GOVERNMENT NOTICES

NATIONAL TREASURY

No. R. 192 **2 March 2012**

LONG-TERM INSURANCE ACT, 1998: PUBLICATION OF PROPOSED AMENDMENT OF REGULATIONS MADE UNDER SECTION 72 FOR PUBLIC COMMENT

I, Pravin J Gordhan, Minister of Finance, in accordance with section 72(2B) of the Long-term Insurance Act, 1998 (Act No. 52 of 1998), hereby publish the proposed amendment of the Regulations made under section 72 of the Long-term Insurance Act and published under GNR.1492 of 27 November 1998, to be made under section 72(2A) of the Long-term Insurance Act, as set out in Schedule A hereto, for public comment.

The proposed amendment will be made in consultation with the Minister of Health and after consultation between the National Treasury, the Registrar and the Registrar of Medical Schemes established under the Medical Schemes Act.

An explanatory memorandum on the proposed amendment is set out in Schedule B hereto.

Comments on the proposed amendment may be submitted in writing on or before 23 April 2012 to the National Treasury per email to LTDemarcation@treasury.gov.za. .

The proposed draft amendment of the regulations is available on the National Treasury's website at http://www.treasury.gov.za and the Financial Services Board's web site at http://www.fsb.co.za.

PRAVIN J GORDHAN

MINISTER OF FINANCE

Date: 02/03/2012

SCHEDULE A

1. Substitution of Part 7 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R192 of 2012[1]:

The following Part is hereby substituted for Part 7 of the Regulations:

"PART 7
CONTRACTS IDENTIFIED AS HEALTH POLICIES UNDER PARAGRAPH (b) OF THE DEFINITION OF HEALTH POLICY

Definitions and interpretation

7.1 In this Part 7, unless the context indicates otherwise -

"insurer" means a long-term insurer;

"medical scheme" has the meaning assigned under section 1 of the Medical Schemes Act;

"Medical Schemes Act" means the Medical Schemes Act, 1998 (Act No. 131 of 1998);

"member" has the meaning assigned under section 1 of the Medical Schemes Act;

"policy" means a long-term policy;

"relevant health service" has the meaning assigned under section 1 of the Medical Schemes Act; and

"this Part" means this Part 7.

Categories of contracts identified as health policies under paragraph (b) of the definition of health policy

7.2 (1) A contract is a health policy under paragraph (b) of the definition of health policy if that contract –

(a) matches any of the categories of contracts, meets the criteria and provides for the policy benefits associated with that category, as set out in the table below.

[1] This amendment refers to the binder regulations still to be promulgated.

Category	Name	Policy benefits	Criteria
1	**Lump sum or income replacement policy benefits payable on a health event**	Covers loss of income and contingency expenses associated with the life insured experiencing a specified health event.	▪ Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract. ▪ Policy benefits are limited to 70% of the policyholder's net income per day. ▪ Policy benefits may be differentiated for different health events. ▪ Policy benefits may be differentiated in accordance with the severity of different health events and expressed as a percentage of the sum assured, up to a maximum of 10 severity levels.. ▪ An elimination or deferred period may apply before policy benefits are paid. ▪ Cover may be offered on a whole of life or defined term basis
2	**Frail care**	Covers custodial care (assistance with activities of daily living) for policyholders.	▪ Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract. ▪ Policy benefits may be paid in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service.

			▪ Policy benefits may be paid on a pre-funded or immediate needs basis.
3	**HIV and Aids**	Covers expenses for HIV-related testing and HIV and Aids treatment on an employee group basis.	▪ Cover offered to employers in respect of employees. ▪ Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract. ▪ Policy benefits may be paid in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service. ▪ Cover may be offered on a pre-funded or immediate needs basis.
4	**Emergency Evacuation or Transport**	Covers guaranteed access to and utilisation of specialised medical transportation and / or guaranteed hospital admission to ensure that the life insured is admitted to an emergency treatment facility and stabilised.	▪ Policy benefits are ancillary to the main policy benefits provided under the policy. ▪ Policy benefits may be payable in kind or to a provider of a relevant health service. ▪ Policy benefits may be linked to actual costs or expenses of a relevant health service

