national treasury

Department:
National Treasury
REPUBLIC OF SOUTH AFRICA

RESPONSE TO KEY ISSUES RAISED IN PUBLIC SUBMISSIONS ON REGULATIONS WHICH GIVE EFFECT TO THE DEMARCATION BETWEEN HEALTH INSURANCE POLICIES AND MEDICAL SCHEMES

2016

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List of acronyms

Association for Savings and Investment South Africa	ASISA
Board of Healthcare Funders of South Africa	BHF
Council for Medical Schemes	CMS
Department of Health	DoH
Financial Intermediaries Association of South Africa	FIA
Financial Services Board	FSB
Financial Services Laws General Amendment Act No. 45 of 2013	FSLGA Act
Frequently Asked questions	FAQ
General Practitioner	GP
Insurance Laws Amendment Act No. 27 of 2008	ILA Act
Low-Income medical scheme	LIMS
Long-term Insurance Act No. 52 of 1998	LTIA
Medical Schemes Act No. 131 of 1998	MSA
Minister of Finance	MoF
Minister of Health	MoH
National Treasury	NT
Prescribed Minimum Benefit	PMB
Private Health Insurance	PHI
Short-term Insurance Act No. 53 of 1998	STIA
South African Insurance Association	SAIA
Treating Customers Fairly	TCF

1. Introduction

The National Treasury (NT) with the concurrence of the Department of Health (DoH) and in consultation with the Financial Services Board (FSB) and Council for Medical Schemes (CMS) is releasing this Key Response paper, which explains the approach taken in the draft Demarcation Regulations (draft Regulations) as submitted to Parliament. This paper discusses the context of the Regulations against the background of the current health policy framework in South Africa and the Demarcation policy process to date. It then considers main concerns expressed in public submissions on the Second Draft Demarcation Regulations (Second Regulations) released in April 2014 and outlines the responses on each of the main comment themes. Finally, this paper will set out the transition arrangements and supervisory approach to health insurance products once the final Regulations are implemented.

The Demarcation between health insurance products and medical schemes has a long history, with the process commencing in 2000 after the enactment of the Medical Schemes Act No. 131 of 1998 (MSA). Certain insurance products offering health policy benefits seemed to infringe on the medical schemes environment by doing the business of a medical scheme without being subject to the same regulatory requirements. Various industry agreements and court challenges attempted to clearly distinguish between health policies sold by life insurers and those sold by medical schemes; however, these attempts did not achieve the intended results, as many insurance products continued to operate in a regulatory vacuum with no clear regulatory home.[1]

In terms of section 72(2A) of the Long-term Insurance Act, No. 52 of 1998 (LTIA) and section 70(2A) of the Short-term Insurance Act, No. 53 of 1998 (STIA), the Minister of Finance is empowered to make Regulations in consultation with the Minister of Health (MoH) and after consultation between the National Treasury, Council for Medical Schemes (CMS) and the Financial Services Board (FSB).

In terms of section 72(2B) LTIA and section 70(2B) of the STIA, before the Regulations are promulgated, the Minister must publish the draft regulations in the Gazette for public comment and submit the regulations to Parliament, while it is in session, for parliamentary scrutiny at least one month before their promulgation.

The First draft Demarcation Regulations (First Regulations) were published for public comment on 2 March 2012. Two proposals in the First Regulations, namely a prohibition on Gap Cover products[2] and restrictions on Hospital Cash Plan[3] insurance policies, elicited considerable public comment. A transparent process was followed in engaging all interested stakeholders. Of the 343 submission received on the First Regulations, the main categories of comment were from 180 individuals, 115 brokers, 20 insurers, 4 medical schemes,7

[1] A more detailed explanation of the process to conclude the Demarcation Regulations is set out in section 4.1 of this paper.
[2] Policies covering medical expense shortfalls for medical scheme members.
[3] Lump sum or income replacement policy benefits payable on a health event.

associations and 17 other categories. On 15 October 2013, the NT released on its website all 343 comments received during the initial consultation process.

The Second Regulations were published for further public comment on 30 April 2014. A total of 461 submissions were received.

To further enhance public consultation, the NT and FSB met with stakeholders to facilitate a better understanding of the Regulations. Discussions were held with the CMS, DoH, ASISA, SAIA, FIA, BHF, Section 27, the Helen Suzman Foundation and affected insurers. The NT released a FAQ document on 17 July 2014 to provide further clarity on some of the questions received from stakeholders during the consultation phase. The NT, FSB and CMS also hosted workshops with providers of Primary Healthcare insurance products.

The Regulations seek to strike a better balance between medical schemes and health insurance products so that consumers are better protected. It also recognises the role that appropriately-designed and marketed health insurance policies can play in meeting the need for protection against unanticipated health events.

NT and DoH recognise that Regulations must be practical and take into account current realities. In this regard, the Regulations reflect a reasonable compromise to allow for the continued sale of certain health insurance products under the LTIA and STIA in a manner that complements medical schemes through strict underwriting and marketing conditions. The effect of these conditions is that health insurance products that do not complement medical schemes will be prohibited unless they are registered under the MSA or operate under exemption from the MSA.

The publication of the Regulations also follows the enactment of the Financial Services Laws General Amendment Act No. 45 of 2013 (the FSLGA Act) which came into operation on 28 February 2014.[4] The amendment to the definition of a "*business of a medical scheme*" was deferred to come into effect at the same time as the Regulations are finalised. Health insurance products that fall within the ambit of this amended definition will be prohibited, unless they are explicitly exempted through the Regulations or the MSA.

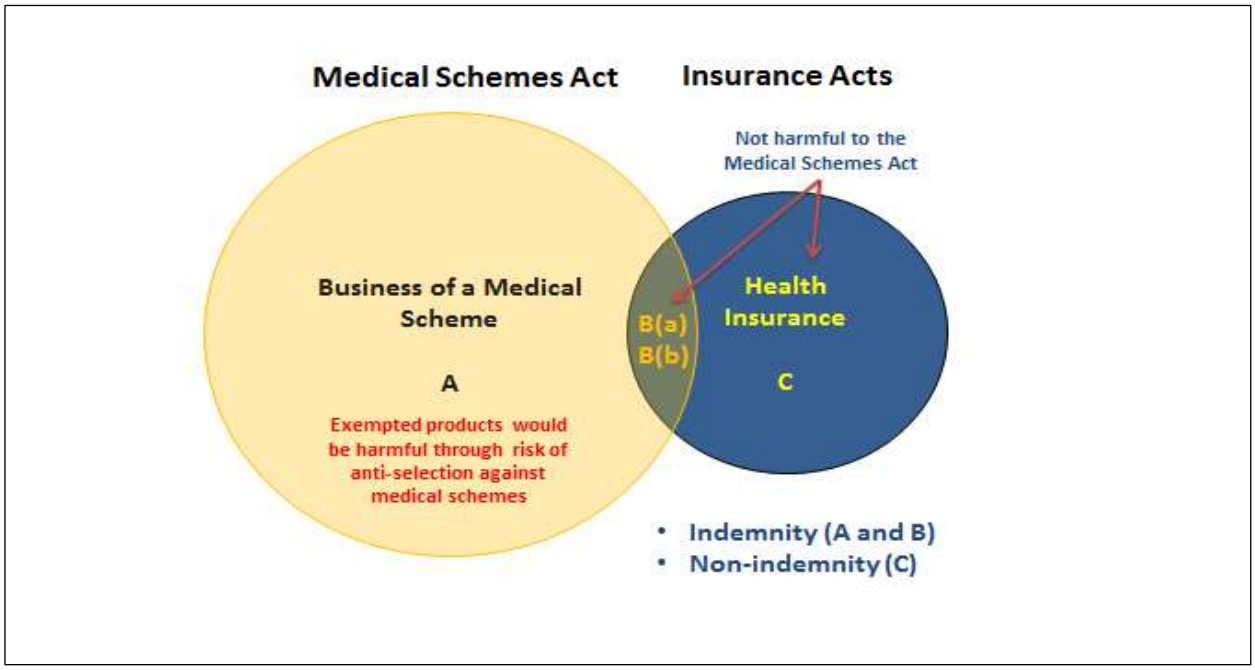
2. Context of the Demarcation Regulations

The process of finalising the Regulations has been a challenging one to conclude, given that it touches on a number of complex health and financial sector challenges and affects many stakeholders. It is recognised that medical schemes are in substance a form of insurance, hence the Regulations cannot simply be regarded as a pure insurance policy or health policy issue.

[4]The Act, which was passed by Parliament on 12 November 2013, assented to by the President on 14 January 2014, and published in Government Gazette No. 37237 of 16 January 2014, amends the definition of a "business of a medical scheme" to support the second Draft Demarcation Regulations and address recent court case judgments which widen the interpretation of this definition.

The following figure shows the overlap between the two markets:

Figure 1: Contrasting medical schemes and health insurance policies



Source: Presentation by Professor Alex van den Heever, 15th BHF Southern African Conference

Core to the MSA is the principle of social solidarity, where the young and healthy subsidise the old and sick. Pooling healthier and sicker individuals into a medical scheme facilitates a form of cross-subsidisation that improves the overall affordability of medical schemes and protects more vulnerable individuals. The practice of discriminating between individuals based on age or health status is expressly prohibited in the MSA. This means that any individual is entitled to be a member irrespective of their age or health status. Any compromise on this principle will mean that health providers will penalise the old and the sick, and make healthcare expensive and inaccessible to them. Insurers, on the other hand, are not bound by the same restrictions and may discriminate through individual risk rating.

The Regulations apply to the area of overlap between the business of a medical scheme and health insurance products (area B on Figure 1) and seek to limit health insurance products that discriminate against the old and sick. Core to the Demarcation debate is the difference between indemnity and non-indemnity products. The former refers to any insurance that covers the actual cost of any insurable loss incurred. In the case of health insurance this would involve the reimbursement of actual health expenses incurred.[5] The latter refers to insurance benefits paid out as a lump sum unrelated to the value of any loss actually incurred.[6] The overlap between the business of a medical scheme pertains to products that indemnify against medical expenses (such as gap cover products) as well as

[5] Source: Submission by Professor A van den Heever on the Second Draft Demarcation Regulations
[6] Source: Submission by Professor A van den Heever on the Second Draft Demarcation Regulations

products that may misleadingly create the impression that the policies indemnify against medical expenses or are a substitute for medical scheme cover. Other health insurance policies, such as dread disease, critical illness or personal accident policies, would be classified in area C.

The Regulations acknowledge that the overlap between medical schemes and health insurance policies also include some policy types aimed specifically at the poor that would otherwise be entirely excluded from private healthcare and that a space should therefore be carved out for these products that is complementary to the business of a medical scheme without undermining the objectives and purpose of the MSA.

The Regulations introduce a community rating rather than a risk-rating approach to health insurance in an attempt to reduce the regulatory arbitrage between medical schemes and health insurance. The concept of group risk rating is not new to the insurance market. It is standard practice for group schemes, as well as mass market policies in for example funeral insurance, consumer credit insurance and hospital cash plans to be underwritten on a group rather than an individual risk rating basis. The group rating convention already contains elements that support solidarity principles.

The current problems with health insurance products are a direct result of providers circumventing the medical schemes framework. It is therefore critical that the FSB and CMS work together on these intersecting health policy issues rather than in silos. For this reason, the Regulations are a joint initiative of both the NT and the DoH, and have been approved for publication by both Ministers, as required by law. For the same reason, there was a joint approach to amend the definition of the business of a medical scheme in the FSLGA Act.

Public comments suggest that the reason why consumers take up health insurance products is because they simply cannot afford medical schemes or their existing medical schemes do not cover their medical expenses in full thereby leaving them out of pocket to settle outstanding medical expenses. The NT agrees that more needs to be done to lower the high medical scheme costs for consumers. To this end, the NT supports the Competition Commission inquiry into the high costs of private healthcare. Further, the NT believes that the Twin Peaks approach to regulating the financial sector holds lessons for the regulation of medical schemes, as tougher market conduct regulation over medical schemes should aim to treat customers more fairly. To this end the NT and the FSB are working together with the DoH and the CMS to improve market conduct practices in medical schemes and lower the costs of medical scheme coverage.

Government is also exploring how best to provide universal coverage through National Health Insurance, and to do so in a way that minimises costs and ensures quality care. The transition to this objective is an equally complex process, and is further complicated by the existence of health insurance products operating under the LTIA and STIA as well as the current MSA framework.

The revised Regulations take into account the need to provide access to quality healthcare to all at an affordable price while National Health Insurance is being developed. It seeks to

define a complementary regulatory space for health insurance products, which supports rather than undermines medical schemes.

The NT agrees with commentators on the complexities of health policy, but doing nothing and maintaining the status quo will only undermine the current system of medical schemes. The challenge therefore is to find lower cost medical schemes that are more affordable to more South Africans, and to regulate health insurance products more appropriately.

To this end, the DoH and CMS is taking concrete steps to develop a Low-Cost medical scheme option that can be provided under the MSA, in order to ensure that more low income households can access medical schemes. In the transition, there is strong recognition that there is a need for better monitoring and data on the health insurance products that will be allowed.

The FSB will require insurers to submit specific information on policies that will be allowed in term of the Regulations when the products are launched. The information will have to be submitted to the FSB and the CMS within a specified timeframe. To monitor and regulate these insurance products, annual and quarterly reporting by insurers on these products will be entrenched in the statutory returns of insurers going forward. Furthermore, the FSB will as part of its day-to-day supervisory activities conduct thematic visits at insurers offering these products to monitor the transition. The FSB is in the process of strengthening the capacity of its staff to adequately monitor the requirements attached to these products.

