PURPOSE AND NATURE OF THIS DOCUMENT

The purpose of this document is to assist insurers with implementing and complying with the demarcation regulations[1].

This document will be updated and revised from time to time as the need arises. Every updated and revised version of this document will be identifiable by the successive version number that will be allocated to it.

WHAT DOES THE FREQUENTLY ASKED QUESTIONS ADDRESS?

The frequently asked questions address those areas relating to the demarcation regulations in respect of which significant requests for clarification were received subsequent to the publication of the demarcation regulations and are grouped into 8 categories namely:

1. Implications of the 1 April 2017 effective date of the demarcation regulations
2. Product descriptions (regulation 7.2)
3. Underwriting (regulation 7.3(2)-(4))
4. Waiting periods, variation and termination of contract (regulation 7.3 (5) – (11))
5. Commission (regulations 3.4(1a)(LTIA) and 5.3(1)(b)(STIA))
6. Reporting requirements (regulation 7.6)
7. Transitional arrangements (regulation 7.7)
8. General

FREQUENTLY ASKED QUESTIONS

TOPIC	QUESTION	ANSWER
1. IMPLICATIONS OF THE 1 APRIL 2017 EFFECTIVE DATE OF THE DEMARCATION REGULATIONS		
Effective date	What are the implications of the 1 April 2017 effective date of the demarcation regulations?	On 23 December 2016, the demarcation regulations were issued with an effective date of 1 April 2017 (subject to certain transitional provisions discussed below). In addition, on 30 March 2017 the Minister of Finance determined the effective date of the following amended definitions as being 1 April 2017: • "health policy" defined in the Long-term Insurance Act, 1998 (LTIA) as amended by section 1(f) of the Insurance Laws Amendment Act, 2008; • "accident and health policy" as defined in the Short-term Insurance Act, 1998 (STIA) as amended by section 27(a) of the Insurance Laws Amendment Act, 2008; and

[1] Made by the Minister of Finance under sections 72(2A) of the LTIA and 70(2A) of the STIA in Government Notices 1585 and 1582 in Government Gazette 40515 of 23 December 2016; effective 1 April 2017.

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		• "business of a medical scheme" defined in the Medical Schemes Act, 1998 (MSA) as amended through the Schedule to the Financial Services Laws General Amendment Act, 2013 (Act No. 45 of 2013). The amended definitions of "health policy" and "accident and health policy", amongst others, provide that a contract that provides for the conducting of the business of a medical scheme referred to in section 1(1) of the MSA is not a health policy or accident and health policy, unless that type of contract has been identified by the Minister by regulation as a health policy or accident and health policy. The amended definition of "business of a medical scheme" defines the business of a medical scheme as 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; (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). The demarcation regulations identify the types of contracts that, despite the contracts meeting the definition of business of a medical scheme, are health policies or accident and health policies that are subject to the jurisdiction of the Long-term Insurance Act (LTIA) or the Short-term Insurance Act (STIA) and not the MSA. This means that on 1 April 2017 when the amended definition of business of a medical scheme takes effect certain contracts offered by insurers as health or accident and health policies will no longer be these types of policies, but will instead be subject to the MSA. *The following health policies / accident and health policies will be or continue to be subject to the LTIA and STIA after 1 April 2017:* a. Unaffected policies (i.e. policies that are not impacted by the demarcation regulations as they do not meet the definition of "business of a medical scheme") such as dread disease and personal accident policies offering a lump sum benefit or an annuity income when diagnosed with a severe illness. b. Contracts identified in the demarcation regulations: • "Medical expense shortfall" (hereafter referred to as "Gap cover policies"), but only in respect of

