COUNCIL FOR MEDICAL SCHEMES

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TO:

CHAIRPERSON
PORTFOLIO COMMITTEE ON FINANCE

and

MINISTER OF HEALTH

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INSURANCE LAWS AMENDMENT BILL 2008

Introduction

Note: It is understood that a process of engagement was underway between the Department of Health and National Treasury with a view to resolving some of the key concerns raised in this submission. At the time of making this submission, we are unaware of the extent to which these concerns may satisfactorily be resolved though this process and, in view of the deadlines for the submission, have proceeded on the basis of the version of the Bill as tabled before Parliament.

1. The Council for Medical Schemes ("the Council") appreciates the opportunity afforded by the Portfolio Committee on Finance to comment on the provisions of the Insurance Laws Amendment Bill, 2008 ("the Bill").

2. The Council is extremely concerned about provisions of the Bill which pose significant risk to the exercise of the regulatory mandate of the Council and the development and implementation of national health policy which falls within the executive mandate of the Minister of Health.

3. These provisions of the Bill effectively give the Minister of Finance and the Registrars of Short- and Long-term Insurance the powers to restrict the application of the Medical Schemes Act, 1998, by effectively excluding products (or categories of products) from the ambit of that Act. The conditions for this and mechanisms by which this is done are described more fully below.

4. In so doing, the Insurance Laws Amendment Bill seeks to resolve legal problems with the demarcation between medical schemes and health insurance products, with major health policy implications.

5. There is a need for legislative amendments to resolve legal problems relating to the demarcation issue, which problems have escalated since a recent judgment of the Supreme

Court of Appeal in a matter between the Council for Medical Schemes and a short-term insurer, Guardrisk (discussed more fully below).

6. However, the legislative framework provided in this Bill is inappropriate and unacceptable from a health policy perspective – and an alternative legislative framework to address this issue, involving amendments to the Medical Schemes Act (MSA"), 1998, the Long-term Insurance ("LTI") Act, 1998, and the Short-term Insurance ("STI") Act, 1998, is proposed.

7. In this submission, we –
   7.1. provide historical context to the issue of demarcation between medical schemes and health insurance products;
   7.2. explain the concerns from a policy perspective with particular provisions of the Bill; and
   7.3. provide recommendations as to how these concerns should be addressed.

Historical context

8. The historical context provided below demonstrates that the legal demarcation between medical schemes and insurance products is a major issue of health policy. Its limited impact on commercial financial markets pales into insignificance when compared to the health policy implications of this demarcation.

9. This is immediately apparent from the scale of the existing medical scheme and private health insurance sectors in South Africa:

   9.1. Medical schemes are the major intermediaries providing financial indemnity cover for the costs of health services in the South African private health sector, with annual gross contribution income of some R57.6 billion (2006), or 46% of total health insurance in South Africa.

   9.2. Private health insurance, on the other hand, is estimated to account for some R0.762 billion in premium income per annum, or 0.6% of total health expenditure in South Africa.[i]

10. Most importantly, medical schemes and private health insurance are subject to very different legal and policy frameworks.

    10.1. Medical schemes are subject to the provisions of the Medical Schemes Act, 1998, (MSA) which is a legislative measure designed to promote access to health care in terms of section 27 of the Constitution of the Republic of South Africa in an equitable and non-discriminatory manner. They are required to operate on principles of community rating and open enrollment, to ensure cross-subsidisation between the young and healthy, on the one hand, and the old and sickly, on the other.

    10.2. Medical schemes are therefore important vehicles for the implementation of national health policy, and accordingly the MSA falls under the jurisdiction of the Minister of Health and are regulated in terms of the MSA by the Council for Medical Schemes, which reports to the Minister of Health.

10.3. Private health insurers operate on a commercially for-profit basis through traditional insurance underwriting principles of risk-rating and exclusion of high-risk individuals. They are regulated in terms of the Long-term and Short-term Insurance Acts of 1998, which fall under the jurisdiction of the Minister of Finance.