(2) A contract referred to under sub-regulation (1) may not -

(a) provide that the policyholder or life insured must be a member of a medical scheme;

(b) entitle the insurer to refuse any claim for policy benefits on the grounds that the life insured had experienced a health event prior to the commencement of the applicable cover, unless material misrepresentation or non-disclosure in regard to such health event has occurred;

(c) provide for the cancellation, variation or non-renewal of the contract by the insurer as a result of the health or claims experience of a life insured, unless material

misrepresentation or non-disclosure in regard to the life insured's health or claims experience has occurred; and

(d) in relation to a contract referred to in category 1 in the table under sub-regulation (1), -

(i) provide policy benefits that are fully or partially, linked to indemnifying the policyholder against medical expenses incurred as a result of a relevant health service; or

(ii) allow for the cession or payment of any policy benefits payable under the contract to a provider of a relevant health service.

Marketing and disclosures

7.3 Any marketing activity or marketing material in respect of a contract referred to under regulation 7.2 must –

(a) not be identified by the term "medical", "hospital" or any derivative thereof;

(b) not in any manner create the perception that the contract –

(i) indemnifies a policyholder against medical expenses incurred as a result of a relevant health service; or

(ii) is a substitute for medical scheme membership;

(c) display the following statement in clear legible print in a prominent position:
"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.";

(d) in relation to a contract referred to in category 1 in the table under regulation 7.2(1), in addition to paragraph (b) above, display the following statement in clear legible print in a prominent position:
"The intention of the policy is to cover contingencies other than medical expenses. This policy may not be ceded and no benefit payments are allowed to be paid to a provider of a relevant health service through cessions or similar means."; and

(e) clearly disclose and explain in easily understood language –

(i) the matters referred to in section 48 of the Act; and

(ii) that the contract is not a medical scheme and the cover is not a substitute for or equivalent to a medical scheme.

Reporting of product information

7.4 (1) An insurer must, at least 1 month prior to introducing or launching a new health policy referred to in this Part, submit a summary of the benefits, terms and conditions and marketing material of that health policy to the Registrar and Registrar of Medical Schemes.

(2) The Registrar of Medical Schemes may, within the month referred to under sub-regulation (1) or at any time thereafter, advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act as set out in that Act, with specific reference to sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.

(3) The Registrar may within the month referred to under sub-regulation (1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (2), by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy submitted under sub-regulation (1), and –

(a) prohibit the insurer from introducing or launching the health policy; or

(b) instruct the insurer to stop offering or renewing those health policies to the public and within 90-days of the date determined by the Registrar, terminate any health policy; or

(c) require the insurer to amend any of the benefits, terms and conditions and marketing material of a health policy in accordance with the requirements of the Registrar.

Transitional arrangements

7.5 (1) An insurer must, 3 months after this Part comes into operation, submit a summary of the benefits, terms and conditions and marketing material of all existing health policies referred to in this Part introduced or launched on or after 15 December 2008 to the Registrar and Registrar of Medical Schemes.

(2) The Registrar of Medical Schemes may, within the 3 months referred to under sub-regulation (1), or at any time thereafter, advise the Registrar that the Registrar of Medical Schemes is of the opinion that the benefits, terms and conditions or marketing material concerned is contrary to the objectives and purpose of the Medical Schemes Act as set out in that Act, with specific reference to sections 72(2A)(b)(i)(cc)(A) to (C) of the Act, and the reasons for this opinion.

(3) The Registrar may within the 3 months referred to under sub-regulation (1) or at any time thereafter, of the Registrar's own accord or after due consideration of an opinion of the Registrar of Medical Schemes referred to under sub-regulation (2), by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy submitted, and –

(a) instruct the insurer to stop offering or renewing those health policies to the public and within 90-days of the date determined by the Registrar, terminate any health policy; or

(b) instruct the insurer, by a date determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of a health policy in accordance with the requirements of the Registrar before offering those health policies or renewing any existing health policies to the public.