3. Overview of health insurance landscape

A health insurance policy[7] is issued by an insurer to a policyholder in terms of the LTIA or STIA and is subject to regulatory oversight by the FSB. The policy promises to pay for certain stated benefits when the policyholder is ill, or injured, in return for a premium. The premium may be directly related to the age, health status or income of the individual covered by the policy (i.e. “individually risk-rated”). Specific types of exclusions and conditions may also be built into a policy, which can have the effect of limiting who the policy can be sold to, or excluding certain circumstances under which the policyholder can claim under the policy.

The policy is triggered by a health event, which is defined in both acts as “… an event relating to the health of the mind or body of a person or unborn.” In the case of the STIA, health policies are classified along with accident policies as a “…contract in terms of which a person, in return for a premium, undertakes to provide policy benefits if a disability event, health event, or death event contemplated in the contract as a risk, occurs”. This definition is echoed in the LTIA, except that disability and death events are excluded.

In both cases, limitations on the policy apply. Firstly, the policyholder may not be a medical aid scheme seeking to hedge risks. Secondly, the benefits provided may not be provided to

[7] Referred to as health policies under the LTIA and accident and health policies under the STIA.

cover or defray costs associated with health expenditures, as the latter would constitute the business of a medical scheme.

There are currently three categories of products in the health insurance market that are of particular relevance to the Regulations: Gap cover, Hospital cash plans, as well as primary healthcare insurance.

Medical Expense Shortfall policies (Gap cover plans) is an insurance product developed in terms of the STIA that is designed to cover the shortfall between medical scheme benefits and the rates that private medical care providers may charge. Typical premiums, based on industry submissions, range from R78.95 per month for employer groups, to R275 per month for individuals. The difference is attributed to underwriting expenses associated with individuals. According to 2014 data supplied by industry, most claims tend to be lower than R30,000 (the large majority of which, in turn, are below R10,000), with a number also ranging up to R50,000. Less than 1% of claims are above R50,000 and only a handful exceed R100,000. Note, however, that this refers to the typical claim value and not total claims per member per year, which could be higher, should a member experience more than one claim event.

Even though gap cover is typically only available to those that already belong to a medical scheme, the concern is that it may encourage members of medical schemes to 'buy down' and opt to contribute less to medical schemes whilst using the gap cover to 'top up' benefits. Since these top up benefits are not provided equally to the sick and the healthy, they may be provided at a lower cost than medical schemes and as such undermine the principle of social solidarity.

Non-medical expense cover as a result of hospitalisation policies (Hospital cash plans) refer to income replacement policies that pay out a stated benefit upon hospitalisation as trigger, usually paid per day spent in hospital. The level of cover is unrelated to the cost of treatment and claims are paid to the beneficiary rather than the health service provider. These plans may or may not be held concurrently with a medical scheme, but research conducted in 2012 and 2013, respectively, found that the primary target market is individuals who do not belong to a medical scheme and are relying on public healthcare. They are using the hospital cash plan as income replacement and towards ancillary expenses, rather than directly to offset medical costs.

Typical premiums range from R98 to R850 per month depending on age and cover requested, and typical benefits from R250 to R5000 per day, depending on time hospitalised and ward cover. According to industry data gathered for a 2012 report, benefits packages at the lower end of the spectrum are most popular.

Primary healthcare insurance or **primary health plans** refer to limited benefit package options provided by some insurers (often to employee groups or bargaining councils) covering elements such as general practitioner visits, acute and chronic medication, emergency medical care, dentistry and optometry. Table 1 illustrates the types of benefits offered at the hand of one prominent bargaining council scheme example. In this particular example, the premium is R95 per month, paid by the employer and the insurer has negotiated rates with a particular provider network:

Table 1: Overview of benefits provided under a Primary Health Plan

Benefit Type	Limits
GP Visits	5 Per annum per beneficiary
Acute Medication	Limited to R500 per annum prescribed during the 5 allowed visits
Chronic Medication	Various limits apply
Basic radiology	Core scans when requested during the 5 allowed visits covered. Various conditions apply
Basic pathology	Those requested during the 5 allowed visits are covered. Various conditions apply
Emergency Management Services	Treatment and stabilisation on scene. Transport to closest hospital, and inter hospital transfers. Various helplines are also made available
Hospital Indemnity Benefits	Month 1-24: R250 per day, R500 if intensive care unit is required. After month 24: R50 000 of hospital admission costs covered
Hospital Casualty Benefit	R10 000 relating to an accident or emergency treatment in casualty

Source: Submissions to National Treasury, 2014

Table 2 indicates that available estimates on the number of health policies vary substantially:

Table 2: Overview of various products in the health insurance market

Type of Policy	Estimated number of policies	Estimated number of lives covered	Reported claims ratios
Gap Cover	11 000 - 300 000	11 000 - 585 000	30%-82.75%
Hospital Cash Plan	1.1-1.5 million	1.5-2 million	20%-35%
Primary Health Plans	95 000	110 000	101%

Source: Submissions made to National Treasury, 2014

In 2011, the FSB estimated that approximately 11 000 gap cover policies exist, whilst industry estimates in 2012 indicated approximately 300 000 policies, with up to 400 000 total lives covered. A recent submission by one of the largest gap cover industry players indicated that the industry is comprised of approximately 250 000 to 300 000 policies and covers approximately 585 000 lives in total.

The difficulty of obtaining accurate figures also extends to claims ratios, with data collated by the NT in 2012 indicating that claims ratios are typically between 35-50% for gap cover. In recent submissions to the NT, several industry players however indicated that claims ratios range from 68% to 101%, with an average of 82.75% for a select number of insurers.

As is the case with Gap cover plans, overall industry data for hospital cash plans are difficult to obtain. An estimate by the FSB indicated that 1.1 million of these policies existed in 2011, whilst a 2012 analysis of industry data (Lighthouse Actuarial Consulting report for FinMark Trust, 2012) indicated that the figure is likely to be closer to 1.5 million, covering between 2-3 million lives.

The size of the primary healthcare insurance market is likewise difficult to gauge. Based on data received in recent submissions to the NT by a key market participant, in the order of 110,000 lives are covered. The FSB issued an information request in December 2015 to all insurers registered to offer health insurance policies. The purpose of the information request is to get a clearer understanding of the state of the current health insurance market. Responses were due on 29 April 2016 and the FSB is currently finalising its analysis.

4. Framework for the Demarcation Regulations

The Regulations seek to address concerns that certain long-term and short-term health insurance policies may undermine the sustainability of medical schemes by attracting younger and generally healthy members out of medical schemes. In addition, there are health insurance policies which are being misleadingly marketed as alternatives to medical scheme cover, while the protection they offer against health events is not equivalent to that of medical schemes.

The Regulations seek to balance policy objectives across two spheres: the objectives and purpose of the MSA as set out above, as well as the financial sector objectives contained in the 2011 National Treasury Policy Document “A safer financial sector to serve South Africa better”, namely: financial stability; consumer protection and market conduct; expanding access through financial inclusion; and combating financial crime. Where the two policy objectives intersect, a careful balance needs to be struck, with compromise from both sides, to level the playing field and strike a better balance between medical schemes and health insurance products.

The Demarcation framework provides for the continued sale of certain health insurance products under the Insurance Laws in a manner that complements medical schemes, with strict underwriting and marketing conditions. The effect of these conditions is that health insurance products that are harmful to the medical schemes environment will be prohibited unless they are registered under the MSA. However, those that do not pose a threat to the medical schemes environment will continue under the market conduct provisions set, and the limits have been defined to allow innovation and achieve reasonable cover within the parameters of the lower-income market.

Particular emphasis was placed on why and how community rating can be achieved in the insurance environment. The consultation process established that current group risk rating practices in the insurance market can be reconciled with the objectives of community rating in the medical schemes environment without major disruptions.

The Regulations seek to avoid regulatory arbitrage, as well as to uphold the objectives of the MSA in pursuit of greater access to quality healthcare for all in South Africa:

- *Prevent regulatory arbitrage*: Since the practices of medical schemes and insurance firms are regulated by different statutory bodies, the risk of regulatory arbitrage exists. To date, this arbitrage has favoured the provision of health insurance products since these products suffer from less restrictions and obligations than medical schemes whilst simultaneously being allowed to operate for profit. Furthermore, the commission payable to a broker for the sale of an insurance product exceeds that of a medical scheme.

- *Uphold the objectives of MSA*: The Regulations seek to uphold the four fundamental principles of solidarity, community rating, open enrolment and risk equalisation. Without clear separation, the protection afforded to the sick and elderly through medical schemes may be undermined, since these vulnerable individuals would be ineligible for many health insurance products. A consistent and large scale migration away from medical scheme by the young and healthy would threaten the risk pool of medical schemes.

- *Promote access to financial services*: The process of drafting Regulations has highlighted the important role that health insurance can play in meeting a need, especially in the low-income market. It has therefore reinforced the need for an enabling regulatory framework to be created that balances different policy objectives.

Box 1: OECD guidelines for mitigating PHI risks

Policy makers have addressed some of the challenges posed by PHI markets through a variety of interventions – including regulation of the role of PHI, access and benefit-related standards for PHI insurers, disclosure requirements and fiscal incentives directed to PHI markets, and broader policies towards private sector providers. A number of useful practices have been identified:

- A combination of insurance and rating rules can be an effective means to alleviate some access-related PHI challenges. Access-related standards help to promote insurance coverage for high-risk individuals, and may be particularly useful in primary PHI markets. The need for these interventions often depends on the comprehensiveness of the PHI benefits they apply to, and the extent to which the costs of any high-risk coverage are cross-subsidised by other private insures or by other financing sources. If publicly funded systems provide adequate access to needed health services, policy makers may question the need for such interventions in their PHI markets.
- Fiscal incentives and subsidies can boost the purchase of PHI and shape its market structure by reducing the net price of insurance policies for individuals, thereby potentially increasing take-up. However, compared with other types of policy interventions, fiscal incentives and subsidies may not be the most cost-effective way to increase take-up of insurance among certain populations. In addition, especially if large incentives are needed to spur purchase of PHI, the cost to public revenues needs to be weighed against the savings in public health spending associated with increased PHI take-up.
- When PHI creates access disparities, policy makers can intervene by regulating the roles that PHI is permitted (or prohibited) to have; regulating price differentials between publicly and privately

financed medical practice; specifying providers' obligation to public patients and monitoring compliance with those obligations.

- When cost sharing in public systems is high, PHI enhances access to care. Yet, if PHI offers full coverage of high cost-sharing levels on public programmes, insures do not retain awareness of cost and PHI encourages moral hazard-induced utilisation, creating trade-off with cost-containment goals. Maintaining at least some modest cost sharing helps to minimise undesired cost consequences of complementary PHI.
- Policy makers can maximise effective choice within PHI markets by fostering readily understood comparative information and product disclosure requirements. Disclosure requirements can work together with benefit standards to promote and reinforce consumers' understanding of their PHI products and coverage options. Some limits on benefit packages, or their standardisation, may be appropriate, particularly if products are sold to vulnerable population groups, such as the elderly and chronically ill. Yet, benefit standardisation reduces insurers' ability to innovate and tailor products to individuals' demands.
- Policy makers can maximise cost shifting between the public and private sector by encouraging private insures not to rely on public systems for PHI-covered services. Applying cost-control measures within the overall health system, including the private sector, improves the ability to control cost within PHI markets.
- Incentives or regulatory requirements might encourage PHI markets to improve cost-effectiveness of care, for example by removing insurers' obligations to contract with all providers, or providing incentives for insurers to be involved in preventative care or care management. Improved consumer information could facilitate effective competition among insurers. Systems to compensate insurers with a worse risk structure can help reduce insurers' incentives to select good risks, thus promoting equitable risk pooling. However, they can also remove or reduce incentives for insurers' efficiency.

Sources OECD, 2004. Private health insurance in OECD countries. OECD Health Project (extract quoted directly).

4.1. Process

Section 1 outlined the Demarcation policy process. Here, more detail is provided.

The debate regarding the Demarcation between health insurance products and medical schemes dates back to the enactment of the MSA in 1998. In 2000, an informal agreement was entered into between the CMS and the FSB, with the aim to make a clear distinction between health policies sold by the life assurers and those sold by medical schemes. Short-term insurers were not party to the agreement. In 2004, the CMS, FSB and the Life Offices' Association (LOA – now ASISA), released a Demarcation Code to provide clarity regarding the definition of the "business of a medical scheme" as defined in the MSA. In 2006, the High Court found that an insurer had crossed the Demarcation divide, thereby setting an important legal precedent. In 2008, the Supreme Court of Appeal overturned the 2006

ruling, paving the way for expanded offerings of health insurance products such as “gap cover” and “hospital cash plans”.

The enhancement of the legislative framework relating to the Demarcation between health insurance policies and medical schemes commenced with the enactment of the ILA Act in 2008, where provision was made to allow the MoF to delineate specific categories of health insurance products which will be allowed to be sold to the public, despite such products constituting the “business of a medical scheme” as defined in the MSA. Health insurance products which will be allowed to be sold to the public in terms of the Demarcation Regulations will fall outside the scope of the MSA and will be subject to regulatory oversight by the FSB and not the CMS. The ILA Act requires that regard be given to the objectives of the MSA and the current or potential harm that a health insurance policy may cause to medical schemes environment. It also requires that the MoF must reach consensus with the MoH and consulted with the FSB and CMS before the Regulations are published.