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		short-term insurance; • "Non-medical expense as a result of hospitalisation" (hereafter referred to as "Hospitalisation policy") in respect of long-term insurance and short-term insurance; • "HIV, Aids, tuberculosis and malaria testing and treatment" (hereafter referred to as "HIV policies") in respect of long-term insurance (as a rider benefit) and short-term insurance; • "Medical emergency evacuation or transport" in respect of long-term insurance (as a rider benefit) and short-term insurance; • "International travel insurance", but only in respect of short-term insurance; and • "Frail care", but only in respect of long-term insurance. *The following contracts will be subject to the MSA after 1 April 2017:* Contracts not identified in the demarcation regulations that meet the definition of business of a medical scheme. This includes all contracts that defray expenditure incurred in connection with the rendering of any relevant health service instead of providing lump sum benefits unrelated to expenditure. However, the CMS on 17 March 2017 issued a framework for the exemption of providers of indemnity products from the provisions of the MSA. In terms of the framework, insurers that apply and meet the requirements set out in the framework will be exempted from the MSA to enable the development of a Low Cost Benefit Option (LCBO) Guideline. Insurers will be able to continue to write new business in respect of these contracts for a period no longer than 2 years from 1 April 2017, subject to the any conditions imposed by the CMS.
2. PRODUCT DESCRIPTIONS (REGULATION 7.2)		
Gap cover policy (ST only)	Must a policyholder under a Gap cover policy be a member of a medical scheme?	Although not specifically stated in the demarcation regulations made under the STIA, because the contract description of the Gap cover policy type provides that it may only cover the difference between the actual cost of a relevant health service and the amount the person's medical scheme paid towards such costs, it is implicit that the policyholder must be a member of a medical scheme. Also, the prohibition on requiring that the policyholder or insured person must be a member of a medical scheme only applies to categories 2 to 5 in the table under Regulation 7.2(1); not category 1 (Gap cover policies).
Hospitalisation	Can both a R3,000 daily benefit and R20,000	No. The requirements relating to policy benefits that may be paid in respect of this type of contract

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policy	lump sum benefit be provided/paid in the same policy under this contract type?[2]	provides that a maximum of R3,000 daily benefit ***or*** a maximum of R20,000 lump sum benefit is payable. This does not preclude a policy from stating that it will provide either a daily benefit or a lump sum benefit (e.g. depending on which benefit is greater/less at claims stage), it merely means that both of these benefits cannot be paid under the same policy.
	Is the maximum R3,000 per day daily benefit limited to an aggregate maximum of R20,000 per annum?	No. The R3,000 daily limit and R20,000 annual limit are stated as two separate limits. If the policy provides a daily benefit the benefit per day is limited to R3,000 per day. There is no limit to the number of days per year for which the R3,000 per day benefit may be offered. In other words, theoretically R3,000 per day may be provided for 365 days if a person is in hospital for that number of days. If the policy provides for a lump sum benefit, the amount of lump sum benefit paid under the policy in a year cannot exceed, in aggregate, R20,000 irrespective of the number of days in hospital.
	Can I pay policy benefits to the provider of a health service?	No. The purpose of the Hospital policy type is to cover expenses other than medical expenses and therefore no benefits may be paid to the provider of a health service. The purpose is to cover *non-medical* expenses associated with hospitalisation. The same limitation does not apply to the other contract types identified in the demarcation regulations because the demarcation regulations are silent on this aspect in respect of the other contract types.
International travel insurance **(ST only)**	If the health event occurred outside of South Africa whilst the insured was travelling, can the policy covers medical costs in South Africa when the insured returns to South Africa?	The contract description of an international travel insurance contract type policy provides that the purpose must be to cover costs associated with a relevant health service while traveling in a country which the insured is not ordinarily resident. Policies that cover South African residents can therefore only cover medical costs incurred outside of South Africa; the policies cannot cover medical costs incurred in South Africa.
	Can the policy cover medical costs in South Africa for a person travelling in South Africa that is not ordinarily resident in South Africa	Yes. The contract description of an international travel insurance contract type policy provides that the purpose must be to cover costs associated with a relevant health service while traveling in a country which the insured is not ordinarily resident. Where the insured person is not ordinarily resident in South Africa and is traveling to South Africa and takes out a policy here, such person may be covered for medical costs incurred in South Africa.