11. Private health insurance is considered to be of significance from a health policy perspective because, to the extent that young and healthy individuals opt out of the medical schemes environment or buy less comprehensive medical scheme coverage in favour of the purchase of private health insurance, the opportunity for cross-subsidisation between good and poor risk individuals in the medical schemes environment is diminished. This results in an escalation of the cost (and consequent decrease in the affordability) of medical scheme coverage for vulnerable and high-risk individuals.

12. From a health policy perspective, it is crucially important therefore that the legislative framework does not allow the impingement of private health insurance onto the medical schemes environment – a fact well recognized at the time of passage of the MSA in 1998.

13. The policy principles underpinning the MSA are clear from statements made by the then Minister of Health and the then Chairperson of the Health Portfolio Committee in the Parliamentary debates giving rise to passage of the Act in November 1998.

14. The then Minister of Health made the following statement, as recorded in Hansard:

> "The MINISTER OF HEALTH: Madam Chairperson and hon members, the Medical Schemes Bill that members have before them is one of the most important pieces of legislation that the Health Ministry will submit to this House.
>
> Our Government has approached health care reform with a clear commitment to ensure equity and access for all citizens. In the sphere of health financing, this manifests itself through a reinforcement of the principle of social solidarity. This is intended to ensure that where health care is concerned, people should not be discriminated against in obtaining health insurance, on the basis of their health risk. We should, as a nation, attempt as far as possible to ensure that people contribute financially towards the health system according to their means, and that they can gain access to services according to their needs.
>
> The former government did this country a great disservice during 1989 and again in 1994 with its changes to the Medical Schemes Act. It allowed medical schemes to discriminate against members on the basis of their age and health status – a principle which is forbidden in many health systems around the world. Such discrimination was a consistent trend in the NP's world and in its approach to social policy which was to separate, to discriminate and to treat differently those who could not fight back. The NP's approach was to abdicate their social responsibility towards the people of this country and to appease the vested interests that have been tearing our health system apart.
>
> A great problem facing Government today is the fact that most of the expenditure on health care is spent in the private sector. We must remember that a substantial portion of this amount is leveraged through Government tax subsidies to employers. In spite of spending such a disproportionate amount of health resources, more and more

medical schemes are forcing sicker and elderly people out of health cover. This trend is in conflict with the principle of social solidarity which underlies the ANC health policy. It also results in many people being shifted onto an already overburdened state sector.

The situation in which people are refused cover or forced out of cover because of their health status is clearly untenable. In many instances, these are people who have contributed to medical schemes throughout their working life and are now being told they are too old or too sickly to continue as members of medical schemes.

There is also another very pragmatic reason why we cannot continue to countenance the transfer of people out of medical schemes and into the public sector. Such cost-shifting diminishes the cross-subsidy to the poor who use the public health system. Clearly something has to change, and it will change.

Whereas the Nationalists – they now call themselves the new NP, though I have still to see the grave of the old one – and other parties see pensioners, the disabled, the chronically ill and those with HIV as dispensable, the ANC Government would like to give the assurance that these people will not be abandoned or discriminated against. The Government will continue to pursue the progressive realisation of the right to access health care for all people as mandated by the Constitution.

The Medical Schemes Bill proposes a range of mechanisms in order to achieve the objective of expanding access for all our people to medical schemes. The first key strategy relates to the enforcement of community rating. The core element of community rating proposed in the Bill is to prevent the determination of contributions on the basis of age, sex and health status. This provision will bring our private health system much more in line with international practice in those countries where access to health care is secured and health outcomes are equally good.

In addition, the Bill introduces an open enrollment for medical schemes. Open enrollment will require that schemes accept any applicant who can pay the average community-rated contribution. The adoption of a new definition of dependants will recognise the type of family structures that the majority of South African families live in. ...

The third requirement will be that all medical schemes must provide a set of core services. These will be services that are medically necessary and life-saving. The Bill will also require that medical scheme reimburse the public sector in full when their members use public hospitals for the minimum benefits. This approach will go a long way towards preventing unfair discrimination on the basis of benefit design and will prevent the dumping of unfunded medical scheme patients onto the public hospital system."