The ILA Act formed the basis for the development of the Regulations. After the publication of the ILA Act, a lengthy process of public consultation was followed towards the finalisation of the Regulations. The following table summarises the key moments in the process:

Table 3. Demarcation timeline

2009	Demarcation Working Group formed	Established by NT with representation from the FSB, DoH, CMS, ASISA and SAIA. Mandated to collate information on all long and short-term health insurance products that exist in the market to enable NT and DoH to better understand the product characteristics in order to facilitate a policy decision.
2011	FSB releases Information Request 5/2011	Request for information (in spreadsheet template format) on different products offered as health policies, and accident and health policies under the LTIA and STIA, respective. The information was used to assist the FSB and the NT in assessing the potential economic impact of the eminent Regulations.
2012	NT releases *Draft Regulations* for comment along with explanatory memo	Outlines Demarcation proposals, including prohibition of so-called “gap cover” and substantial curtailment of so-called “hospital cash plans”
2013 (Oct)	NT press release: Process for the release of the envisaged revised draft Regulations on the Demarcation between health insurance policies and medical schemes	To provide update on plans for revised Regulations and signal policy direction. Signalled that the second Regulations will acknowledge that while health insurance products have a role in the market place, these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical schemes. The revised second Regulations, will therefore, provide for the continued sale of Gap Cover and Hospital Cash Plan insurance within defined regulatory product parameters. These parameters, by explicitly requiring that health insurance products be provided on similar

		terms as medical schemes, seek to ensure that medical schemes are not compromised.
2013	Enactment of Financial Services Laws General Amendment Act No. 45 of 2013	Amends the definition of a *"business of a medical scheme"* to support the second Regulations and address recent court case judgments which widen the interpretation of this definition. The amendment to the definition of a "business of a medical scheme" was deferred to come into effect at the same time as the Regulations are finalised.
2014 (Apr)	NT releases *Second draft Regulations on the Demarcation between health insurance policies and medical schemes* for comment along with explanatory memo for LTIA Regulations and STIA Regulations, respectively	Outlines revised position, taking into account the diverse comments received on the first draft. Recognises the role that appropriately designed and marketed health insurance policies can play, but reiterates that these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical scheme cover. The second Regulations, therefore, provide for the continued sale of Gap Cover and Hospital Cash Plan insurance within defined product parameters, including: • prohibition on health insurance policies from discriminating against any person on the grounds of age, gender and other criteria; • enhanced product disclosure/marketing requirements; • alignment of broker commission between health insurance and medical scheme products; • enhanced regulatory reporting and monitoring; • product standards which limit policy benefits; and • limitations on bundled type health insurance products which replicate medical schemes.
2014 (Jul)	NT publishes Updated Frequently Asked Questions document: second Regulations on the Demarcation between health insurance policies and medical schemes	To clarify intention and scope of second Regulations, including the differences between medical schemes and health insurance, the scope of the Regulations and the basis for the chosen product parameters, as well as the impact of the revised definition of the business of a medical scheme.

4.2. Key issues raised in the First Draft Regulations

The NT published the First draft Regulations in March 2012. In determining whether a product will or will not be allowed to be sold to the public, consideration was given to the following three categories of products and the current or potential harm that such products may cause to medical schemes environment:

- **Category 1** - health insurance products which unambiguously constitute the business of medical scheme and could compromise it and therefore will not be allowed to be sold to the public.

- **Category 2** - health insurance products which explicitly do not constitute the business of a medical scheme and do not compromise it and will be allowed to be sold to the public.

- **Category 3** - health insurance products which unambiguously constitute the business of a medical scheme but do not compromise it and will be allowed to be sold to the public under certain conditions.

The following products were identified as controversial:

- Gap cover: covers the difference between actual medical costs on specified events and medical scheme rates

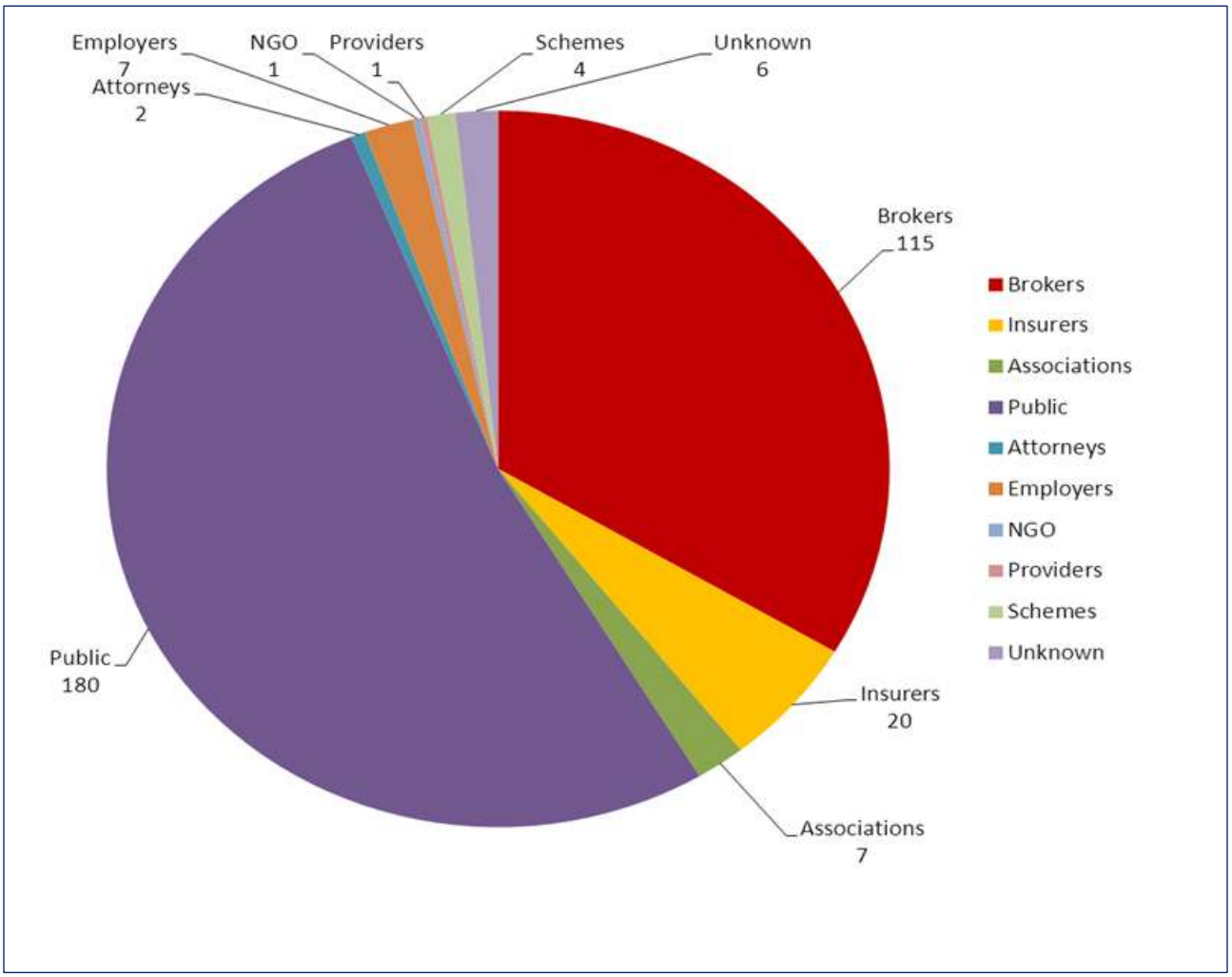
- Top-up Cover: covers benefits when a policyholder has breached the per benefit or annual limit imposed by his/her medical scheme

- Hospital Cash Plans: covers a specific amount per day a person is hospitalised

The first Regulations prohibited the provision of gap cover, as well as top-up cover, dental insurance and comprehensive health insurance (Category 1 products). It also significantly curtailed the provision of hospital cash plans. Other products included in the ambit of the Regulations (Category 3) were travel insurance (domestic and international), emergency evacuation insurance, motor and property third party liability insurance, employer-provided HIV/AIDS cover and frail care cover. These products were included because they may be interpreted as doing the business of a medical scheme. Category 2 products (health insurance products not included in the ambit of the Regulations because they were not regarded as constituting the business of a medical scheme) include lump sum cover, dread disease cover, income replacement cover, premium waivers and major medical event cover.

The following diagram breaks down the comments received by type of commentator:

Figure 2. Breakdown of comments received on the first Regulations



Source: Submissions to National Treasury, 2012

The two key proposals in the First draft Regulations, which elicited the most public responses, relate to the prohibition of Gap Cover and product restrictions on Hospital Cash Plan insurance policies. The public concern was that these insurance policies meet a real need for protection in covering the cost of medical care. In the absence of such cover, unnecessary debt will be incurred to cover short falls in medical expenses.

The comments also highlighted affordability and market conduct concerns with respect to medical schemes; specifically, the need for medical schemes to seek ways to be more affordable and to improve disclosure to their members. The NT will engage the Department of Health and the CMS on these issues, in line with the market conduct reforms proposed for the rest of the financial sector as part of the Twin Peak review.

The following table provides a more detailed breakdown of comment themes and number of submissions pertaining to each:

Table 4. Breakdown of comment themes in the first Regulations

Medical scheme cover is insufficient with gaps, co-payments and deductibles, PMBs not paid in full	209
Medical schemes not affordable	169
Need / demand for GAP cover / Top-up cover now and with NHI	133
Gap cover protects households against catastrophic financial loss	130
Health professional fees higher than scheme rates	85
Denies negative impact on medical schemes	85
Infringes on constitutional	54
Gap cover protects the under-privileged	48
Other problems in health system / Bargaining Council Schemes / No REF / No mandatory membership / Tax credit regime	30
High hospital costs	29
Gap-cover plus lower option is affordable	26

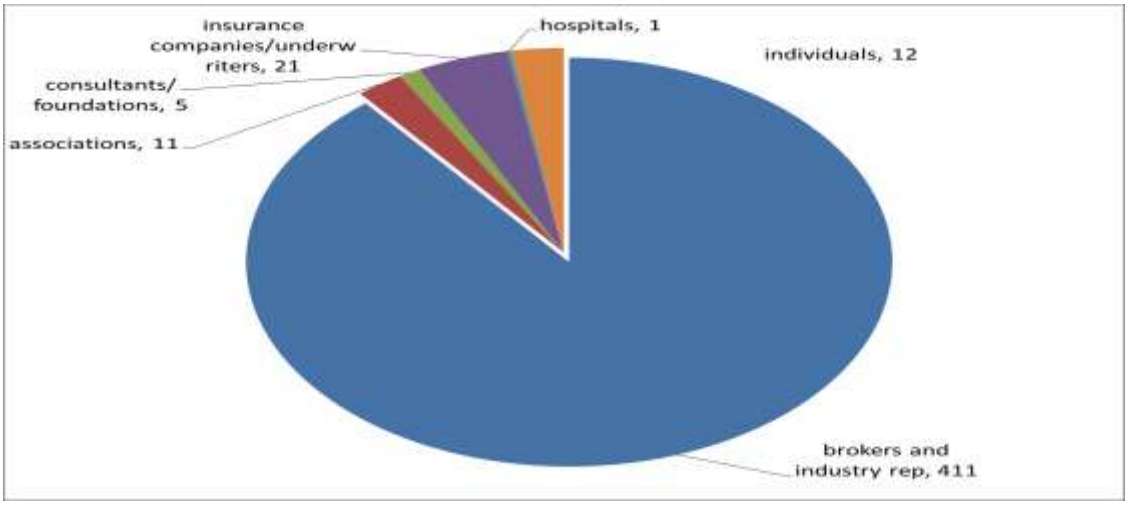
Source: Submissions to National Treasury 2012

Following an extensive public consultation process, the positions were revised in the second draft Regulations to allow for the continued sale of what was previously known as gap cover products, but under strict conditions to ensure complementarity, as well as to broaden the scope for what was previously known as hospital cash plans.

4.3. Key issues raised in Second Draft Regulations

The second Regulations were published for public comment on 30 April 2014. A total of 461 submissions were received, the majority of which are from the broker fraternity:

Figure 3. Breakdown of submissions on the second Regulations



Source: Submissions to National Treasurv. 2014

Commentator type	Key comment areas
Brokers & industry representatives	• Commission structure • Benefit limit for shortfall cover
Individuals	• Commission structure • Benefit limit for shortfall cover
Insurance companies/ underwriters	• Constitutionality of Regulations • Basis of underwriting and anti-selection measures • Product category limits and definitions
Associations	• Commission structure • Basis of underwriting and anti-selection measures • Product category limits and definitions • Limitations on product combinations • Transitional arrangements
Consultants/ foundations	• Matters of constitutionality/legality, policy process
Hospitals	• Importance of health insurance products as complementary to medical schemes in ensuring access to private healthcare • Basis of underwriting and anti-selection measures • Product category limits and definitions • The rationale for requiring reporting to CMS

Subsequent to the publication of the second Regulations, NT and the FSB, in consultation with the CMS, analysed all submissions received and sourced further industry data to inform the final position.

4.4. Responses to key issues and Demarcation positions

This section summarises the main comments received on each aspect of the revised draft Demarcation Regulations, provides a response and states the updated position contained in the final Demarcation Regulations.