[2] This question and response thereto has been amended on version 2 when compared to version 1.

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	The Insurance Bill (Schedule 2, Table 2) defines the Travel class of business as covering damage or loss resulting from, amongst other things, a health event. Can insurers cover medical costs under this class irrespective of the Demarcation Regulations and definition of business of a medical scheme when the Insurance Bill becomes law?	The Insurance Bill must be read with the MSA and the demarcation regulations. If an insurer provides a policy under the travel class of business that meets the definition of the business of a medical scheme as defined in the MSA (which includes an undertaking, in return for a premium, to defray medical expenses in South Africa) and that policy is not a contract type identified in the demarcation regulations the policy will be subject to the MSA.
Medical emergency evacuation or transport	What would constitute "emergency medical treatment" for purpose of this policy?	The Regulations is not prescriptive in respect of what would constitute medical emergency treatment. Insurers must in designing product lines under this contact type take into consideration the common law and relevant jurisprudence (amongst others the Constitutional Court case of *Soobramoney v Minister of Health (Kwazulu-Natal*) CCT32/97 [1997] ZACC 17; 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (27 November 1997)).
	Can I outsource the provision of policy benefits to a provider of a health service provider (e.g. like an ambulance service)?	Yes, an insurer may use a health service provider on an outsourced basis to provide the policy benefits. However, it is the insurer that undertakes to provide the policy benefits and therefore the insurer will remain accountable for providing the benefits and the quality of the benefits.
3. UNDERWRITING (REGULATION 7.3(2) – (4)[3])		
Underwriting restrictions and	What are the underwriting restrictions?	The relevant product lines must be underwritten on a group basis (i.e. no individual risk rating) and there may not be discrimination between policyholders on the basis of race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health or any similar grounds.

[3] Note that the requirements set out in Regulation 7.3(2) – (4) only applies to Gap cover policies (ST only), Hospitalisation policies (ST&LT) and HIV policies (ST&LT).

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discrimination	What would discrimination on "any similar grounds" entail?	The intention of introducing Regulation 7.3(2)(b) was to ensure that certain products that could potentially undermine medical schemes (e.g. Gap cover policies, Hospitalisation policies and HIV policies) are subject to the same underlying principles as medical schemes (as provided for in the MSA). Therefore, as a general rule ratings factors that apply in the medical schemes environment should be applied under the Regulations. The FSB is reluctant to generally specify certain underwriting criteria that would or would not constitute "any similar grounds" for purposes of Regulation 7.3(2)(b). Each case will have to be assessed on its merits to determine whether applying a certain factor would meet the requirements of Regulation 7.3(2)(b). Insurers must in designing product lines under this contact type take into consideration the common law and relevant jurisprudence. The FSB is also open to engaging on an individual basis in respect of proposed product lines.
Age limits	Can an insurer have a cut-off age for entering into the policy? I.e. have a requirement that a policyholder must be younger than 65 to enter into the policy?	No. Refusing a person older than 65 to enter into a policy with an insurer will be discriminating against that person based on age and would be contrary to the requirements of Regulation 7.3(2)(b).
Differentiating in premiums	Are there any criteria I can use to differentiate in premiums between policies forming part of a product line?	Any criteria that will not result in discrimination referred to in Regulation 7.3(2)(b) may be used to differentiate in premiums between policies in product lines. In addition, Regulation 7.3(4) provides that insurers can (despite the "non-discrimination requirement") require that a policyholder who enters into a policy at an older age must pay a higher premium than a policyholder that enters into a policy at a younger age.[4] Essentially insurers can establish different age brackets and differentiate in premiums based on age at stage of entry into the policy. Under the MSA differentiation in premium at entry stage based on age is not allowed - however, medical schemes may impose a late joiner penalty for people that enter the scheme at an older age. The reasoning behind Regulation 7.3(4) was to provide for something similar to a late joiner penalty under the MSA, but in a different way. As mentioned, the intention is that product lines subject to the underwriting restrictions should be underwritten on the same basis as medical schemes are underwritten.
"Underwritten on a group basis"	"Underwritten on a group basis" states that risks related to a policy forming part of a product line are rated based on the characteristics of a group of people together	The definition of underwriting on a group basis refers to risks under a policy forming part of a product line and how such risks must be rated based on a group of people and not individuals. An insurer could use a different underwriting basis for, as an example, different employer groups. This approach would be consistent with closed schemes that currently operate in the medical schemes environment. However,