2. Insertion of Part 8 in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R[-] of 2012:

Part 8 is hereby inserted after Part 7 of the Regulations:

"PART 8

TITLE AND COMMENCEMENT

7.1 These regulations are called the Regulations under the Long-term Insurance Act, 1998.

7.2 (1) Regulations 1 to 4 came into operation on commencement of the Act.

(2) Regulations 3A and 5A came into operation on 1 December 2006.

(3) Regulations 3B and 5B came into operation on 1 January 2009.

(4) Regulation 6 came into operation on [*insert date*].

(5) Regulation 7 came into operation on [*insert date*].

(6) Any amendments to regulations 1 to 7 come into operation on the date of publication thereof in the *Government Gazette* or on such other date specified by the Minister in the *Government Gazette* or specified in a regulation."

SCHEDULE B

EXPLANATORY MEMORANDUM

1. PURPOSE

The purpose of this Explanatory Memorandum is to provide insight into the policy principles that informed the draft regulations and explain how these principles are reflected in the draft regulations.

2. BACKGROUND

The enhancement of the legislative framework relating to demarcation between insurance business (health policies) and medical schemes business (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 and the Short-term Insurance Act No. 53 of 1998, 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[2]. These identified categories of contracts will be excluded from the medical schemes regulatory environment, and will be regulated under the Long-term and Short-term Insurance Acts, respectively.

Subsequent to the enactment of the Insurance Laws Amendment Act, the National Treasury established a sectoral work group with representation from the National Treasury, the National Department of Health, the Financial Services Board (FSB), the Council of Medical Schemes (CMS) and industry associations (the Association for Savings & Investment South Africa (ASISA) and the South African Insurance Association (SAIA). The mandate of the sectoral working group was to make recommendations to be included in draft regulations.

The draft demarcation regulations are therefore the result of robust and inclusive consultation with interested and affected stakeholders.

3. POLICY PRINCIPLES THAT INFORMED THE DRAFT REGULATIONS

A clear demarcation between health policies and medical schemes is 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 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.

[2] An amendment to the existing definition of the business of a medical scheme is proposed under the draft Financial Services Laws General Amendment Bill (under consideration by the National Treasury). See the extract from the Medical Schemes Act No. 131 of 1998, in Annexure 1.

Section 72(2A) of the Long-term Insurance Act 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:

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.

4. HOW DO THE DRAFT REGULATIONS ACHIEVE THE POLICY PRINCIPLES?

The policy principles referred to in paragraph 3 above are achieved by –

4.1 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;

4.2 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;

4.3 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;

4.4 prescribing matters relating to the marketing of these categories of heath policies;

4.5 prescribing matters relating to disclosures that must be made by insurers and intermediaries relating to these categories of health policies;

4.6 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

4.7 prescribing transitional provisions for regularising existing health policies that are inconsistent with the draft regulations.

5. SCOPE OF THE DRAFT REGULATIONS

The draft regulations relate only to contracts referred to in paragraph (b) of the definition of health policy in section 1 of the Long-term Insurance Act. That is policies identified by the Minister of Finance as 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 health policies in general.

6. RELEVANT ACTS AND THE DRAFT REGULATIONS

6.1 **The Long-term Insurance Act**: The Long-term Insurance Act (the Act) contains the fundamental policy or underlying principles relating to the demarcation between insurance business and medical schemes business. It delegates legislative (law-making) and other authority to implement and enforce the Act to the Minister of Finance.

The draft regulations are the detailed regulation of matters provided for in the Act. They elaborate on the policy and principles entrenched in the Act by prescribing detailed and technical matters.

The relevant extracts from the Act (section 1, 48 and 72(2A) & (2B)) are included at the end of this Schedule as Annexure 1.

The draft regulations must be read with the Act

6.2 **The Medical Schemes Act:** The draft regulations refer to the Medical Schemes Act (the MS Act). This is so to, in as far as reasonably possible, ensure consistency in respect of terminology used in the Act and the MS Act and to avoid any interpretation difficulties that may arise in implementing the draft regulations[3].

The draft regulations must therefore also be read with the MS Act.

The relevant extracts from the MS Act (section 1) are included at the end of this Schedule as Annexure 1.