4.4.1. Matters of principle

A number of submissions raised matters not related to a specific section of the Regulations. These matters relate to the constitutionality of the Regulations, the grounds for placing restrictions on health insurance in light of structural problems in the medical schemes environment (with the argument being that one cannot compensate for problems in one market by restricting another), as well as to the definition of the business of a medical scheme. Where the latter is concerned, a number of submissions challenged the ambit of the Regulations and the implications thereof for the treatment of primary healthcare insurance products.

Below, the response to each issue is set out in turn. Given the prominence of the topic, the treatment of primary healthcare insurance products is discussed in a separate sub-section.

Main comments

Element	Who commented?
Constitutional rights: Access to quality healthcare is a constitutional right and denying access to insurance amounts to unfair discrimination. Such discrimination is mostly against the low-income, non-formally employed population who are unable to join a medical scheme.	• Health insurers and underwriting management agents
Structural problems in the medical scheme environment: It is argued that insurance products serve a market not served by medical schemes, or cover gaps not filled by medical schemes. Unless a LIMS-type dispensation or mandatory cover is implemented, restricting health insurance is unfair to those in the low-income market.	• Health insurers and underwriting management agents • Industry associations
Ambit of the Regulations: *personal accident, dread disease, critical illness and other products that do not have a bearing on the medical schemes environment* It is argued that the reference to "specified health event" in the definition of lump sum or income replacement policies (LTIA Regulations Category 1, STIA Regulations Category 2) is too broad. A number of submissions point out that this may be interpreted to include a number of policy types (including personal accident, dread disease or critical illness policies) that do not have a bearing on the business of a medical scheme. "It is submitted that the Regulations should clearly indicate that the health event referred to in the “name” and “policy benefits” columns is limited to hospital admission.”	• Health insurers and underwriting management agents • Industry associations

Response

<u>Constitutionality</u>

The comments suggest that because medical schemes are more expensive than its counterpart insurance policies, by moving such insurance policies away from the ambit of the Insurance Acts into the ambit of the MSA, there will be individuals, who could afford the cost of the insurance policies, who will not be able to afford the cost of the medical scheme. It is submitted that this results in unfair discrimination against such individuals and impedes on their constitutional right to have access to healthcare.

Medical schemes are in substance a form of insurance. This is also recognised by the LTIA and STIA which specifically excludes a medical scheme registered under the MSA from the ambit of such Acts. Housing the regulation of specific products or business under different Acts is done for administrative purposes and do not amount to discrimination. Under the Regulations, access to insurance products that cover specified health events as well as medical schemes (which is in substance insurance) which covers health events other than those events specified under the LTIA and STIA is enabled.

The main contention rather appears to be the cost of medical schemes and that such costs are higher than costs associated with insurance policies. It has been reiterated that there are various initiatives underway focusing on how costs relating to medical schemes can be reduced. Amongst these initiatives is the proposed Twin Peaks approach to market conduct regulation which envisages improving market conduct practices relating to medical schemes and lowering the price of medical schemes as well as the CMS of developing a low-cost medical scheme option. Further, the continued emphasis on the financial inclusion objective, which specifically focuses on expanding access to the low-income, non-formally employed population, will contribute in protecting the rights of these individuals.

There is a fine balance that has to be struck between the proven risks or harm that the current system poses to society and the risk that implementing changes to the current system may lead to discomfort for some. The importance of the proposed Demarcation has been explained and reiterated over the duration of the project. Less restrictive means to achieve the desired outcome do not exist and no viable alternative proposals exist. Retaining the status quo would be more detrimental than the proposed Demarcation. Further, the proposed Demarcation must be viewed in conjunction with other projects or initiatives that will support the Demarcation framework (such as the proposed Twin Peaks approach to market conduct regulation). Ultimately, in balancing the risks to society, the Demarcation Regulations is reasonable and justifiable.

The NT recognises that a number of structural problems exist in the medical scheme environment such as the absence of a reference price list, poor disclosure, no risk equilisation fund and no requirement for mandatory contributions, The final Regulations are not intended to compensate for structural problems in the medical scheme environment. They acknowledge and attempt to optimise the complementary role of the insurance sector in the broader health financing landscape, while upholding the objectives and principles of the MSA.

Only the categories of contracts identified in the Regulations are subject to the Regulations. These categories relate to contracts that may be interpreted as doing the business of a medical scheme within the amended definition of the “business of a medical scheme” in the MSA if it were not for the fact that they have been specifically identified as health insurance policies by the Regulations. Examples of such insurance policies include non-medical expense cover as a result of hospitalisation, medical expense shortfall cover, HIV, Aids, tuberculosis or malaria testing and treatment, frail care, and medical emergency evacuation or transport (subject to certain limitations).

Other types of health insurance policies are not listed in the Regulations because they are fully removed from or unrelated to the business of a medical scheme, and accordingly do not need to be excluded from the amended definition of the “business of a medical scheme”. Examples of such health insurance policies include dread disease, motor and property third party liability, personal accident and disability policies which offer a lump sum benefit or annuity income when you are diagnosed with a severe illness or disability, or when a death event occurs.

Demarcation Regulation position

The drafting of the income replacement category has been amended to clarify any ambiguity in this regard.

Ambit of the Regulations: Primary Health Insurance and Bargaining Council Schemes

The intention of the Final Demarcation Regulations is to acknowledge that while health insurance policies have a role in the market, these policies must operate within a framework whereby they complement medical schemes and support the social solidarity principle inherent in the medical schemes. The intention is not to provide health policies that are equivalent to that of medical schemes. This process has highlighted the urgency for medical schemes to widen the net of coverage to allow a broader group of people with low income access to affordable coverage.

In this regard the Department of Health together with the CMS will be undertaking further research into the development of a Low Cost Benefit Option (LCBO) guideline. It is envisaged that the existing primary healthcare insurance policies will be required to transition into a LCBO framework once finalised.

Main comments

Element	Who commented?
It is argued that there have not been any legislative measures put in place to create LIMS and, in the interim, primary healthcare insurance cover provides an affordable alternative to medical aid. Submissions quote claims by Min. Motsoaledi on the need to move away from a hospi-centric model to a preventative primary healthcare model and argue that the Regulations overlook the fact that MS by and large do not cover primary healthcare outside of savings accounts. Therefore, primary health insurance products do not impact on the cross-subsidisation or community rating principles and it is argued that there is no good reason to prohibit insurers from offering primary health insurance products. Yet these products are not included in the Regulations and hence fall within the ambit of the MSA once the new definition of the business of a medical scheme comes into force. Much of these products are offered as a benefit by employers to their employee groups (called "employee assistance plans", "employee wellness plans", etc.) and are not available on the open market. On this basis, insurers are then able to contract provider networks. It is argued that any contract in terms of which benefits are provided by a benefit fund established in terms of a collective agreement concluded in terms of the Labour Relations Act, 1995 should be included in the ambit of the Regulations. It would be untenable for them to register as a medical scheme as they cannot meet the PMBs; neither would they be able to meet the administration costs and statutory solvency requirements. Currently, some bargaining councils obtain cover from long-term insurers at a low monthly premium, which affords employees limited, but useful benefits and access to some private	• Health insurers and underwriting management agents • Bargaining councils • Industry associations

healthcare that they would not otherwise have, though they will still rely on the public healthcare system for hospitalisation.	

Response and Demarcation Regulation position

The topic of Primary Health insurance products has come up in the Demarcation Regulations, as currently they are provided by insurers, however going forward, they will fall under the medical schemes regulatory framework once the expanded definition of the business of a medical scheme is implemented. No amendment has been made to the Regulations, as the appropriate framework for such products needs to be created within the ambit of the MSA.

The MoH has requested that the CMS grant a two year exemption for primary healthcare insurance policies, subject to certain conditions, while further research is being led by the Department of Health into the development of a LCBO guideline. It is envisaged that the existing primary healthcare insurance policies will be required to transition into a LCBO framework once finalised.

4.4.2. Process and technical inputs

A few submissions address the public consultation process followed and seek clarity on the technical basis for some of the positions reached in the second Regulations.

Main comments

Element	Who commented?
Policy process followed insufficient public consultation and technical work as basis for the provisions.	1 individual; health insurers
Competition Commission Inquiry As the inquiry will include reference of regulatory framework and insurance products, it is premature to implement regulation pending its outcome	Health insurers

Response

Process followed

Section 4.1 outlined the policy process followed and indicated the consultative nature of the process, including the formation of a public-private Demarcation Working Group. As indicated, the Regulations have undergone two rounds of public comments:

The first draft Regulations, published in March 2012, received a total of 365 submissions

Given the public interest in the Regulations, the NT issued the first Regulations for a second round of consultation in April 2014 and extended the closing date for comments on the second draft to the end of July 2014 after receiving some 40 requests for such an extension. The NT received 461 comments on the second draft.

Government has been fully transparent, publishing all comments received and compiling a detailed comments matrix to inform the deliberations around the revised positions. During the consultation process, Government has met with various insurance, medical scheme as well as NGO stakeholders. The NT and the Department of Health have undertaken an open process of engaging all interested parties and giving consideration to their comments in refining the policy proposals.

Technical inputs

The First draft Regulations were informed by industry data sourced through an FSB information request, as well as a technical analysis conducted by the CMS and submitted to the Demarcation Working Group.

The revisions in the March 2012 version were informed by data and information provided in the submissions, as well as further inputs by the FSB and CMS. Certain elements, such as the proposed R3,000 limit for LTIA Regulations Category 1 and STIA Regulations Category 2 were informed by data contained in a report prepared by Lighthouse Actuarial Consulting for the FinMark Trust in 2012.

Competition Commission Inquiry

Waiting for the Inquiry is likely to push the Regulations out significantly. Given the long process to date, this would be an undue delay. NT will review the position once the inquiry results are finalised.

Demarcation Regulation position

The finalisation of the Regulations was informed by data and information in the 461 submissions received, as well as additional data on claims, product features and policyholders requested on the basis of a number of the submissions received. The final positions represent a position agreed upon between NT, the FSB, the DoH and the CMS in terms of those product parameters and market conduct requirements necessary to ensure that a complementary space is carved out for insurance products while ensuring that the objectives and principles of the MSA are not undermined.

4.4.3. Drafting clarifications

Category	Name	Policy benefits	Criteria
1	Medical expense shortfall cover	Covers the costs or expenses of a relevant health service that in respect of the minimum benefits provided for under Regulation 8 of the Regulations made under section 67 of the Medical Schemes Act, 1998 (Act No. 131 of	▪ Policy benefits are one or more sums assured stated in the contract in Rand terms. ▪ Policy benefits may not

		1998) as published in GN R1262 of 1999, as amended from time to time, – (a) does not constitute a minimum benefit; or (b) constitutes a minimum benefit not paid in full by a medical scheme.	exceed the maximum amount referred to in sub-regulation (3) per day per insured person. ▪ Insured person/s must be a member/s of a medical scheme. ▪ Contract must provide for an annual term and monthly premiums.

Relevant Second Draft Demarcation Regulations extract

Regulation 7.2(1):

(4) The maximum amount referred to under category 1 in the table under sub-regulation (1) is R 3 000,00 (three thousand Rand) and category 2 in the table under sub-regulation (1) is R 50 000,00 (fifty thousand Rand), which amounts escalate annually from the effective date of this Part by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

Element	**Who commented?**
Drafting errors: Several submissions pointed out the wrong category reference in the description of benefit limits for shortfall cover in the STIA Regulations, as well as the need for clarification of what limits apply to aggregate annual benefits, what to lump sum and what to daily benefits. The following revised wording was suggested: "The maximum amount referred to under category 1 in the table under sub-regulation (1) is R 50 000, 00 (fifty thousand Rand) per individual per annum and category 2 in the table under sub-regulation (1) is R 3 000, 00 (three thousand Rand) per individual per day…" Furthermore, there was an erroneous reference to "sub-regulation 3" in the STIA Regulations instead of "sub-regulation 4". *Drafting clarifications*: The submissions point out the need for clarifications in a number of instances, including: - Only use "frail care" and not custodial care to prevent confusion with regard to frail care benefits - Current wording of Category 1 (LTIA Regulations) and Category 2 (STIA Regulations) definition may be extended to all income replacement policies on a health event, e.g. critical illness, and that is not the intention.	Several insurers, a medical scheme and industry associations

Element	Who commented?
- The fact that the word "variation" is not permitted (7.7.2(d)), may imply that no pricing changes are allowed - For income replacement/lump sum policies, clarify the trigger as being a health event or disability; propose removal of term “lump sum” from name, as may also pay per day. - Clarify what exactly is meant by “a minimum benefit not paid in full by a medical scheme”, as MSA requires the PMBs must be paid in full and at cost.	

Response

All drafting errors have been corrected in the final Regulations. Drafting has been amended to ensure that the intended meaning is clear in all of the instances highlighted above.

4.4.4. Commission structures

The matter of commission was the single biggest point of contention in all of the broker and most of the individual submissions and was also given prominence in most of the other submissions.

Relevant Second Regulations extract

STIA Regulations:

1. Amendment of Part 5 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 R1076 of 2011:

Regulation 5.3 of the Regulations is hereby substituted for the following:

“Maximum commission payable

5.3 (1) No commission shall exceed, in respect of -

(a) a motor policy, 12,5 per cent of the premium payable under the policy;

(b) any other short-term policy, other than a contract identified as an accident and health policy under Part 7 of the Regulations, 20 per cent of the premium payable under the policy.

