No. R. 193 **2 March 2012**

SHORT-TERM INSURANCE ACT, 1998: PUBLICATION OF PROPOSED AMENDMENT OF REGULATIONS MADE UNDER SECTION 70 FOR PUBLIC COMMENT

I, Pravin J Gordhan, Minister of Finance, in accordance with section 70(2B) of the Short-term Insurance Act, 1998 (Act No. 53 of 1998), hereby publish the proposed amendment of the Regulations made under section 70 of the Short-term Insurance Act and published under GNR. 1493 of 27 November 1998, to be made under section 70(2A) of the Short-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 STDemarcation@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 website 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 Short-term Insurance Act, 1998 as published in GN R1493 of 1998 and amended by GN R462 of 2008 and GN R193 of 2012[1]:

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

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

Definitions and interpretation

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

"insurer" means a short-term insurer or a Lloyd's underwriter;

"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 short-term policy;

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

"this Part" means this Part 7.

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

7.2 (1) A contract is an accident and health policy under paragraph (b) of the definition of accident and health policy if that contract matches any of the categories of contracts, and

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

meets the criteria and provides for the policy benefits associated with that category, as set out in the table below.

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 an insured person 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.
2	**Motor: Third Party Liability.**	Covers policyholders and insured persons for the costs associated with damages incurred during a theft or accident of a vehicle, including the costs of a relevant health service following the injury to occupants of the vehicle or a third party as a result of an accident.	▪ Policy benefits may be linked to actual costs or expenses of a relevant health service.

Category	Name	Policy benefits	Criteria
3	**Property: Third Party Liability**	Covers policyholders and insured persons for all damages or theft from property, including any costs of a relevant health service following the injury of third parties while on that property and/or compensation for bodily injury of the policyholder or insured person as a result of violent and external means.	▪ Policy benefits may be linked to actual costs or expenses of a relevant health service.
4	**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 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.
5	**International travel insurance**	Covers costs associated with a relevant health service incurred while travelling outside of the Republic of South Africa, as a result of a health, disability or death event that occurs while not in the Republic.	▪ 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. ▪ Cover may be offered on a pre-funded or immediate needs basis.
6	**Domestic travel insurance**	Covers costs associated with a relevant health service incurred while travelling inside South Africa, as a result of health, disability or death event that occurs while in South Africa.	▪ 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. ▪ Cover may be offered on a pre-funded or immediate needs basis.

Category	Name	Policy benefits	Criteria
7	**Emergency Evacuation or Transport**	Covers guaranteed access to and utilisation of specialised medical transportation and / or guaranteed hospital admission to ensure that the policyholder or insured persons are 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 insured person must be a member of a medical scheme;

(b) entitle the insurer to refuse any claim for policy benefits on the grounds that the policyholder or insured person 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 policyholder or insured person, unless material misrepresentation or non-disclosure in regard to the insured person'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), provide policy benefits that are fully or partially related to indemnifying the policyholder against medical expenses incurred in respect of a relevant health service; or

(e) in relation to a contract referred to in category 1, 2 or 3 in the table under sub-regulation (1), allow for the cession or payment of any policy benefits payable under the contract to a provider of a relevant health service.

(3) A contract referred to under sub-regulation (1) must –

(a) provide for a 90-day notice of termination period to a policyholder if an insurer no longer will be offering contracts that relate to the same or similar policy benefits, or the same event as part of its short-term insurance business.

(b) in clear and in easily understood language –

(i) identify those representations made by or on behalf of the policyholder or an insured person to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy;

(ii) state the premiums payable and the policy benefits to be provided under the policy; and

(iii) state 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.

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."; and

(d) clearly disclose and explain in easily understood language the matters referred to in regulation 7.2(3)(b).