The draft regulations must be read with the Act

7. SUMMARY OF THE DRAFT REGULATIONS

7.1 Which categories of contracts are identified as health policies for purposes of paragraph (b) of the definition of health policy in the Act?

[See regulation 7.2(1) and columns 1 and 2 of the table in regulations 7.2(1)]

The following categories of contracts are identified as health policies for purposes of paragraph (b) of the definition of health policy in the Act:

[3] See footnote 2.

Category 1: Lump sum or income replacement policy benefits payable on a health event

Category 2: Frail care

Category 3: HIV and Aids

Category 4: Emergency evacuation or transport

For the purposes of these regulations, a contract is a health policy only if that contract matches any of these categories of contracts, and provides for the policy benefits and meets the criteria associated with that category referred to below.

7.2 What are the policy benefits that may be provided under a contract for that contract to fall into a category of contracts identified as health policies?

[See regulation 7.2(1) and columns 1 and 2 of the table in regulations 7.2(1)]

- **Categories 1** relate to contracts that provide for policy benefits relating to loss of income and contingency expenses associated with a health event. These contracts may not provide policy benefits relating to medical expenses associated with a health event.

  It may be argued that contracts that relate to category 1 do not constitute the business of a medical scheme as defined in the MS Act. However, these categories have been provided for in the draft regulations to avoid any interpretational difficulties that may arise in respect of the status of contracts that relate to these categories.

- **Categories 2, 3 and 4** relate to contracts that provide for policy benefits relating to actual medical expenses associated with the health event/s identified in respect of those categories.

  Contracts that relate to these categories unambiguously constitute the business of a medical scheme as defined in the MS Act. These categories of contracts, however, are excluded from the definition of the business of a medical scheme as they are not harmful to the medical schemes environment.

7.3 What are the specific criteria that a contract must meet to fall into a specific category of contracts identified as health policies?

[See column 3 of the table in regulations 7.2(1) and regulation 7.2(2)]

Specific criteria for each category

The specific criteria that must be met by a contract in respect of a specific category of contract identified as constituting health policies are set out in column 3 of the table in regulation 7.2(1). These criteria relate to the purposes for which policy benefits may be paid and to whom such policy benefits may be paid.

Specific criteria for category 1

The specific criteria that must be met by a contract in respect of category 1 (Lump sum or income replacement policy benefits payable on a health event are that the contract may not -

- provide policy benefits that fully or partially indemnifies the policyholder against medical expenses. This means the policy benefits may not be linked to medical expenses;
- allow for the cession or payment of any policy benefits to a provider of a relevant health service.

General criteria for all categories

The general criteria that must be met by any contract to be a health policy for the purposes of these regulations are as follows. A contract -

- may not make membership of a medical scheme a condition for eligibility to enter into such a contract;
- may not provide for underwriting at claims stage;
- may not provide for the cancellation, variation or non-renewal of the contract by the insurer as a result of the health status or claims experience of a policyholder; or
- may not be described or identified by the use of the term "medical", "hospital" or any derivative thereof; and
- must, in clearly and in easily understood language, identify the matters referred to in section 48 of the Act and state that the contract is not a medical scheme and the cover is not a substitute for or equivalent to a medical scheme.

Box 2:

Section 48 of the Act refers to:

- ✓ representations made by or on behalf of a person to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy
- ✓ the premiums payable and the policy benefits to be provided under the policy
- ✓ 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

7.4 What requirements must marketing activities and marketing materials of health policies adhere to?

[See regulation 7.3]

All categories

Any marketing activity or material in respect of a health policy identified in the draft regulations must –

- not be identified by the term "medical", "hospital" or any derivative thereof;
- not in any manner create the perception that the contract indemnifies a policyholder against medical expenses incurred as a result of a relevant health service or is a substitute for medical scheme membership;
- display the following statement in clear legible print in a prominent position:

  "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."; and
- clearly disclose and explain in easily understood language the matters referred to in Box 2 above.