15. Dr S A NKOMO, chairperson of the Health Portfolio Committee made the following statements in the same sessions:

"Here today we have before us a Bill of immense importance for the future of the South African health system – a Bill that for the first time introduces fairness and justice into the financing of private health care. It is a Bill that protects the sick from crude and arbitrary exploitation by commercial interests and that protects the

pensioner, the widower and the orphan from being thrown out of cover. It is a Bill that protects the public health system from becoming a dumping ground for those discarded for the simple reason that they curtail short-term profits.

Thus ultimately what does this Bill attempt to do? For a start, it reverses the change in regulation that occurred in 1989, which permitted medical schemes to differentiate contributions or premiums on the basis of age, gender, experience, geographical region, income and number of dependants. In fact, this permitted an environment to exist that is not even allowed in the United States – if Dr King is listening – a country known for its problematic and perverse health system."

16. The Memorandum on the Medical Schemes Bill, 1998 states in the introduction inter alia the following:

"There are a number of features of the current situation within the medical scheme sector which underlie the need for new legislation. These include the need to:

- Expand access to medical schemes, especially by the elderly and sickly who currently tend to be excluded, by means of reinforcing a system of community rating and non-exclusion ....

- Provide for prescribed benefits, both as a way of ensuring that members have access to necessary care and costs are not unfairly shifted onto public hospitals ... ,

- Provide appropriate protection against the tendency, within a voluntary environment where there is some form of open enrolment, to deliberately apply for membership of medical schemes and be admitted only when persons are sick or at an advance or late age (adverse-selection); ... .

- Establish an appropriate demarcation between the business of community rated medical schemes which effect cross-subsidisation from the young and healthy to the elderly and sickly members, and that of other sickness insurance products offered by the Insurance Acts. In order to create a singly regulatory framework within which one Act of Parliament will apply to all the organizations which carry on the business of a medical scheme, medical schemes which came into operation under other legislation, will be required to register in terms of this Act."

17. The last point in the above memorandum is an explicit recognition of the threat posed to the objectives of the MSA should commercial health insurance be permitted to encroach upon cover provided by medical schemes. The definition of "business of a medical scheme" read with the definitions of "health policy" and "accident and health policy" in the LTI and STI Acts passed at that time, were intended to prevent such encroachment.

18. The Department of Health submission to the Finance Portfolio Committee (which was responsible for reviewing the LTI and STI amendment Bills in 1998) dated 12 June 1998 notes in reference to the proposed Medical Schemes Act:

"These new reforms, which are aimed at reinforcing a medical schemes environment that does not discriminate on the basis of age and health status depend critically on ensuring that there is a clear understanding of what constitutes the business of a medical scheme on the one hand, and that of other risk rated sickness insurance products offered under the Insurance Acts. If this understanding is not developed, then there is the potential that products can be created that do the business of a medical scheme but are not registered under the Medical Schemes Act. Such an outcome would nullify the reforms of to the medical schemes."

19. The risk to a community rated environment from commercial health insurance based on traditional underwriting principles is not only recognized in South Africa, but internationally as well. For example, the Health Care Working Party in Ireland notes the following, consistent with the policy framework adopted by the South African legislature, under the title "effects of an unregulated market and objectives of regulation":

> "In an unregulated market health insurance could be sold on a risk-rated basis and newcomers to the market would probably, not unnaturally, target the young and other low risk groups to whom they would be in a position to offer cover at rates of premium below those paid at present under the community-rated schemes which have traditionally been a feature of the Irish market.
>
> In the event of large numbers of low risk subscribers leaving the existing schemes, community rating would collapse because the system cannot survive without the support which the low risk groups provide to the high risk subscribers to health insurance (This is the principle of inter-generational solidarity.)
>
> This in turn would lead to a reduction in overall members with private health cover and cause large numbers of high risk persons to fall back upon the public system. Such a development would be to the detriment of the Irish health care system as a whole.
>
> Since community rating, open enrolment and the right to lifetime cover provides the best means of maintaining the maximum numbers of persons, including those in high risk categories, in affordable private health insurance cover, these principles have been incorporated in the new legislation and are mandatory requirements for all health insurers operating in the Irish market."