(2) Commission payable in respect of a contract identified as an accident and health policy under Part 7 of the Regulations is subject to the maximum compensation and other requirements prescribed under regulation 28 of the Regulations made under the Medical Schemes Act, 1998 (Act No. 131of131 of 1998) pursuant to section 65(2) of that Act, 1998 (Act No. 131 of 1998).”.

1. Amendment of Part 3A in the Regulations under the Long-term Insurance Act, 1998 as published in GN R1492 of 1998 and amended by GN R197 of 2000, GN R164 of 2002, GN R1209 of 2003, GNR.1218 of 2006, GN R186 of 2007, GN R952 of 2008 and GN R1076 of 2011:

Part 3A of the Regulations are hereby amended by:

(a) the substitution for sub regulation (2) in Regulation 3.2 of the Regulations for the following sub regulation:

"(2) Subject to sub regulation (3A), no commission shall be paid or accepted otherwise than in accordance with this Part generally, and specifically as specified in the Table.";

(b) the insertion after sub regulation (2A) in Regulation 3.2 of the Regulations of the following sub regulation:

"(3A) Commission payable in respect of a contract identified as an accident and health policy under Part 7 of the Regulations is subject to the maximum compensation and other requirements prescribed under regulation 28 of the Regulations made under the Medical Schemes Act, 1998 (Act No. 131of 1998) pursuant to section 65(2) of that Act, 1998 (Act No. 131 of 1998) ."; and

LTIA Regulations

Brokers or financial advisers who sell health insurance products covered by the Regulations will be subject to the same commission limit that applies to medical scheme brokers and advisers. This limit was set at three percent of contributions, to a maximum of R71.07 a month (excluding VAT).

Main comments

Element	Who commented?
Alignment with MSA commission levels will undermine sales and servicing of these insurance products. Higher premiums in medical schemes mean that the absolute monthly amount of commission is much higher in the MS environment than the percentage allowance in the Regulations would entail. Most clients make the decision to join a medical scheme before an insurance product is sold as add-on/complementary and limiting broker commissions will therefore not impact on the choice of medical scheme option. Furthermore, the medical scheme limit of R71.07 ex VAT has not been revised to keep track with inflation. Several submissions make a proposal for a sliding scale commission structure aimed at encouraging low-income market sales.	All broker submissions, plus most other submissions, including individuals, insurers and associations

Response and Demarcation Regulation position

The regulation of commission is aimed at introducing parity in the incentives to sell medical schemes and health insurance policies covered by the Regulations and limits product providers from incentivising brokers to excessively sell health insurance products instead of medical scheme membership. In finalising the position in this regard, NT has considered to which categories of products such adverse broker incentives could apply and has determined the following:

STIA Category 1 (medical expense shortfall cover): This category of products is only available to medical scheme members; thus no adverse broker incentives should exist to substitute medical scheme membership with insurance. However, it may be that buy-down is being encouraged. For this reason, a commission structure is called for that provides adequate compensation while aligning with practices in the medical schemes environment.
STIA Category 2/LTIA Category 1 (Non-medical expense cover as a result of hospitalisation): strong arguments have been made that this product does not serve the same target market as medical schemes. However, a situation could be conceived where broker incentives may matter.
STIA Category 3/LTIA Category 3 (HIV, Aids, tuberculosis or malaria testing and treatment): Similar to above, a situation could be conceived where broker incentives may matter.
The rest of the categories are clearly not directly in conflict with medical scheme membership and therefore does not need to be subject to the same commission restrictions.

NT acknowledges the arguments put forth in the submissions regarding the impact on the broker industry and the implications of generally lower absolute commission amounts than under the medical schemes environment. A sliding scale commission structure has been adopted whereby a maximum of 5% monthly commission is applicable to premiums above R1,200/month, a maximum of 10% for premiums between R601 to R1,200, a maximum of 15% on premiums between R300 to R600 and a maximum of 20% for premiums less than R300. This structure will only apply to LTIA Category 1 and 3; and STIA Category 1, 2 and 3 products. The normal commission regulations will apply to the remaining products.

This structure incentivises the selling of low cost policies whilst not creating adverse broker incentives in respect of products with medium to high premiums. The decision was taken not to increase the number of monthly premium bands relating to the sliding scale to avoid an over complicated structure.

Where a policy has different benefit components of which one of the components are a product contemplated in LTIA Category 1 or 3; or STIA Category 1, 2 or 3, and it is not possible to ascertain what portion of the total premium is attributable to the different components, the maximum amount of commission that may be paid in respect of the whole of the combined policy may not exceed the maximum commission allowable in respect of LTIA Category 1 or 3; or STIA Category 1, 2 or 3 products.

The following table outlines the sliding scale:

TABLE A	
Monthly premium band	**Maximum Commission Level**
Above R1,200	5%
R601 to R1,200	10%
R300 to R600	15%
Less than R300	20%

4.4.5. Product category definitions

This sub-section sets out the main comments and responses regarding the definition and limits (where applicable) for each of the categories of products included in the STIA Regulations and LTIA Regulations, respectively.

LTIA Regulations Category 1, STIA Regulations Category 2 (income replacement policies)

Relevant Second Regulations extract:

LTIA Regulation 7.2(1):

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 insured persons experiencing a specified health event.	• Policy benefits are one or more sums assured stated in the contract in Rand terms. • The aggregate of the policy benefits payable under all policies issued by an insurer and its related parties to a specific person may not exceed the maximum amount referred to in sub-regulation (4) per day per insured person. • Contract must provide for an annual term and monthly premiums. • An elimination or deferred period may apply before policy benefits are paid.

(3) The maximum amount referred to under category 1 in the table under sub-regulation (1) is R 3 000,00 (three thousand Rand) escalate annually from the effective date of this Part by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

Element	Who commented?
R3,000 daily limit not sufficient in line with TCF requirement to meet consumer needs. Proposals are made to allow for either daily benefit or a lump sum benefit on such policies. It is also stated that medical inflation is well above CPI and that CPI adjustments will therefore not be sufficient. Benefits are usually payable per day, even though they do not indemnify against medical expenses. Reference in the definition to policy benefits being one or more sum assureds stated in the contract in Rand terms is therefore misleading and should be revised. It is also proposed that the term "lump sum" be removed from the name of the category, as it creates confusion where the benefits are payable per day. Some submissions, however, argue that provision should also be made for the payment of lump sum income replacement amounts upon hospitalisation that are not paid on a per-day basis. Overall, drafting clarification is required on the definition. Annual term too long for short-term policies, too short for long-term policies: most ST policies are based on monthly contracts, thus annual term will affect capital reserving. Specification of annual term excludes whole life policies, which are common in so-called Hospital Cash Plans currently on the market; why necessary to restrict?	Industry associations Insurers

Response and Demarcation Regulation position

Based on a review of industry practices, it was decided not to amend the R3,000 per day limit, but to include provision for future review of the limit in line with market practices. A lump sum benefit of R20,000 per annum, irrespective of the days in hospital, will also be allowed.

In addition, it has been made a requirement that such a contract may not require that a person is hospitalised for longer than three days before benefits becomes payable and, if benefits become payable, they must be paid from day one of hospitalisation. These requirements have been inserted to avoid the exploitation of policyholder through the offering of inappropriate products. A mechanism must be found to deal with fraud in the market.

No provision is made for "medical inflation" as such provision will entrench the phenomenon of above-CPI medical cost increases.

Due to the potential confusion that might result from the term "lump sum or income replacement", the contract has been renamed "non-medical expense cover as a result of

hospitalisation". Wording has been amended to remove all other uncertainties. The intention is that where a person is hospitalised, such policies should cover expenses other than medical expenses. This is to ensure that such policies do not compete and undermine the medical schemes environment. To further this intention, policy benefits under the contract may not be paid or ceded to a provider of a health service. The requirement for an annual term will not be retained.

STIA Regulations Category 1 (shortfall cover)

Relevant Second Draft Demarcation Regulations extract

STIA Regulations Regulation 7.2(1):

Category	Name	Policy benefits	Criteria
1	Medical expense shortfall cover	Covers the costs or expenses of a relevant health service that in respect of the minimum benefits provided for under Regulation 8 of the Regulations made under section 67 of the Medical Schemes Act, 1998 (Act No. 131 of 1998) as published in GN R1262 of 1999, as amended from time to time, – **(c)** does not constitute a minimum benefit; or **(d)** constitutes a minimum benefit not paid in full by a medical scheme.	• Policy benefits are one or more sums assured stated in the contract in Rand terms. • Policy benefits may not exceed the maximum amount referred to in sub-regulation (3) per day per insured person. • Insured person/s must be a member/s of a medical scheme. • Contract must provide for an annual term and monthly premiums.

STIA Regulations, Regulation 7.2(4):

(4) The maximum amount referred to under category 1 in the table under sub-regulation (1) is R 3 000,00 (three thousand Rand) and category 2 in the table under sub-regulation (1) is R 50 000,00 (fifty thousand Rand), which amounts escalate annually from the effective date of this Part by the Consumer Price Index (CPI) annual inflation rate published by Statistics South Africa (as defined in section 1 of the Statistics Act, 1999 (Act No. 6 of 1999)).

Element	Who commented?
It is argued that the R50,000 shortfall cover limit is not sufficient, especially where procedures not covered by PMBs are concerned. Several submissions quote claims data where clients would be left out of pocket in the event of a R50,000 limit and suggest that a R100,000 limit would be more realistic. It is also stated that medical inflation is well above CPI and that CPI adjustments will therefore not be sufficient. The fact that shortfall cover may only cover PMBs if not paid in full by a medical scheme is not a necessary or feasible restriction, as PMB legislation is complex to implement and subject to interpretation challenges, plus is not the ambit of health and accident and health insurers, but of medical schemes. Proposals are made to remove all reference to PMBs from the STIA Regulations. Category 1 (STIA) policies should be able to cover any shortfall in medical expenses within the limits stipulated for members of medical schemes. This will mean that any dispute arising from the action of a medical scheme in relation to a PMB expense will be adjudicated only by the CMS, as is currently the case. Where the product category definition is concerned, it is specified that “Policy benefits are one or more sum assured stated in the contract in Rand terms”. It is argued that shortfall cover by nature covers a shortfall of which the exact amount cannot be determined ex ante. Imposing a defined benefit structure on shortfall cover will push up average claims cost. Several proposals suggest revising the reference to sum assured to refer to the *maximum cover amount* or, alternatively, to replace reference to "sum assured" with "events". Annual term too long for short-term policies, too short for long-term policies most short-term policies are based on monthly contracts, thus annual term will affect capital reserving.	Industry associations Insurers & underwriting management agents Individual brokers & financial planner industry association

Response and Demarcation Regulation position

Based on data provided in submissions, the decision was made to raise the annual limit to R150,000. Indications are that such a limit would not undermine the objectives and purpose of the MSA and will allow enough room to ensure that members are not left significantly out of pocket for certain procedures.

Wording has been amended in the STIA and LTIA tables to clarify the intention. The revised wording is in line with the intention of the Regulations to cap the maximum amount for shortfall cover, not to completely delink it from expenses.

Reference to policy benefits having to be a “sum assured” has been removed.

The complexity introduced by reference to PMB legislation is noted. Reference to PMBs in STIA category 1 has been removed. Insurers will now only be able to cover the difference between the total costs or expenses of a relevant health service and the amount a person’s medical scheme paid towards such costs. Costs or expenses not covered by a person’s

medical scheme may not be covered. The requirement for an annual term will not be retained.

Third party liability policies (motor and property)

Relevant Second Regulations extract

3	**Motor: Third Party Liability**	Covers insured persons for the costs of a relevant health service following the injury of a third party (other than the insured persons) as a result of an accident.	• Policy benefits may be linked to actual costs or expenses of a relevant health service.
4	**Property Third Party Liability**	Covers insured persons for the costs of a relevant health service following the injury of third parties (other than the insured persons) while at the property of the insured persons.	• Same as for category 3.

STIA Regulations 7.2(1) Categories 3&4

Main comments

Element	Who commented?
Third party liability/indemnity insurance does not impact on the objectives and purpose of MSA and hence do not warrant the product restrictions contained in Sections 7.3 through 7.6.	Industry associations Underwriting management agent

<u>Response and Demarcation position</u>

These products were reconsidered. The decision has been taken that where such a product meets the expanded definition of the business of a medical scheme, the product must be sold under the MSA. Liability type products that do not meet the expanded definition of a medical scheme as defined in the MSA can be sold under the STIA as a liability policy. For this reason, category 3 and 4 (ST) were removed from the ambit of the Regulations.

Frail care cover

Relevant Second Regulations extract

LTIA Regulation 7.2(1) Category 2:

2	Frail care	Covers custodial care (assistance with activities of daily living) for insured persons.	• Policy benefits are one or more sums assured stated in the contract in Rand terms or ascertainable on a pre-determined basis set out in the contract. • Policy benefits may be paid in kind or to a provider of a relevant health service. • Policy benefits may be linked to actual costs or expenses of a relevant health service. • Policy benefits may be paid on a pre-funded or immediate needs basis. • An elimination or deferred period may apply before policy benefits are paid.

Main comments

Element	Who commented?
The definition reads that policy benefits may be paid in kind or to a provider of a relevant health service. Clarify that it will also be permitted to pay policy benefits directly to the insured.	One insurer, one medical scheme

Response and Demarcation Regulation position

Drafting has been amended to allow policy benefits to also be payable to the insured directly. These products are included in the Regulations because they meet the expanded definition of the business of a medical scheme by virtue of providing for obtaining a health service. It has been accepted that policy benefits do not have to be a sum assured.