Category 1

In addition, any marketing activity or material in respect of a health policy in category 1 (Lump sum or income replacement policy benefits payable on contracting a dread disease), 2 (Lump sum or income replacement policy benefits payable on disability) or 3 (Major health event) must display the following statement in clear legible print in a prominent position:

"The intention of the policy is to cover contingencies other than medical expenses. This policy may not be ceded and no benefit payments are allowed to be paid to a provider of a relevant health service through cessions or similar means."

7.5 What information must an insurer submit to the Registrars in respect of a health policy referred to in paragraph (b) of the definition of health policy?

[See regulation 7.4(1)]

An insurer must submit a summary of the benefits, terms and conditions and marketing material of any health policy it wishes to introduce or launch to the Registrar and Registrar of Medical Schemes. The information must be submitted 1 month prior to introducing or launching such a policy.

No periodic reporting on health policies are provided for in the draft regulations as it was deemed more appropriate to require such reporting in the quarterly and annual statutory returns.

7.6 What may the Registrars do in respect of information submitted to it under regulation 7.4?

[See regulation 7.4(2)]

The Registrar of Medical Schemes may object to any of the benefits, terms and conditions and marketing material of a health policy to the Registrar.

The Registrar, of his/her own accord or after considering an objection from the Registrar of Medical Schemes, may by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy, and –

- prohibit the insurer from introducing or launching the health policy; or
- require the insurer to amend any of the benefits, terms and conditions and marketing material of a health policy in accordance with the requirements of the Registrar.

The Registrar or Registrar of Medical Schemes may at any time object to any of the benefits, terms and conditions and marketing material of a health policy.

7.7 Must health policies entered into prior to the effective date of the draft regulations comply with the draft regulations?

[See regulation 7.5]

Health policies entered into by an insurer after 15 December 2008[4] but prior to the effective date of the draft regulations must be brought in line with the draft regulations. The draft regulations provide for the following process in this regard:

- An insurer must, 3 months after the draft regulations comes into operation, submit a summary of the benefits, terms and conditions and marketing material of all existing health policies that may be inconsistent with the definition of the business of a medical scheme (as it will be amended[5]) to the Registrar and Registrar of Medical Schemes.
- The Registrar of Medical Schemes may object to any of the benefits, terms and conditions and marketing material of a health policy to the Registrar.
- The Registrar of his/her own accord or after considering an objection from the Registrar of Medical Schemes, may by notice to the insurer, object to any of the benefits, terms and conditions and marketing material of a health policy, and –
  - ✓ instruct the insurer to stop offering those health policies to the public and within 90-days of the date determined by the Registrar, terminate those health policies; or
  - ✓ instruct the insurer, by a date determined by the Registrar, to amend any of the benefits, terms and conditions and marketing material of those health policies in accordance with the requirements of the Registrar before offering those policies or renewing any existing policies.

  The Registrar or Registrar of Medical Schemes may at any time object to any of the benefits, terms and conditions and marketing material of a health policy.

---

[4] The date on which the Insurance Laws Amendment Act No. 27 of 2008 that introduced provisions in the Long-term Insurance Act and the Short-term Insurance Act, to facilitate a clear demarcation between what constitutes insurance business and what constitutes the business of a medical scheme, took effect.

[5] See footnote 2.

8. WHAT ARE THE 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, 7.4 or 7.5 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[6] as defined in the MS Act.

9. WHAT ARE THE 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[7] 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, 7.4 or 7.5 of the draft regulations to the enforcement committee established under section 10 of the Financial Services Board Act No. 97 of 1990.

[6] See footnote 2.
[7] See footnote 2.

ANNEXURE 1 TO SCHEDULE B

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

SECTION 1: PROPOSED AMENDMENT

'business of a medical scheme' the business of undertaking liability in return for a premium or contribution –

(a) to make provision for the obtaining of any relevant health service;

(b) to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant health service; **[and]**

(c) where applicable, to render 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; or

(d) to undertake two or more of the activities referred to under paragraphs (a), (b) or (c)[8].

"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;

[8] The definition as quoted highlights the proposed amendment of the definition of a business of a medical scheme to be proposed under the draft Financial Services Laws General Amendment Bill (under consideration by the National Treasury). The word in bold type in square brackets indicates an omission from the existing definition and the words underlined with a solid line indicate insertions in the existing definition.