20. Because in the period immediately prior to introduction of the MSA, medical schemes had been permitted to risk-rate, there was initially resistance to the new legislative requirements in the MSA related to community rating and open enrolment. This manifested in the emergence of new insurance-type products which attempted to substitute medical scheme cover, as well as so-called "hybrid" products which incorporated elements of medical scheme and insurance cover in single products. The emergence of these products was clearly intended to circumvent the provisions – and policy intent – of the MSA.

21. The manner in which such circumvention could be achieved is illustrated by the conduct of two very large medical schemes, which had a strong relationship with their existing administrators. The administrators had insurance licenses. In anticipation of the full implementation of the MS Act, during 1999 the two medical schemes collaborated with their administrators to circumvent the community rating provisions of the MSA, once it came into

effect, by combining medical scheme arrangements with insurance products. The two schemes were Discovery Health Medical Scheme ("DHMS") and Fedsure Medical Scheme ("Fedsure"). The collaboration permitted the two medical schemes to create de facto risk rated contribution, thereby circumventing the provisions of the MS Act which prohibited risk rated contributions.

22. The Council for Medical Schemes ("the Council") acted swiftly to deal with these circumventions, and the DHMS and Fedsure arrangements were terminated after intervention by the Council, based on application of the provisions of the MS Act.

23. A process of engagement was also initiated between the Council and the Financial Services Board ("FSB") as well as the Life Offices' Association to give rise to an agreement on interpretation of the relevant definitions in the MSA and the LTI and STI Acts to ensure that "grey areas" in the demarcation between medical schemes and insurance products were minimized. This gave rise to a "demarcation agreement" between the Council and the FSB being published in September 2000, followed by more detailed guidelines published jointly with the Life Offices' Association, which represents long-term insurers.

24. The essence of this agreement and these guidelines is that the relevant Acts are properly interpreted to mean that medical scheme business entails the undertaking of liability to grant assistance in defrayal of actual expenditure incurred in connection with the rendering of relevant health services. Health insurance benefits, on the other hand, cannot relate directly to the cost of treatment of a health event or condition, and must provide for predetermined amounts to be paid out on the occurrence of a specified health event triggered by the diagnosis of a health condition.

25. Notwithstanding these agreements, there have been attempts by particularly short-term insurers to conduct business which in terms of the above-mentioned delineations, would conduct the business of a medical scheme, although the rampant development of these products has been constrained by risk of prosecution under the MSA.

26. One such short-term insurer which persisted in a product of this nature was Guardrisk, which offers "top-up" cover to cover the difference between medical scheme benefits and the actual price charged for particular health services. The Council objected to this product on the basis that it was doing the business of a medical scheme while not being registered in terms of the Medical Schemes Act.

27. From a policy perspective, the Council was concerned that "top-up" products of this nature will result in young and healthy members of medical schemes "buying down" to less comprehensive medical scheme products (and supplementing their medical scheme coverage with 'top-up' insurance), with consequent –

    27.1. lessening of cross-subsidisation between young and healthy members and older or more sickly people who remain on more comprehensive benefit options;

    27.2. increase in costs of comprehensive coverage for older and less healthy beneficiaries of medical schemes;

    27.3. systemic reduction in the availability of comprehensive benefit options by medical schemes, given their costs and their ability, and thereby discouraging older and less healthy people from joining the medical schemes; and

27.4. discriminatory access to health care services.

28. The Council sought an interdict against Guardrisk to prevent it from marketing these products, to which Guardrisk raised a technical defence to the effect that paragraphs (a), (b) and (c) of the definition of "business of a medical scheme" in the MSA[1] were to be read conjunctively – and that all three of these paragraphs did not apply to the Guardrisk products. The Council argued that this could never have been the intention of the legislature and that the paragraphs should be read disjunctively.

29. It was common cause that the Guardrisk products entailed undertaking liability to grant assistance in defrayal of expenditure incurred in connection with the rendering of any relevant health service – paragraph (b) of the definition and the essence of the "business of a medical scheme" in the demarcation agreements discussed above.