Drafting has been amended to ensure that only restrictions or requirements that are relevant to these product categories are made applicable to such products.

HIV/AIDS cover

Relevant Second Regulations extract

STIA Regulations, Regulation 7.2(1) Category 5:

5	HIV and Aids	Covers expenses for HIV-related testing and HIV and Aids treatment on an employee group basis for employees and their dependents.	• 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. • An elimination or deferred period may apply before policy benefits are paid.

Main comments

Element	Who commented?
• A number of submissions argue that there is no reason for singling out HIV/AIDS cover as permissible. It is suggested that, if the same policy objectives are met, the category should be extended to other conditions such as TB and diabetes, as well as to events such as emergency care and counselling for rape victims, and to other groups like unions or church groups. Some argue that HIV/AIDS cover should not be limited to employee groups to the exclusion of the unemployed and other groups; this would entail "unfair discrimination". • A drafting clarification is requested so that policy benefits can also be payable directly to the insured (not only in-kind or to the service provider).	Industry associations, insurers and underwriting management agents

Response and Demarcation Regulation position

Drafting has been amended to allow policy benefits to also be payable to the insured directly.

The category has been expanded to include tuberculosis and malaria. The provisions regarding group risk rating in in the new regulation 7.3(2) of the LTIA and STIA Regulations will apply to this product category. Discrimination will only be allowed in the circumstances provided for in the new regulations.

In respect of the LTIA Regulations, the HIV, Aids, tuberculosis or malaria testing and treatment benefit can only be provided as a rider benefit.

Travel insurance policies

Relevant second Regulations extract

6	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.
7	Domestic travel insurance	Covers costs associated with a relevant health service incurred as a result of a health, disability or death event that occurs while travelling – **(a)** inside the Republic of South Africa; and **(b)** in a province other than the province in which the insured persons and their dependants are not ordinarily resident.	Same as for category 6.

Main comments

Element	**Who commented?**
It is argued that the restrictions on travel insurance are not necessary in light of market features, and will severely curtail the market. Amongst others, it is argued that travel insurance has no bearing on the objectives and purpose of the MSA, including the principles of community rating, open enrolment and cross-subsidisation. Reduced commission and file and view requirements will simply halt any sales. No risk rating means that a young person must now subsidise an older person's business or holiday trip.	Industry associations, insurers and underwriting management agents

Response and Demarcation position

These products are included in the Regulations because they meet the expanded definition of the business of a medical scheme by virtue of providing for obtaining a health service.

After careful consideration it has been decided to remove the Domestic travel insurance category as the benefits usually provided under such policies can be accounted for under other insurance policies / classes of insurance business. The International travel insurance category will remain. The restrictions provided for in regulations 7.2 to 7.6 (contained in the second Draft STIA Regulations) as it relates to this category have been reconsidered. Drafting has been amended to ensure that only restrictions or requirements that are relevant to this product category is made applicable to such product. The contract description has been amended slightly to ensure that the international travel insurance category can be written to also cover foreign nationals travelling in South Africa.

Emergency evacuation policies

Relevant Second Regulations extract

STIA Regulation 7.2(1) Category 8:

8	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 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.

Main comments

Element	Who commented?
The restrictions are unnecessary given the nature of emergency evacuation products and are unconstitutional given the right to emergency care. Submissions caution against use of terms like "stabilised" and "guaranteed access" and request clarification whether the intention is to limit the category to an emergency facility.	Industry associations, insurers and underwriting management agents

Response and Demarcation Regulation position

These products are included in the Regulations because they meet the expanded definition of the business of a medical scheme by virtue of providing for obtaining a health service. The restrictions provided for in regulations 7.2 to 7.6 (contained in the second draft Regulations) as it relates to this product category have been reconsidered. Drafting has been amended to ensure that only restrictions or requirements that are relevant to this product category is made applicable to such product.

The description has been clarified to give effect to the true intention of the Regulations. The contract description has been changed by removing the reference to "stabilised" and "guaranteed access" and providing that the cost of emergency medical treatment can be covered. This product category will therefore entail a contract that covers the costs of emergency evacuation or transport, or provides emergency evacuation or transport, to a medical treatment facility; or cover the cost of emergency medical treatment.

4.4.6. Basis of underwriting

This sub-section considers the provisions requiring no individual risk rating (stated in the second Regulations as "no unfair discrimination"). The comments in this regard cover three sub-topics, namely:

- Pre-existing conditions / exclusions;
- Waiting period restriction; and
- Age banding of premiums and/or stipulations for maximum age of entry.

Relevant Second Regulations extract

STIA & LTIA Regulations, 7.2(2), extract from STIA Regulations:

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

(a) unfairly discriminate directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health;

(b) provide for waiting periods exceeding 6 months;

(c) 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;

(d) 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; and

(e) in relation to a contract referred to in category 2 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

(f) in relation to a contract referred to in categories 1, 2, 3 or 4 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; or

(g) in relation to a contract referred to in categories 2 to 8, provide that the policyholder or insured person

Main comments

Elements	Who commented?
Without being accompanied by provisions for maximum age of entry, allowable exclusions/premium penalties and longer waiting periods, this provision will lead to anti-selection to the extent that it will undermine the provision of such insurance products. It is argued that it is already common practice for health and accident and health policies to apply group risk rating, whereby no individual medical underwriting is done to determine premiums at an individual level, but premiums are simply a function of level of cover and age of entry. Such group-rated products apply measures to curb anti-selection that apply across all policyholders, such as prolonged waiting periods for certain conditions (for example pregnancy, for which a six month only waiting period would lead to anti-selection) and excluding certain pre-existing conditions. The individual is not refused cover, but the condition on which they can claim is managed. Moreover, it is argued that MSA provisions effectively allow for many of the practices applied in the group rating space in the insurance market. Several submissions request alignment with equivalent provisions in the MSA: In terms of MSA Regulation 29A, medical schemes may impose a general waiting period of up to three months or a condition-specific waiting period of up to twelve months. "Late joiner" fees may also be imposed in terms of Regulation 13 of the MSA. This is essentially a form of risk rating. A number of submissions argue for the inclusion of the ability to charge different premiums for different age at entry categories (but without any individual discrimination). For example: one premium would apply to all that enter into the policy before age 60 and another for all those who enter above age 60. It is also argued that limiting the maximum age of entry is an essential feature to prevent anti-selection and that removing the ability to do so will have a substantial impact on pricing in the market. It is submitted that the ambiguity in the term "no unfair discrimination" should be removed by including specific reference to community rating (allowable mechanisms for premium variation that do not apply on an individual level). Wording is proposed to the effect that premiums may not vary by age, health status or gender for policies with equivalent levels of benefits. This would entrench principles of community rating as currently afforded to members in the medical scheme environment. It is also requested that the concepts of "open enrolment" and "guaranteed	Industry associations Insurers Underwriting management agents A hospital group A medical scheme

access” need to be clearly defined. Clarify whether "no underwriting" is applicable to all products, or just shortfall cover. If to all, the submission is that there cannot be a blanket prohibition on pre-existing conditions in all instances, as for example travel insurance excludes pregnant women over a certain number of weeks in line with travel restrictions. Clarify whether the requirement for no discrimination is applicable to across groups, or only within groups. For example: should the same pricing be applied to different employer groups? In line with the practice of different closed medical schemes being able to charge different contributions to their members depending on the group’s profile and utilization, the contention is that it would seem logical that different groups should be charged different premiums if they are the policyholder of a group policy.	

Response and Demarcation Regulation position

The NT acknowledges the validity of the anti-selection arguments made and the fact that the requirements need not be more onerous than those that apply in the medical schemes environment.

A definition of “underwritten on a group basis” has been introduced in both the LTIA and STIA Regulations. Only category 1 and 3 products under the LTIA Regulations and category 1, 2 and 3 products under the STIA Regulations must be underwritten on a group basis.

In respect of products underwritten on a group basis, discrimination will still not be allowed except in the circumstances provided for. An insurer will however be able to determine different premiums based on the age of policyholders. However, the premium bands must apply to all policyholders under that specific age.

In respect of waiting periods that may be imposed under products underwritten on a group basis, the following will apply: a general waiting period of three months may always be imposed; anda condition-specific waiting period of 9 months may be imposed. However, if a policyholder had a similar policy within 90 days of entering into the new policy and already completed a condition-specific waiting period, a new condition specific waiting period may not be imposed on the policyholder under the new policy. If a condition-specific waiting period was partially completed, a pro-rata condition-specific waiting period may be imposed.

4.4.7. Product provisions

Relevant Second Regulations extract:

STIA Regulations, regulation 7.2(2):

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

(a) unfairly discriminate directly or indirectly against any person on any of the following or similar grounds: race, age, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health;

(b) provide for waiting periods exceeding 6 months;

(c) 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;

(d) 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; and

(e) in relation to a contract referred to in category 2 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

(f) in relation to a contract referred to in categories 1, 2, 3 or 4 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; or

(g) in relation to a contract referred to in categories 2 to 8, provide that the policyholder or insured person must be a member of a medical scheme.

STIA Regulations, Regulation 7.2(3):

(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) if that contract is a contract referred to in category 1 that relates to a relevant health service that is not a prescribed minimum benefit, provide for a 90-day notice of termination period to a policyholder if the relevant health services becomes a prescribed minimum benefit because of any amendment made under the Medical Schemes Act, 1998 as to what constitutes minimum benefits;

(c) 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;

Element	Who commented?
A number of submissions ask for clarification of the practical implications of the provisions set out in Section 7.2(2) of the revised Regulations, including: 7.2(2)(d) requires no "variation" in response to claims experience. What if a person's claims experience contributed, in aggregate, to premium increase due to the overall book experience? Is variation allowed for the whole book based on overall claims experience? It is also submitted that premium increases are in fact a variation of an insurance contract and, accordingly, that the reference to "variation" should be removed. 7.2(2)(a), read together with (c) and (d) effectively remove any option of cancellation outside of entire book cancellations. It is argued that the inability to cancel will impact adversely on insurers and policyholders by negatively impacting on pricing and reserving. It is argued that allowing refusal of claims due to a health event having occurred prior to commencement of the cover goes against current insurance practices and is inconsistent with the STIA and the definition of risk contained therein. With regard to STIA Regulations Section 7.2(3)(a), which relates to the need for a 90-day notice period in the case of termination, it is argued that: Category 2 should be excluded from this provision due to the fact that category 2 does not deal with medical expenses. It is also suggested that categories 6 and 7 be excluded from this provision as same is not applicable to the travel environment. This provision should be amended to relate only to annual policies and not to short-duration polices, as it is not possible to give 90 days' notice on a one-month policy. It is furthermore argued that STIA Regulations Section 7.2(3)(c), which requires disclosure of all details to the policyholder which are regarded by the insurer as material to its assessment of the risks under the policy, contradicts Regulation 7.2(2)(a), which requires no individual risk assessment	Industry associations

Response and Demarcation Regulation position

NT acknowledges the arguments around premium adjustments on the entire book based on claims experience, the implications of a 90-day notice period for short-term policies, as well as the confusion around references to material risk elements in cases where no individual risk rating is allowed.

Regulation 7.2 has mostly been redrafted. With regards to underwriting requirements, discrimination and waiting periods please refer to the discussion under section 4.4.6 above.

The limitations and product provisions which previously applied to all product categories, have been amended to mostly apply to category 1 and 3 (LT) and category 1, 2 and 3 (ST) products and, where applicable, the other product categories.

Limitations regarding category 1 and 3 (LT) and category 1, 2 and 3 (ST) products which have been clarified are the following:

- Such products may be varied as a result of the health or claims experience of the whole book of policies, but may not be varied as a result of the health or claims experience of an individual policyholder; and
- Such products may only be terminated (excluding category 3 (LT)) under certain circumstances, e.g. non-payment of premiums, fraud or if the insurer will, as part of its business, stop offering such policies altogether.

No product categories may require that a policyholder is a member of a medical scheme except a category 1 (ST) product (as the member must be a member of a medical scheme under such a product).

Information similar to the information referred to in section 48(1) of the LTIA must be contained in any of the contracts under the STIA Demarcation Regulations.

4.4.8. Marketing and disclosure provisions

Relevant Second Regulations extract

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

(a) not identify that contract 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)(c).

Main comments

Element	Who commented?
Section 7.3 requires that marketing may not: *Use the term "hospital" or "medical":* It is argued that this is not in line with TCF requirements for simple and clear language and that the public must not be misled. A number of submissions argue that policies that pay cash upon hospitalisation should be advertised as such so that customers know what they are getting. The same argument is put forth for emergency and evacuation cover where guaranteed admission to a hospital is included. Commentators are willing to accept a prohibition against the term "medical" or "doctor", but request that the term "hospital" or "hospitalisation" may be included in the policy wording, if not in the name of the product. *Create the impression that a contract indemnifies a person against medical expenses* It is argued that cover such as HIV/AIDS cover, emergency evacuation and shortfall cover does indemnify against certain medical expenses.	Industry associations Insurers One medical scheme

Response and Demarcation Regulation position

It is acknowledged that the words "hospital" and "medical" may be essential to defining the nature of the policies in question. It is however still a concern that their use for marketing purposes can be misleading to the public, who may confuse such products with medical schemes.