[4] Regulation 7.3(4), however, does not apply to HIV policies under the long-term Regulations.

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	as opposed to that of the individual to whom the policy relates. Must the risks related to a policy be rated based on the characteristics of the same group of people that is used to rate the risks of other policies forming part of the product line?	the principles contained in Regulation 7.3(2)(b) must still be applied when defining different groups.
Different product plans	Can an insurer offer multiple plans to the market with different benefit amounts similar to medical schemes? For example a Main member only plan, Family plan and the like.	It is possible to provide for multiple plans (including main member or family plans) and different benefit amounts to different groups of people. However, the groups and different plans must still comply with Regulation 7.3(2) (requirements relating to underwriting on a group basis and non-discrimination).
Exclusions	Can an insurer impose the usual exclusions? For example, can insurer exclude conditions which appear on the Prescribed Minimum Benefits (PMB's) list?	The Regulations do not specify what type of risks an insurer must cover. There are no PMB's applicable to insurers. Therefore, it remains a business decision of the insurer to decide what type of risks it will cover. The insurer can therefore choose to cover all of the PMB's, some of the PMB's or none of the PMB's. In developing the product line and identifying the target market the insurer must comply with Regulation 7.3(2)(b). An insurer must, however, be clear on exactly what is being covered. If an insurer undertakes to cover certain conditions, it is obliged to provide policy benefits if the condition materialises (subject to any waiting periods- see waiting period section below).
Open enrolment	Can an insurer refuse to cover a policyholder for whatsoever reason?	Regulation 7.3(3) provides that an insurer may not refuse to enter into a contract with a policyholder, except where that policyholder committed an act related to fraud.[5] The intention was to embed a requirement in the Regulations similar to the open enrolment principle contained in the MSA.
4. WAITING PERIODS, VARIATION AND TERMINATION OF CONTRACT (REGULATION 7.3(5) – (11))		
Waiting periods	Can accidental claims be paid during a general waiting period?	Yes. According to the definition a "general waiting period" is a period during which a policyholder is not entitled to claim any or may only claim certain policy benefits. An insurer is not obliged to impose a general waiting period but if it chooses to do so, they can choose which benefits are payable or not payable in such a period.
	What is a condition specific waiting period?	An insurer can impose a waiting period for a specific condition for which medical advice, diagnosis, care or treatment was recommended to or received by policyholder within a period of 12 months before entering into the policy.

[5] Regulation 7.3(3), however, does not apply to HIV policies under the long-term Regulations.