30. However, the Guardrisk products did not also make provision for the obtaining of any relevant health service (paragraph (a)), so on a conjunctive reading the Guardrisk products would not be doing the business of a medical scheme.

31. Whereas the High Court found for the Council, the Supreme Court of Appeal found in favour of Guardrisk and the disjunctive reading of the definition – and the Council's request for leave to appeal this decision to the Constitutional Court was declined on 19 May 2008.

32. The consequences of the SCA decision are disastrous from a health policy and regulatory perspective as any manner of insurance products – top-up or other types of product – can now operate outside the ambit of the Medical Schemes Act although defraying medical expenses (by simply avoiding falling within the scope of paragraph (a) of the definition of business of a medical scheme). In fact, in terms of this interpretation, some two-thirds of existing medical schemes function outside the ambit of the definition and therefore technically are not required to remain registered in terms of the MSA!

33. This clearly creates an enormous hole in the regulatory regime created by the MSA which would be rapidly exploited by everybody keen to carry on the business of a medical scheme but free of regulation under the MSA.

34. Amendment to the existing legislative framework is therefore urgently required, but it is crucial that these revisions to the legislative framework are made to entrench the health policy intentions of the MSA and to protect the medical schemes environment from being undermined by the encroachment of private health insurance into the policy domain of medical schemes.

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[1] **"business of a medical scheme"** means 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;

Discussion of provisions of the Bill of concern from a health policy perspective

35. The specific provisions of the Bill which form the basis for our concerns are the following:

    35.1. section 3(c) of the Bill insofar as it inserts paragraph (c) into section 4(7) of the Long-term Insurance Act, 52 of 1998 ("the LTI Act");

    35.2. section 23 of the Bill insofar as it inserts subsection (1A) into section 72 of the LTI Act;

    35.3. section 29 of the Bill insofar as it inserts paragraph (c) into section 4(7) of the Short-term Insurance Act, 53 of 1998 ("the STI Act"); and

    35.4. section 52 of the Bill insofar as it inserts subsection (1A) into section 70 of the STI Act.

36. Also of relevance to the discussion are the amendments to the definitions of "health policy" in the LTI Act, effected through section 1(f) of the Bill, and "accident and health policy", effected through section 27(a) of the Bill. The amendments, while not themselves problematic, must be read in conjunction with the above-mentioned provisions.

37. The proposed amendments to the definitions of "health policy" and "accident and health policy" are positive in that they now clearly exclude contracts which provide for the conducting of the "business of a medical scheme" in terms of the Medical Schemes Act, 1998 ("MSA") from the ambit of these definitions.

38. This clarifies confusion which emanated from the previous definitions which excluded contracts which met certain criteria, but where those criteria did not match exactly the business of a medical scheme. Those provisions created a grey area in terms of which products which did the business of a medical scheme may also have fallen within the ambit of "health policies" or "accident and health policies" in terms of the LTI and STI Acts.

39. The amendments to these definitions in the Bill therefore make it clear that once a product does the business of a medical scheme in terms of the MSA, it falls outside the ambit of the STI and LTI Acts.

40. In our view, this is the only amendment that is required to the LTI and STI Acts to resolve the demarcation issue, and consequential amendments are then required to the MSA which ensure complete legal certainty about the definition of the "business of a medical scheme."

41. The Bill, however, does not leave determination of what constitutes the "business of a medical scheme" to interpretations of that definition in the MSA. Instead, the proposed amendments to section 72 of the LTI Act and 70 of the STI Act allow the Minister of Finance to make regulations identifying any "kind, type or category of product" as a "health policy" or an "accident or health policy", as the case may be. Any product of such designated kind type or category of product, is then "not subject to the Medical Schemes Act, 1998".

42. The Minister of Finance, in making these regulations, is required to "have regard to" certain factors, namely: the need to ensure the sustainability of medical schemes; the need to ensure access to health care services; limitations on the liability undertaken by medical

schemes, and the extent to which medical schemes are able or willing to provide certain services.

