CONNECT

FINAL HEALTHCARE DEMARCATION REGULATIONS PUBLISHED

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The Minister of Finance and the Minister of Health tabled the second draft demarcation regulations in Parliament on 28 October 2016, and these regulations were published in the Government Gazette in December 2016. The regulations specify the type of contracts that will be regulated under the Long-term and Short-term Insurance Acts as accident and health insurance policies, therefore excluding them from the *Medical Schemes Act*.

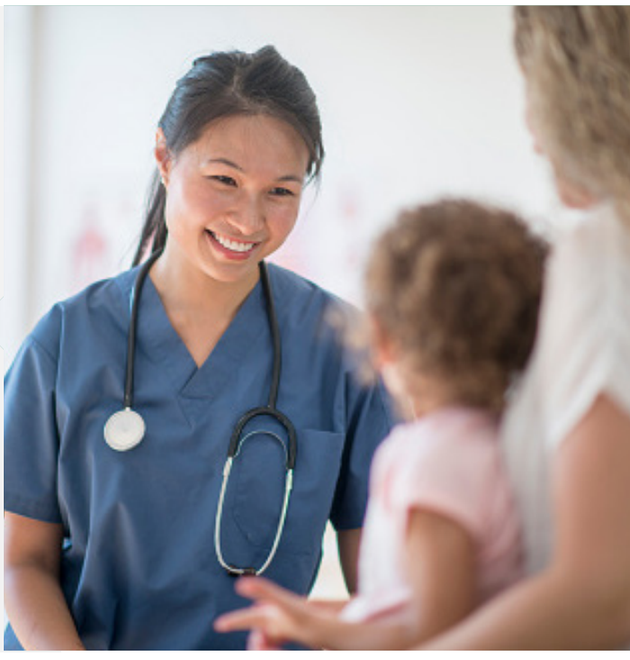
The issues considered during the Demarcation Debate included:

- medical expense shortfall policies (gap cover policies)
- non-medical expenses cover as a result of hospitalisation (hospital cash plans)
- primary healthcare insurance policies.

The regulations do not allow insurers to continue to provide primary healthcare insurance products. These products will be regulated in terms of the *Medical Schemes Act*, and will likely fall under the low-cost benefit framework currently being investigated by the Council for Medical Schemes. In this regard, the Minister of Health has requested that the Council for Medical Schemes grants a two-year exemption to primary health insurance products subject to certain conditions.

Gap cover policies and hospital cash plans will be allowed to continue operating under the *Long-term* and *Short-term Insurance Acts* in a way that complements medical schemes (subject to strict underwriting and marketing conditions). These include the following:

- Open enrolment, community rating and group underwriting. Age rating is permitted for individuals who enter into a contract after a specific age, provided that all individuals entering after that specified age pay the same premium.
- A general waiting period and a condition-specific waiting period of up to three months and up to 12 months respectively can be applied. However, an insurer may not apply a condition-specific waiting period if the policyholder had similar prior cover for a period of at least 90 days.
- Products can only be terminated if the policyholder does not pay premiums, submits fraudulent claims or commits a fraudulent act.
- Additional limitations apply on broker commission payable for these products.



These product providers will be required to submit a summary of benefits, terms and conditions, and marketing material to the Council for Medical Schemes at least a month before marketing a product. The Council for Medical Schemes will be able to request discontinuation of products by the registrars of long- and short-term insurance if they deem these products to be undermining medical schemes.

The new regulations are expected to take effect on 1 April 2017. Existing products currently falling under the *Long-term Insurance Act* will be required to align to the new regulations on renewal, while the existing products, which currently fall under the *Short-term Insurance Act*, will be expected to align to the new regulations by 1 January 2018.

MEDICAL EXPENSE SHORTFALL POLICIES

These policies are commonly referred to as gap cover policies and cover the difference, or a portion of the difference, between the actual cost of a health service and the amount paid by the policyholder's medical scheme. Medical expense shortfall policies are allowed under the *Short-term Insurance Act* only.

The amendments to the regulations limit policy benefits to R150 000 per insured person each year. Previously these types of policies did not limit any policy benefits.

NON-MEDICAL EXPENSE COVER AS A RESULT OF HOSPITALISATION

These policies are commonly referred to as hospital cash plans and provide a fixed cash benefit if the policyholder is hospitalised. These policies are allowed under the *Short-term Insurance Act* as well as the *Long-term Insurance Act*.

The amendments to the regulations limit policy benefits to R3 000 a day while the policyholder is hospitalised or to R20 000 each year, regardless of the number of days spent in hospital. Insurers may require that a policyholder is hospitalised for up to three days before a policy benefit becomes payable, but the benefit is still payable from the first day of hospitalisation.

FRAIL CARE

These policies provide cover for the cost of assistance for activities of daily living and are allowed under the *Long-term Insurance Act* only. The revised regulations do not limit policy benefits for frail care policies.

HIV, AIDS, TUBERCULOSIS AND MALARIA TESTING AND TREATMENT

These policies provide cover for the cost of testing and treatment of HIV, Aids, tuberculosis and malaria. These policies are allowed under the *Short-term Insurance Act* and the *Long-term Insurance Act*.

The revised regulations don't limit policy benefits, but require that the policy benefits must be provided as a rider benefit if the policy is registered under the *Long-term Insurance Act*. This means that the policy benefits for testing and treatment of HIV, Aids, tuberculosis and malaria are added to the basic insurance policy in a rider to provide additional benefits at an additional cost.

INTERNATIONAL TRAVEL INSURANCE

These policies provide cover for the cost of health services while travelling in a country where the policyholder is not normally resident. International travel insurance policies are allowed under the *Short-term Insurance Act* only. The revised regulations do not limit policy benefits for international travel insurance.

MEDICAL EMERGENCY EVACUATION OR TRANSPORT

These policies provide cover for the cost of emergency evacuation, transport or treatment. Medical emergency evacuation or transport policies are allowed under the *Short-term Insurance Act* and *Long-term Insurance Act*.

The revised regulations do not limit policy benefits, but require that the policy benefits be provided as a rider benefit if the policy is registered under the *Long-term Insurance Act*. This means that the policy benefits for medical emergency evacuation or transport must not be the primary policy benefit.

Other major changes to the regulations relate mostly to the marketing of accident and health policies and broker fees payable for these policies.

All marketing material must display the following statement: '*This is not a medical scheme and the cover is not the same as that of a medical scheme. This policy is not a substitute for medical scheme membership.*'

Marketing material must not contain the terms '*hospital*' or '*medical*' unless used in the terms '*medical expense shortfall*' or 'non-medical expense cover as a result of hospitalisation'.