or temporary disability all the obligations must be paid for at least 12 months, the remaining credit period or till employment is found

- If the consumer is unemployed at inception no premium may be charged for loss of income cover. If the consumer is a pensioner no premium may be charged for occupational disability. How do you work out what is what?

- Self-employed people can get cover but not for occupational disability which is unfairly discriminatory

Credit life regulations

- The cost of credit life insurance must be determined having regard to the actual risks and liabilities associated with the credit agreement whether individually underwritten or on a group basis

- Any current credit provider that increases existing premiums up to the maximum has to demonstrate that this is justified

- There is a limited list of permitted exclusions and limitations including alcohol and drugs, suicide, participation in war, etc, use of nuclear weapons, criminal activities, hazardous activities, pre-existing condition during the previous 12 months

Credit life regulations

- For retrenchment cover you can exclude retrenchment within three months of commencement , lawful dismissal, voluntary forfeiture of income, voluntary retrenchment, resignation, retirement, participation in unprotected strike or pre-existing known potential retrenchment

- The exclusions and limitations must be communicated by the credit provider to the consumer “at regular intervals”

- Annual premiums must be the monthly premium x 12

- Where a consumer wants to substitute another insurer’s policy the credit provider must accept the substitution. What if there is an annual policy already paid for upfront?


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