43. Every one of the above-mentioned list of factors that must be taken into account in making these regulations are issues pertaining to access to health care services and the sustainability of health care coverage through medical schemes – the very issues which are the crux of health policy affecting the private health system. And the effect of any such regulations is to restrict the ambit of the most important piece of health policy legislation affecting private health care coverage, namely the MSA.

44. Notwithstanding this, not only is the responsibility for making these regulations placed with the Minister of Finance, rather than the Minister of Health, but the Minister of Finance is not even required to obtain the concurrence of the Minister of Health in the making of these regulations. There is merely a requirement that these regulations are made *after consultation with* the Minister of Health – the Minister made responsible in terms of the Constitution for the implementation and development of health policy!

45. This untenable situation is exacerbated by the proposed amendments to section 4(7) of the LTI and STI Acts respectively. These provisions provide that where it is uncertain whether a specific policy of a short-term or long-term insurer falls within the categories designated by the Minister of Finance in terms of the regulations described above, the Registrar of Short-term Insurance or Long-term Insurance, as the case may be, may prescribe that such policies are "health policies" or "accident and health policies", as the case may be. The effect of such a determination us that the relevant policy becomes subject to the LTI or STI Act only – and therefore the MSA does not apply to such policy.

46. In making such determination, the Registrar of Short-term Insurance or Long-term Insurance, as the case may be, is not required to obtain the concurrence of the Registrar of Medical Schemes – there is only a requirement that such determinations occur *after consultation with* the Registrar of Medical Schemes.

47. The net effect of these amendments is that the scope of application of a major piece of health policy legislation is subject to carve-outs at the discretion of the Minister of Finance and (in cases of uncertainty), the Registrar of Short- or Long-term Insurance. It is not clear who determines whether such uncertainty exists, but presumably such a determination is also made by the Registrar of Short- or Long-term Insurance.

48. In exercising these discretions, there is only a requirement for consultation but not concurrence with the Minister responsible for health policy and the statutory body responsible for implementation of the Act whose application is being limited by such determinations.

49. It should be clear from the discussion above, however, that the determination of exceptions from application of the MSA are first and foremost *health policy* determinations, and that they should be driven by considerations of impact on access to health care coverage and services.

50. Under these circumstances, it is considered to be unsound public policy for the application of the MSA, which falls under the jurisdiction of the Health Minister of Health, to be restricted by determinations made in terms of the LTI and STI Acts, which fall under the jurisdiction of the Minister of Finance.

51. It is even more problematic for such determinations to be made by the Minister of Finance and (in the case of uncertainty, the Registrars of LTI or STI) without even the requirement for concurrence of the Minister of Health or the Council for Medical Schemes which reports to the Health Ministry.

52. The danger presented by this is that determinations may be made which restrict the application of the Medical Schemes Act in a manner which is not consistent with national health policy – thereby undermining the important policy objectives of the MSA.

Recommendations

53. It is recommended that the Portfolio Committee on Finance should decline to introduce amendments to the LTI Act and the STI Act which have the potential to restrict the application of the MSA or to impinge on the powers of the Minister of Health to exercise the powers assigned to her to develop and implement health policy.

54. Instead, a legislative solution to the current legal uncertainty around the demarcation between health insurance products and medical schemes would be most appropriately achieved in the manner set out below.

55. The definitions of "health policy" in the LTI Act and "accident and health policy" in the STI Act should be amended to explicitly exclude products which do the "business of a medical scheme" as defined in terms of the MSA.

    55.1. The proposed amendments to the definitions of "health policy" in the LTI Act, effected through section 1(f) of the Bill, and "accident and health policy", effected through section 27(a) of the Bill, can be retained for this purpose.

56. To the extent that legislative amendments are made which impact upon the scope of application of the MSA, these amendments must be effected to the MSA and not indirectly through amendments to the LTI and the STI. This is good public policy. Amendments that may appropriately be considered by the Health Ministry in this regard include the following.