Reporting of product information

7.4 (1) An insurer must, at least 1 month prior to introducing or launching a new accident and health policy referred to in this Part, submit a summary of the benefits, terms and conditions and marketing material of that accident and 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 70(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 an accident and health policy submitted, and –

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

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

(c) require the insurer to amend any of the benefits, terms and conditions and marketing material of an accident and 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 accident and 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 70(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 an accident and health policy submitted under sub-regulation (1), and –

(a) instruct the insurer to stop offering or renewing those accident and health policies to the public and within 90-days of the date determined by the Registrar, terminate any accident and 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 an accident and health policy in accordance with the requirements of the Registrar before offering those health policies or renewing any existing accident and health policies to the public.

2. Insertion of Part 7 in the Regulations under the Short-term Insurance Act, 1998 as published in GN R1493 of 1998 and amended by GN R462 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 Short-term Insurance Act, 1998.

7.2 (1) Regulations 1 to 5, other than regulation 4.2, came into operation on commencement of the Act. Regulation 4.2 came into operation on 25 April 2008.

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

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

(4) 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 (accident and 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 indentified 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 accident and 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.

Accident and 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 70(2A) of the Short-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 accident and 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 accident and health policies offer the same protection as a medical scheme, when in fact the protection is partial and conditional; and / or
- that accident and 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 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;

4.2 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;

4.3 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;

4.4 prescribing matters relating to the marketing of these categories of accident and health policies;

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

4.6 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

4.7 prescribing transitional provisions for regularising existing accident and 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 accident and health policy in section 1 of the Short-term Insurance Act. 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.

6. RELEVANT ACTS AND THE DRAFT REGULATIONS

6.1 **The Short-term Insurance Act**: The Short-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 and 70(2A)) 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 accident and health policies for purposes of paragraph (b) of the definition of accident and 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 accident and 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: Motor: Third Party Liability

Category 3: Property: Third Party Liability

Category 4: HIV and Aids

Category 5: International travel insurance

Category 6: Domestic travel insurance

Category 7: Emergency Evacuation or Transport

For the purposes of these regulations, a contract is an accident and 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 accident and health policies?

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

- **Category 1** relates 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, 4, 5, 6 and 7** 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 deemed not to be 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 accident and 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 accident and 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.

Specific criteria for categories 1, 2, 3

A contract in respect of category 1 (Lump sum or income replacement policy benefits payable on a health event), category 2 (Motor: Third Party Liability) or 3 (Home: Third Party Liability) may not 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 an accident and 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 insured person;
- must provide for a 90-day notice of termination period to a policyholder if an insurer no longer will be offering contracts that relate to the same or similar policy benefits, or the same or similar event as part of its short-term insurance business; and
- must in clearly and in easily understood language –
  - identify those representations made by or on behalf of the policyholder or insured person to the insurer which were regarded by that insurer as material to its assessment of the risks under the policy;
  - state the premiums payable and the policy benefits to be provided under the policy; and
  - state 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 accident and health policies adhere to?

[See regulation 7.3]

All categories

Any marketing activity or material in respect of an accident and 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.";
- clearly disclose and explain in easily understood language the matters referred to in the last bullet under paragraph 7.5 above; and
- state that the contract is not a medical scheme and the cover is not a substitute for or equivalent to a medical scheme.

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

[See regulation 7.4(1)]

An insurer must submit a summary of the benefits, terms and conditions and marketing material of any accident and 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 accident and 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 an accident and health policy, and –

- prohibit the insurer from introducing or launching the accident and health policy; or
- instruct the insurer to stop offering or renewing those accident and health policies to the public and within 90-days of the date determined by the Registrar, terminate any accident and health policy; or
- require the insurer to amend any of the benefits, terms and conditions and marketing material of an accident and 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 accident and health policies entered into prior to the effective date of the draft regulations comply with the draft regulations?

[See regulation 7.5]

Accident and 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 accident and 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 an accident and health policy, and –
  - ✓ instruct the insurer to stop offering those accident and health policies to the public and within 90-days of the date determined by the Registrar, terminate those accident and 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 accident and health policies in accordance with the requirements of the Registrar before offering those policies or renewing any existing policies.

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[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.

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.

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 accident and 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 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, 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.

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

ANNEXURE 1 TO SCHEDULE B

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

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.