Section 7.3 has been redrafted to allow for the use of the terms "hospital" and "medical" in descriptions of benefits in policy wordings. However, these terms may not be used in any marketing materials regarding the policies, or in the name of the policy. Further, the term "non-medical expense cover as a result of hospitalisation" may be used to describe a category 1 (LT) and category 2 (ST) product as well as the term "medical expense shortfall" to describe a category 1 (ST) contract. The requirement to display a prominent statement that the product is not a substitute for a medical scheme will be retained. All of the aforementioned requirements will only apply to category 1 and 3 (LT) and 1, 2 and 3 (ST) products.

4.4.9. Limitation on combination of policies

Regulation 7.4 of both sets of revised draft Regulations deals with limitations on the combination of policies.

Relevant Second Regulations extract

7.4 An insurer may not alone or with a related party, directly or indirectly, develop or offer to policyholders or potential policyholders accident and health policies referred to in this Part which policies collectively may result in the aggregate of the policy benefits under those policies being 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.

Main comments

Element	Who commented?
A few commentators question the practicality of unbundling existing products, as well as the impact on consumers' constitutional rights to a benefit package that meets their needs. It is requested that the scope bundling with products outside the business of a medical scheme be clarifies, as well as for bundling with "related parties" in the same group.	Industry associations Two insurers One underwriting management agent

Response and Demarcation Regulation position

The NT and the FSB have agreed to remove the prohibition on bundling in the Regulations however these products will be closely monitored by the FSB.

4.4.10. Reporting of product information

Regulation 7.5 of both sets of revised Regulations deals with reporting of product information.

7.5 (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 to the Registrar and Registrar of Medical Schemes –

(a) a summary of the benefits, terms and conditions and marketing material of that accident and health policy; and

(b) a summary of the benefits, terms and conditions and marketing material of other accident and health policies referred to in this Part offered by the insurer or a related party of the insurer to policyholders and potential policyholders.

(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 and the principles referred to in 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.

Main comments

Element	Who commented?
Reporting of product information before launch: clarify what is included and the means for doing so, as well as whether express approval is required before launch. Clarity is sought on what constitutes a "new" policy and it is argued that this provision should exclude policy adaptations and renewals. It is furthermore argued that marketing materials are often not available yet one month before launch and should also be allowed post-launch. *The need to report to the CMS and powers of objection granted to the Registrar of Medical Schemes*: Several commentators argue against the fact that the CMS will be given "jurisdiction" over a component of the industry regulated by the FSB. It is requested that a time limit of three months be placed on the Registrar of Medical Scheme's ability to object to product features or advise that the insurer should stop offering the product, and that the powers granted to the Registrar be made subject to the Promotion of Administrative Justice Act (PAJA).	Industry associations Three insurers One underwriting management agent One hospital group

Response and Demarcation Regulation position

NT acknowledges the need for clarification as expressed in the submissions and has amended the final Regulations to that effect.

Drafting of regulation 7.4 has been amended and clarified. Reference to "introducing or launching" a new policy has been changed to "prior to marketing or offering a new product line" (the latter also being defined). This means that where an insurer establishes a new product and intends to market or offer it to the public, it will have to submit the requisite

information to the Registrar and registrar of Medical Schemes 3 months before it intends to do so.

The open-ended powers of objection remain in force; such a “file and use” framework is a developed practice within the FSB and internationally.

We take note of the objection to also submit the requisite information to the Registrar of Medical Schemes. However, the LTIA and STIA provides that if the Registrar makes Regulations declaring certain policies as health policies (LT) or accident and health policies (ST), the Regulations must provide for an insurer to submit specified information on such products to the Registrar and the Registrar of Medical Schemes. Therefore, if the Regulations do not require that the information must also be submitted to the Registrar of Medical Schemes, the Regulations will be contrary to the provisions of the STIA and LTIA. The wording has therefore been maintained and insurers will be required to submit the requisite information to both the Registrar and the Registrar of Medical Schemes.

4.4.11. Transitional arrangements

The Regulation (previously 7.6) deals with transitional arrangements. The previous requirements have been amended. The new requirements are as explained below.

7.6 (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 and the principles referred to in 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.

Relevant Second Draft Demarcation Regulations extract

Main comments

Element	Who commented?
It is argued that these provisions may contravene contractual obligations of existing policies and go against the TCF principles; it is proposed that the retrospective application of the regulation be removed, so that the Demarcation framework only applies to products after the effective date of the Regulations.	Industry associations A few insurers

Response and Demarcation Regulation position

NT notes the challenges around the retrospective application of Regulations and the practicality of requiring the cancellation of existing policies. The final Regulations have been redrafted to minimise such issues.

Insurers will not be required to submit information on existing products to the Registrar or Registrar of Medical Schemes.

In respect of the LTIA Regulations, policies entered into before the Regulations took effect must comply with the Regulations as and when such contracts are renewed subsequent to the Regulations becoming effective.

In respect of the STIA Regulations, policies entered into before the Regulations took effect must comply with the Regulations by 1 January 2018.

The Registrar may request information regarding any product from an insurer at any time and instruct an insurer to amend or stop providing the product.

4.5. Enforcement strategy

Several mechanisms will be implemented to monitor and enforce the implementation of the Regulations. The supervisory approach will entail certain off-site monitoring tools as well as the traditional onsite monitoring of insurers.

Off-site monitoring

As required by sections 72(2A)(b)(ii) of the LTIA and 70(2A)(b)(ii) of the STIA, the final Regulations will provide that insurers must submit certain specified information on products falling within the ambit of the Regulations to the Registrar of Insurance and Registrar of Medical Schemes.

It is proposed that this information will entail that insurers must, 3 months before it markets or offers a new product to the public, submit details of the summary of the benefits, terms and conditions and marketing material relating to such policies. This will enable the FSB

and CMS to monitor new policies that are introduced and assess whether such policies conform to the Regulations. Where policies do not conform or are contrary to the objectives of the MSA (on the recommendation of the CMS), the FSB will be able prohibit the insurer from launching such policies.

In respect of existing products, product details and materials for all such products launched before the amendments became effective will not be required to be submitted to the Registrar. However, should the FSB or the CMS become aware of products that do not conform to the new requirements after the products were renewed, the FSB will be able to instruct insurers to terminate or amend such products at any time if the benefits, terms and conditions or marketing material of those products is contrary to the objectives and purpose of the MSA (on the recommendation of the CMS).

The FSB is also in the process of finalising market conduct returns (not specific to the regulations) that will assist it in monitoring on an on-going basis the types of insurance policies, as stipulated in the regulations (amongst others), sold by insurers. This will include obtaining information relating to the number of policies issued for a particular period, number of policies lapsed or transferred in a particular period, claims and lapse ratios, gross premiums written and commission or other consideration paid in lieu of such policies. This information will assist the FSB in keeping abreast of conduct of business developments and market practices surrounding these policies and effectively assessing the risk profile of each insurer offering these types of policies.

The FSB will also take a proactive approach by requesting certain information from insurers (relating to health insurance policies offered by them) prior to the Regulations taking effect. This will enable the FSB to have a snapshot of the “pre-demarcation” landscape and subsequently identify the changes between the “pre-demarcation” landscape and “post-demarcation” landscape.

Onsite monitoring

In addition to onsite visits conducted as part of the normal supervisory approach, the FSB will conduct theme based visits specifically focused on the implementation of the Regulations. A time period of at least one year from the date on which the Regulations take effect will be allowed before such theme visits are initiated to allow ample time for the implementation of the Demarcation Regulations by insurers.

Additional supervisory tools will include Investigating complaints received that relate to the Regulations or other possible contraventions of the LTIA, STIA and MSA that has some bearing on Demarcation issues. Where warranted, such investigations could include conducting inspections. This approach will require close cooperation between the FSB and the CMS to determine where the relevant jurisdiction resides in each specific matter.

The FSB could also embark on mystery shopping initiatives to determine whether the way in which such insurance policies are sold and the perceptions that are created during the sales process aligns with the spirit and intention of the Regulations.

Enforcement

Implementation of the above supervisory mechanisms will ultimately lead to the identification of instances where enforcement actions are required. Enforcement actions will consist of implementing preventive and corrective actions to enforce compliance in respect of contraventions of the Regulations and related legislation. Enforcement actions will be taken against regulated and unregulated entities and individuals.

Enforcement will be achieved through a variation of communication with persons that sell insurance policies falling within the ambit of the Regulations and through more formal mechanisms provided for in legislation (such as directives). The type of enforcement action required will be informed by the financial institution's willingness and promptness in taking preventative or corrective actions and the seriousness and extent of any non-compliance or risks that has been identified.

Where a person fails to implement corrective actions, the FSB will enforce the implementation of such actions in a timely manner and will impose directives and sanctions based on clear and objective criteria. In certain instances, enforcement will result in punitive action in the form of a fine or penalty, not only to penalise the person concerned, but also to act as a deterrent to others.

5. Conclusion

The Regulations are the outcome of a consultative process between the MoF and MoH as well as the CMS and the FSB. This Key Response paper explains the approach taken in the Regulations.

The Regulations acknowledge that while health insurance products have a role in the market place, these products must operate within a framework whereby they complement medical schemes and support the social solidarity principle embodied in medical schemes. It is in this context that the final Regulations seek to strike a better balance between health insurance and medical schemes.

The conditions on health insurance products, as outlined below, seek to ensure that the design, marketing and sale of health insurance policies do not undermine the social solidarity principles in medical schemes, while at the same time serving the needs of those who require additional protection against health-related risks:

- prohibition on health insurance policies from discriminating against any person on the grounds of age, gender and other criteria;
- enhanced product disclosure/marketing requirements;
- alignment of broker commission between health insurance and medical scheme products;
- enhanced regulatory reporting and monitoring;
- product standards which limit policy benefits; and
- limitations on bundled type health insurance products which replicate medical schemes.

The Regulations touches on a number of complex health and financial sector challenges and affects many stakeholders. The Regulations seek to bring about greater policy certainty.

The NT, DoH, FSB and CMS takes this opportunity to thank all stakeholders who commented on the first and second draft Regulations and for their continued contributions to the development of the Regulations.

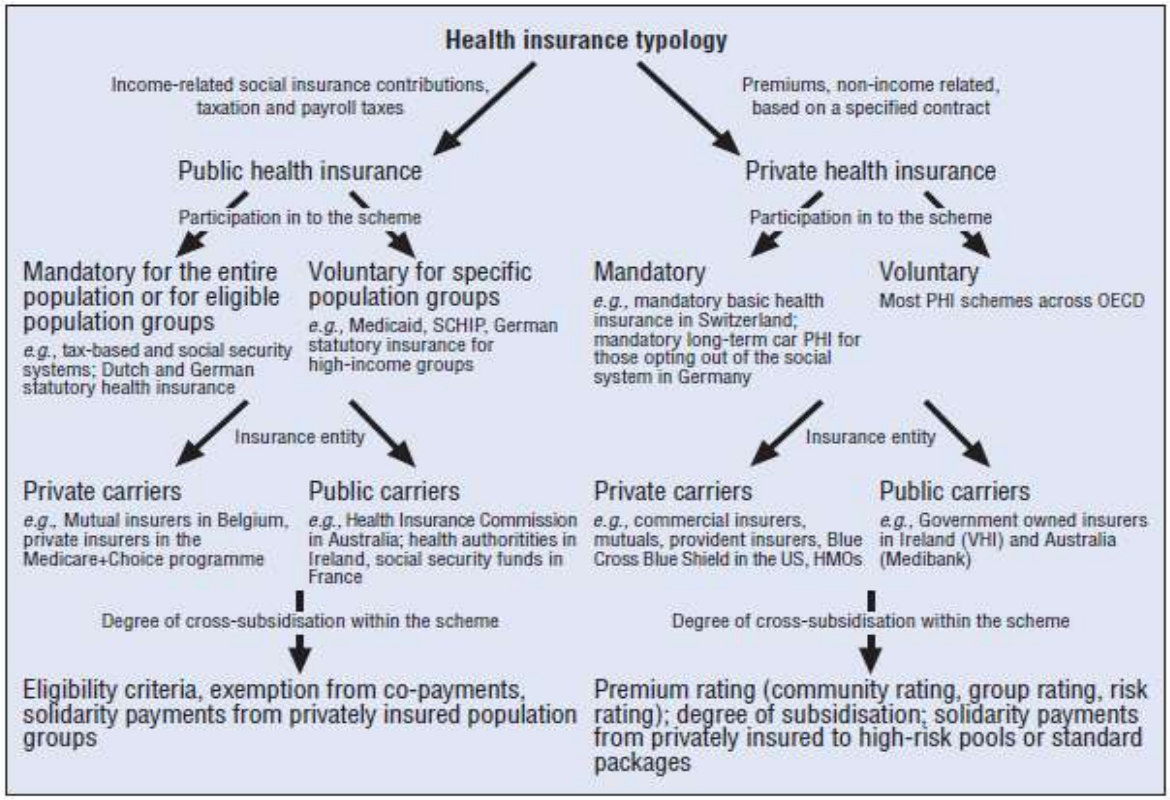
6. Annexure A: Health policy framework in South Africa

Healthcare financing in South Africa consists of two categories: public provision funded by the Department of Health and Private Health Insurance (PHI). The latter consists of medical schemes, which plays a significant role in financing access to private healthcare, and health insurance. PHI is primarily distinguished from public coverage programmes by its funding through non-income related premiums, paid usually on the basis of a contract between a private party and an insurance entity, as opposed to taxes or social security payroll contributions.