57. The definition of "business of a medical scheme" in the MSA should be amended to remove any room for contestation about the disjunctive reading of paragraphs (a) and (b) by insertion of the word "or" between the paragraphs – so that the definition would be explicitly read as (a) or (b) and, where applicable, (c). The definition should also be amended to exclude products to the extent that they have been granted an exemption as contemplated below.

58. An explicit exemption framework should be considered for inclusion in the MSA, to permit insurance products which do not undermine the medical schemes environment or the objectives of the MSA to operate outside the ambit of the MSA. Travel insurance policies which only offer short-term cover outside the borders of South Africa are examples of such products which would legitimately qualify for such an exemption

59. The following considerations are, however, important in the establishment of such a framework:

59.1. The parameters of the exemption framework must be established in the legislation, so that the implementation of that framework occurs at an administrative level through the agencies responsible for administering the relevant legislation and not at a political level.

59.2. The granting of exemptions from the MSA may be made a process requiring concurrence between the Council for Medical Schemes and the Financial Services Board. The process surrounding the granting of these exemptions should be made the subject of a memorandum of understanding established between these two regulatory bodies. In the absence of concurrence, the exemption would not be granted and the default would be that the MSA would apply to the product.

59.3. The framework for exemptions from the MSA is most appropriately provided for in the MSA as opposed to insurance legislation.

59.4. Exempting classes of product, e.g. travel insurance, through regulation is not favoured because the products could in fact opportunistically include detail which could undermine the medical schemes product under the guise of an exempted class of product.

59.5. Exemptions should be subject to review after limited periods, and in any event should be capable of being revoked if the insurer conducts its business in a manner prejudicial to the medical schemes environment.

60. The following provisions are recommended in respect of such an exemption framework, and could be inserted in section 2 of the MSA ("Application of the Act"):

"(4) Notwithstanding any other provision of this Act, the Council may, in concurrence with the Financial Services Board established by section 2 of the Financial Services Board Act, 1990 (Act No. 97 of 1990), on written application exempt the business or part of the business of any person from the application of this Act if —

***(a)* that person makes written application for exemption in a format to be determined jointly by the Council and the Financial Services Board, and provides any further particulars, information or documentation that the Council or the Financial Services Board may require pertaining to that application;**

***(b)* that person is registered as a short-term insurer in terms of the Short Term Insurance Act, 1998 (Act No 53 of 1998) or as a long-term insurer in terms of the Long Term Insurance Act, 1998 (Act No 52 of 1998);**

***(c)* the Council and the Financial Services Board are satisfied that such business or relevant part thereof does not undermine the stability and sustainability of medical schemes or the application of principles of community rating, open enrolment or cross-subsidisation within medical schemes, or the objects of the Act.**

(5) The Council and the Financial Services Board shall enter into a memorandum of agreement setting out a process whereby applications for exemption in terms of subsection (4) shall be jointly considered.

(6) An exemption contemplated in subsection (4) –

(a) **shall be granted for a period not exceeding 3 years, provided that application may be made for renewal of the exemption prior to expiry of the exemption period;**

(b) **may be granted subject to such conditions as the Council and the Financial Services Board may determine;**

(c) **may be revoked at the instance of the Council or the Financial Services Board if the Council or Financial Service Board is satisfied that –**

(i) the conditions contemplated in paragraph (b) have not been complied with;

(ii) information relevant to the application was not fully disclosed at the time of the application; or

(iii) the business which is subject to the exemption is being conducted in a manner which may undermine the stability and sustainability of medical schemes or the application of principles of community rating, open enrolment or cross-subsidisation within medical schemes."

61. From a practical perspective, this matter may be referred to the Health Portfolio Committee to effect suitable amendments to the MSA. Alternatively, if a consensus position can be achieved on these amendments between the Ministries of Health and Finance, these amendments to the MSA can be effected through the Insurance Laws Amendment Bill.

TP Masobe
Chief Executive and Registrar
COUNCIL FOR MEDICAL SCHEMES

[i] McLeod H and S Ramjee "Medical Schemes" in *South African Health Review 2007*, Health Systems Trust, Durban, 2007, p 49.