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	Can an insurer impose a general waiting period if a policyholder is replacing an existing policy under which he/she has already completed a waiting period?	Yes. A general waiting period not exceeding 3 months can always be imposed.
	Can an insurer impose a condition specific waiting period if a policyholder is replacing an existing policy under which he/she has already completed condition specific waiting period?	No. If a policyholder had a similar policy with a previous insurer less than 90 days ago (from the date of entering into the new policy) the new insurer cannot impose a condition specific waiting period (for the same condition) if the policyholder already completed a condition specific waiting period under the previous policy. If the policyholder completed only a part of the condition specific waiting period (e.g. 4 months), the insurer can impose a condition specific waiting period for the remaining part (e.g. 8 months).
Variations	Can an insurer increase the premium or give effect to any other change(s) on an International travel insurance policy (ST); Medical emergency evacuation or transport policy (LT&ST); or Frail care policy (LT) if the policyholder is claiming a lot?	Yes, if the policy contract allows for such an increase or if the policy is a term policy and such an increase is given effect to on renewal.
	Can an insurer increase the premium or give effect to any other changes on a Gap over policy (ST); Hospitalisation policy (LT&ST); or HIV policy (LT&ST) if the policyholder is claiming a lot?	No. An insurer may not increase premiums or make other changes because of the health or claims experience of an individual policyholder. An insurer may however increase premiums or make other changes because of the health or claims experience of all policies forming part of the product line of the insurer. (A product line is seen as policies that have the same or closely related contractual terms offered or entered into by an insurer).
	Does the exclusion from being a variation in Regulation 7.3(8), which states that if agreed to at the commencement of the contract and the adjustments are not inconsistent with Regulation 7.3(2)(b) it is not viewed as a variation, apply to any variation/adjustment to the contract or only to the variation/adjustment of the premium?	Regulation 7.3(8) provides that for purposes of the Demarcation Regulations the variation of the contract includes premium adjustments under a contract, unless agreed to at the commencement of the contract and the adjustments are not inconsistent with sub-regulation 7.3(2)(b). The purpose of this sub-regulation was to confirm that an adjustment to a premium is also viewed as a variation. However, it is not viewed as a variation if the premium adjustment is a contractual increase (agreed at commencement of the contract) and the way in which the adjustment is applied is not inconsistent with the "non-discrimination requirements".
Termination	Can I terminate a Gap over policy (ST); Hospitalisation policy (LT&ST); or HIV policy	No. An insurer may only terminate one of these policies in very specific circumstances, i.e:

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	(LT&ST) if I no longer wish to conduct business with the policyholder?	• If the policyholder stops paying the premium (the normal process and legislative requirement relating to non-payment of premiums must then be followed); • If the policyholder submitted fraudulent claims or committed a fraudulent act; or • If the insurer wants to stop the specific product line in its entirety. It must then terminate all policies forming part of the product line after giving policyholders 90-days' notice of the proposed termination.
	If a Gap over policy (ST); Hospitalisation policy (LT&ST); or HIV policy (LT&ST) is a term policy and the contract term expires, can the insurer choose not to renew the policy?	No. The non-renewal of a contract is viewed as a termination of the contract for purposes of the Regulations. An insurer will only be able to refuse to renew the contract under the circumstances mentioned in the previous response. Therefore, even if it is structured as a term contract, the term will have to be renewed automatically which essentially has the same effect as a whole of life policy term.
5. COMMISSION (REGULATIONS 3.4(1A)(LT) AND 5.3(1)(b)(ST))		
Calculation of commission	How must commission be calculated under the Scale in Regulations 3.4(1)(LT) and 5.3(1)(b)(ST)- is the Scale cumulative in the calculation or does the total premium indicate the commission level?	The Scale is cumulative in the calculation of commission. In other words, if a premium is R1,500 then the total maximum commission will be 20% of the first R299; 15% of the portion of the premium in the R300 – R600 band; 10% of the portion of the premium in the R601 – 1,200 band; and 5% of the portion of the premium of the amount above R1,200 (i.e. R1,201 to R1,500).
Transitional arrangements	Do the amended commission regulations (regulation 3.2 and 3.4 (LT) and regulation 5.3 (ST)) only apply to new policies entered into after 1 April 2017 or will it apply to pre- and post-1 April 2017 policies?	The Regulations do not impact on existing policies; only new policies.
6. REPORTING REQUIREMENTS (REGULATION 7.6)		
Submission of new product line	How long will it take for the FSB to approve new product lines submitted to them?	The FSB will not approve new product lines. The requirement in the Regulations is that an insurer must submit a new product line to the FSB and the Registrar of Medical Schemes at least 1 month before marketing or offering such product line. No approval of the product line is required from either the FSB or the Registrar of Medical Schemes. The FSB can consider the information and may at any time, if deemed necessary, object to marketing material, benefits or terms and conditions of a specific product