Box 2: South Africa's health policy framework in international context

The role of public financing vis-à-vis PHI: an international perspective

The following diagram outlines a typology for health insurance, showing the role of public health insurance vis-à-vis private health insurance (each of which can in turn be mandatory or voluntary)



The role of PHI internationally

PHI includes both medical schemes and health insurance. According to a recent OECD publication on private health insurance, PHI is a source of primary coverage for specific population groups in some countries, while it mainly duplicates universal coverage in in others – thereby offering a private alternative to public systems. PHI complements financing from public programmes by paying for cost-sharing in many OECD countries, and supplements public systems by financing goods, services and providers in

others. Often, PHI plays one main function, together with other less prominent roles.

PHI is purchased by over 30% of the population in a third of OECD members. Policy makers often look to PHI markets as an alternative or additional source of funding for publicly financed health systems, especially when these budgets are stretched to capacity and face increasing demands. Yet the vast majority of health financing in OECD countries continues to be derived from public sources, which account, on average, for 72% of total health expenditure (THE), compared to 6.3% for private health insurance and 19% for out-of-pocket payments (OOP).

The roles PHI performs, the size of the market and the contribution to financing healthcare vary greatly across countries. PHI dimensions and functions are shaped by the design of statutory health coverage and delivery systems, as well as by direct government interventions in PHI markets. Consumer desire to obtain more and faster care and satisfaction with publicly funded services also influence demand for private health insurance.

Access to coverage remains a key challenge facing private health insurance markets. Under light or little regulation, risk selection is typical of PHI markets and higher-risk individuals face access difficulties in obtaining and affording policies. Several OECD countries, especially those where PHI plays a primary or significant role, have intervened to promote availability and affordability of insurance.

Access problems assume more critical dimensions for the attainment of health-system performance goals when there are large gaps in public coverage systems. Access is often not equitable across income-groups, largely because PHI is typically purchased by high-income groups. For example, in duplicate systems, PHI furnishes a level of care, choice and speed of access to care above what is afforded by public systems. Where the private sector offers higher remuneration levels to providers than public systems do, this encourages high service volumes and productivity. However, this can lead to resources being diverted from the public system, which can reduce access to care for those who cannot afford private health insurance.

How does the health policy framework in South Africa compare to international best practice?

A recent paper published by the OECD finds that, compared to most OECD countries, South Africa has fewer doctors and nurses, limitations on revenues and challenges with delivery capacity in the public sector. This occurs against the backdrop of significant inequality and poverty. Over time, these factors have contributed to the emergence of a large private healthcare sector.

South Africa has a higher share of spending on private voluntary health insurance (largely via medical schemes) than any OECD country, and this market serves a smaller share of the population. Commonly found conventions in OECD countries, notably public sector price setting for specialist medical services that is used to purchase services from the private sector and can provide benchmarks for private insurers, and regulation that enables collective bargaining on hospital prices, are not present in South Africa.

Based on a comparative analysis between South Africa and OECD countries where medical schemes play a similar role, the paper recommends that “South Africa should separate the ‘technical’ task of establishing a schedule of medical services ranked according to their complexity from ‘political’ negotiations over overall payments to medical professionals. A technically sound price schedule is a common feature of OECD country health systems. It brings clarity for doctors, those that pay them, and ultimately, the patients that these institutions serve. Today, the South African healthcare system lacks

this clarity. This makes it hard for the public sector to draw on private healthcare services to expand access to care, and makes negotiations between private insurers and private facilities a more difficult process."

Sources:

OECD, 2004. Private health insurance in OECD countries. OECD Health Project (extracts quoted directly).

Kumar, A., et al, 2014. PRICING AND COMPETITION IN SPECIALIST MEDICAL SERVICES: An Overview for South Africa. OECD Health Working Paper No. 70. Available online: www.oecd.org/health/workingpapers

In addition to public healthcare and PHI, many individuals incur out of pocket expenses not covered through an explicit health financing vehicle. The 2004 OECD report emphasises that PHI does not appear to substitute for out-of-pocket payments internationally.

Below, some context is provided on each of the main channels of healthcare financing.

The public health system

Table 5 indicates an overview of the evolution of healthcare spending in South Africa. The public healthcare sector receives almost equal funding when compared to the private healthcare sector in GDP terms, yet is responsible for the healthcare needs of approximately five times the number of people, or around 84% of the population. It is thus critically over-burdened. According to the Health Systems Trust (2014), 37% of general practitioners and 59% of specialists operate in the private sector, which contains 35% of hospitals and 28% of hospital beds.

Table 5: Overview of the evolution of healthcare spending in South Africa

Year	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Total as % of GDP	8.00%	8.70%	8.70%	8.90%	9.00%	9.00%	8.70%	8.50%
Public as % of GDP	3.70%	4.10%	4.10%	4.40%	4.40%	4.40%	4.30%	4.20%
Public as % of total government expenditure	13.90%	14.00%	14.40%	15.00%	15.20%	15.50%	15.10%	15.00%
Private financing as % of total	50.80%	49.40%	49.80%	49.00%	49.40%	48.70%	48.90%	49.00%
Annual public sector real rand spend per capita 2010/11 prices	2 296	2 546	2 709	2 915	2 934	3 021	3 011	3 011

Provincial Departments of Health	74 898	88 465	97 957	111 324	122 551	134 574	140 801	149 592
Provincial expenditure as % of public expenditure	88%	87%	87%	85%	88%	88%	86%	86%

Source: National Treasury data

According to the Green Paper on National Health Insurance in South Africa, the country faces four clear healthcare burdens, which together place severe systemic strain on the public healthcare system, namely HIV/AIDS, maternal and infant mortality rates, non-communicable diseases, and injury and violence related medical events. Poverty exasperates the risks associated with several of the diseases in these categories. Since the public healthcare system is disproportionately responsible for providing care to the lower-income market South Africa, the burden on the public system is not only larger in absolute patient numbers, but also in terms of burden of disease.

In order to reign in private healthcare costs as well as improve healthcare access, particularly for the poor, government has decided to pursue a National Health Insurance Plan, as outlined in the Green Paper on National Health Insurance in South Africa. Funding would be based on the ability to pay principle, whilst access to the system would be based on need.

The DoH is placing priority focus on improving primary healthcare provision with a view to lessening the burden on secondary and tertiary facilities. The need has been identified to change health service delivery from a curative model to one that promotes cost-effective primary healthcare as close to the community and households as possible. This must be supported by strong enhancements in management and supervision of facilities. The Department, with the help of key partners, has undertaken to develop and implement a model for delivering primary healthcare services that gives incentives for health promotion and disease prevention at the household and community level.

Overview of medical schemes landscape

The MSA, as amended by the FSGLA Act, defines the business of a medical scheme as:

"…the business of undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities:

(i) Providing for the obtaining of any relevant health service;
(ii) granting assistance in defraying expenditure incurred in connection with the rendering of any health service; or
(iii) rendering a relevant health service, either by the medical scheme itself or by a 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."

Any entity that is considered as conducting the business of a medical scheme is obliged to conform to the MSAand is subject to regulatory oversight by the CMS. Under the MSA, medical schemes are non-profit organisations and belong to their members. Medical schemes operate through the collective pooling of good and bad risks, and may not discriminate between individuals based on age or health status. Under the core principle of *open enrolment*, any individual is entitled to be a member irrespective of their age or health status.

Medical schemes are subject to community risk rating. Contributions apply universally to all members who are enrolled and may only vary in respect of affordability and family size. Different benefit options are priced differently depending on the level of cover afforded and are determined by the rules of the scheme. The effect is that there are equal premium contributions within options for high and low risk members, which promotes social solidarity in the form of cross-subsidisation amongst the members of the scheme – from the young and healthy to the elderly and sickly.

In terms of the Medical Schemes Act, medical schemes must cover the costs of Prescribed Minimum Benefits (PMBs) related to the diagnosis, treatment and care of:

- any emergency medical condition;
- a limited set of ±270 medical conditions; and
- 25 chronic conditions.

Members are entitled to these benefits regardless of the medical scheme option they have selected.

In 2015, there were a total of 83 medical schemes in South Africa, of which 23 are open or unrestricted schemes and 60 are restricted (that is, available only to defined groups of people such as employees in a specific industry).

Table 6: Trends in sources of private funding by share of total private funding

	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15
Medical schemes	80%	81%	82%	82%	83%	83%	83%
Out of pocket	17%	15%	15%	14%	14%	14%	13%
Medical insurance	3%	3%	2%	2%	2%	2%	2%
Employer private	1%	1%	1%	1%	1%	1%	1%

Source: National Treasury data

As indicated in Table 6 medical schemes play a pivotal role in private healthcare funding, accounting for 83% of private healthcare spending in South Africa in the financial year 2013/2014. Medical insurance covered just 2% of the final private expenditure in South

Africa in the same year, which is roughly 7 times less then out of pocket expenditure. Overall, the share of medical schemes in total private funding has risen slightly since 2008/9, whilst medical insurance and out of pocket expenses have declined somewhat. Employer expenditure has remained small but constant at 1% of total private funding.

As reflected in table 7, medical schemes covered 3.95 million principal members and an additional 4.86 million dependents in 2015, reaching a total of 16% of the population (8.81 million individuals). Of these, 4.9 million are covered by unrestricted schemes and an additional 3.9 million by restricted schemes:

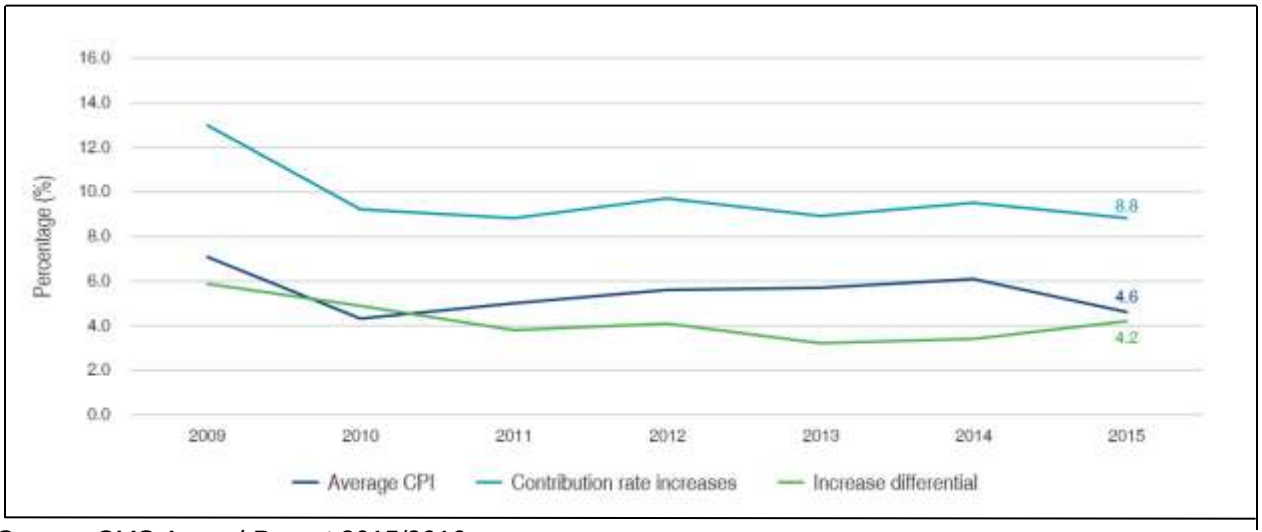
Table 7: Reach of medical schemes, 2015

	Unrestricted schemes	Restricted schemes	Total
Members	2 327 137	1 623 790	3 950 927
Dependents	2 611 316	2 247 280	4 858 596
Total beneficiaries	4 938 453	3 871 070	
Percentage change from 2014	0.79%	-1.11%	-0.06%

Source: CMS Annual Report, 2014-2015

The number of beneficiaries decreased from 8.814 million in 2014 to 8.809 million in 2015. This represents a decrease of 0.06%. Figure 4 depicts medical scheme contributions following a similar trend to inflation. However, the average difference in contribution increases relative to CPI was in the region of 3.9% between 2001 and 2015. This has implications for the long-term affordability of medical schemes as the average consumer's income has not kept up with this real inflationary increase.

Figure 4: Medical Scheme Contributions and Inflation 2009-2015



Source: CMS Annual Report 2015/2016

Despite the prohibition on discrimination in the MSA, the practical implication of the plateauing off in membership is that certain segments of the population are excluded from

medical scheme access. The drivers that have led to the sharp rise in costs in recent times include additional time spent by patients in hospital, increased hospital costs, increased specialist service costs, as well as the inclusion of prescribed minimum benefits.

Table 8 indicates that the age profile of the average person supported by medical schemes remained largely unchanged at 32.3 years in 2015. This however masks a substantial difference between unrestricted and restricted schemes in that the former has an older age profile and supports proportionately more pensioners. This, combined with the fact that the elderly tend to have higher medical costs, results in higher risk contributions as well as savings contributions on average in unrestricted schemes.

Table 8: Overview of key medical scheme statistics

	Unrestricted schemes	Restricted schemes	Total
Claims Ratio	89.6	94.6	91.6
Dependant Ratio	1.12	1.38	1.2
Average age	33.8	30.5	32.3
Pensioner ratio	8.80%	6.10%	7.70%
Risk contribution (per month per beneficiary)	1315.7	1276.8	1298.5
Savings contribution (per month per beneficiary)	212.7	80.9	165.2

Source: CMS Annual Report, 2014-2015

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