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		line. This approach is also known as file-and-use.
	If the summary of a new product line is submitted to the FSB will it suffice or must I also submit the summary to the Registrar of Medical Schemes?	According to Regulation 7.6(1), the summary of the new product line must be submitted to both the Registrar of Long-term/Short-term Insurance and the Registrar of Medical Schemes. However, the FSB and the Council for Medical Schemes (CMS) is considering how best to streamline the submission of documents and reduce the administrative burden on insurers.
7. TRANSITIONAL ARRANGEMENTS (REGULATION 7.7)		
Pre- and post-1 April 2017	Can new policies (that are subject to the Regulations) sold after 1 April 2017 under existing product lines that meet the contract descriptions in the Demarcation Regulations continue as they are until 31 December 2017?	No. According to Regulation 7.7 all new policies *entered into* from 1 April 2017 onwards must be aligned with the Regulations.
	Must a policy (which will be subject to the Regulations) that was entered into before 1 April 2017 be terminated or aligned to comply with the Regulations?	The transitional arrangements under the Long-term- and Short-term Regulations, respectively, differ. *Short-term Regulations* According to Regulation 7.7 all policies entered into before 1 April 2017 must be aligned to the Regulations by 1 January 2018. Short-term policies are mostly monthly or annually renewable and therefore most of the pre-1 April 2017 policies will come up for renewal before 1 January 2018. *Long-term Regulations* According to Regulation 7.7 all policies entered into before 1 April 2017 must be aligned to the Regulations as and when they are varied or renewed subsequent the Regulations taking effect. Long-term policies are mostly entered into for a longer contractual period than short-term policies. Therefore, had a 1 January 2018 alignment date (as is the case for short-term policies) been imposed for existing long-term policies, it could have potentially impeded existing contractual terms under such policies. For this reason the requirement is that policies must be aligned as and when they are varied or renewed. The rationale it that the review or renewal process would allow an insurer an opportunity to amend existing contractual terms to align with the Regulations.
	If a policy in its current format signed/agreed to before 1 April but with an inception date of 1 May, will such policy be subject to the	The transitional arrangements under the Long-term- and Short-term Insurance Demarcation Regulations provide that contracts *entered into* before the Demarcation Regulations took effect is subject to the transitional provisions. In our view the insurance contract is *entered into* when there is consensus

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	transitional arrangements or must it comply with the Regulations as from 1 April 2017?	between both parties as regard to the contractual terms. Therefore, if consensus was reached before 1 April 2017 (evidence by acceptance of the contract by both parties), but the inception date is after 1 April 2017, we would regard the policy as entered into before 1 April 2017 and subject to the transitional arrangements.
Group scheme policy	Will the addition of a group scheme member after 1 April 2017 to a group policy that was entered into before 1 April 2017 mean that the group policy must comply with the Regulations on the date on which the new group scheme member is added?	The transitional arrangements apply to policies entered into before 1 April 2017. When a member is added it is would not necessarily (depending on the group policy structure) result in the entering into of a policy. Seeing that the group policy was entered into before 1 April 2017 and that adding a new member would not constitute a new policy being entered into, the group policy does not have to be aligned with the Regulations on the date on which the member is added. Such policies are subject to the transitional arrangements.
8. GENERAL		
Exemptions	Can an insurer obtain an exemption from the Demarcation Regulations or any provision in the Demarcation Regulations?	The Demarcation Regulations do not provide for – • a person to apply for exemption from any of the provisions of the Regulations; or • the Registrar to exempt any person from any of the provisions (including provisions relating to timeframes) of the Regulations. There is therefore no empowering provision in the Demarcation Regulations (or the Long-term Insurance Act / Short-term Insurance Act) that will accommodate any form of exemption.