LOW-COST BENEFIT OPTION
RISK CONSOLIDATION REPORT
WORKSTREAMS AND STAKEHOLDER'S INPUTS
JULY 2022

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1. INTRODUCTION

The purpose of this document is to consolidate the risks, critical issues and challenges identified by the various stakeholders through the consultative process undertaken by the LCBO workstreams, that is, the Market and Affordability, the Benefit and Pricing and the Legislation and Regulation workstreams. In addition to the risks, this document also identifies mitigating factors and implementation timelines for the LBCO framework.

Table 1 highlights key differences between medical schemes and current demarcated health insurance products. At a high level, medical schemes are non-profit organisations and belong to their members. They operate through the collective pooling of good and bad risks and may not discriminate against individuals based on age or health status. However, a health insurance policy is a binding contract issued by an insurance company to an individual. The policy promises to pay for certain stated benefits when the individual is ill or injured. The individual pays a certain premium which is directly related to the age, health status or income of the individual. Specific types of exclusions may also be built into a policy, which can have the effect of limiting whom the policy can be sold.

Table 1: Medical schemes vs health insurance products

Medical Schemes	Health Insurance
Regulated by the Council of Medical Schemes and governed by the Medical Schemes Act.	Regulated by the Prudential Authority and FSCA and governed by the Insurance Act.
Obligated to cover Prescribed Minimum Benefits (PMBs).	Are not required to cover PMBs.
Any emergency medical condition.	Emergency medical events up to a specific amount.
27 chronic conditions.	Some chronic conditions.
271 medical conditions.	Benefits for specific medical events.
Medical schemes cover a combination of benefits paid from a risk pool at a percentage and may have savings plans.	A rand value is attached to each benefit offered by the product.
Members are often unaware of the amount available as this is a percentage.	Members are informed of the total amount allocated per event.

2. REGULATORY AND LEGISLATIVE CONSIDERATIONS

The Insurance Acts govern the Health Insurance Providers differently to Medical Schemes, which the Medical Schemes Act governs. There are three possible transitory arrangements that would need to be considered in the implementation of the LCBO framework. They are presented below.

1. *Setting up LCBOs as separate medical schemes. This will require complex eligibility definitions to be incorporated into the Medical Schemes Act.*

Risk Identified: Creating different rules for PMB's EDL, Waiting Periods, and LJPs will be highly complex. (Stakeholders, May 2022)

Risk Mitigation**:** Transitional Period to be established.

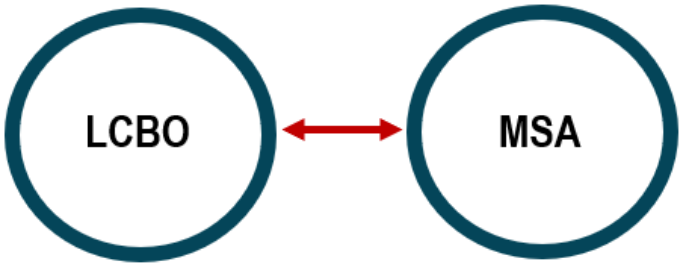


Figure 1: Transitional arrangements - setting up LCBOs as separate medical schemes

2. *Establishing LCBOs under short-term insurance (consistent with the current approach to demarcation products, but with benefit regulation by CMS).* This would ensure maximum benefit rules, and social solidarity principles would be incorporated into these regulations.

   Risk Identified: Obscured and complex rules and procedures resulting in an inability to implement, monitor and report.

   Risk Mitigation: Transitional Period to be established.

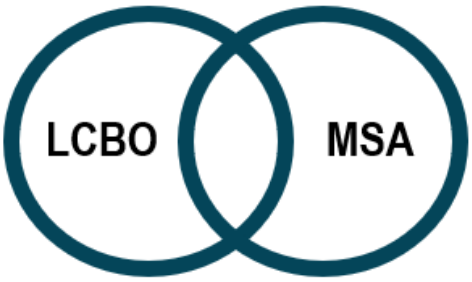


Figure 2: Transitional arrangements - establishing LCBOs under the short-term insurance

3. *LCBOs are set up within medical schemes, but strict underwriting criteria restrict selective movement from traditional options to LCBOs and vice-versa.*

   Risk Identified: Transitional regulatory framework that may result in conflicting underwriting rules.

   Risk Mitigation: Product Testing related to various underwriting rules.

Figure 3: Transitional arrangements - LCBOs are set up within medical schemes

3. TIMELINES & IMPLEMENTATION DATES

Table 2: Proposed timelines and implementation dates

Period	**Task**
April – December 2022	All Inputs received, draft guidelines and report.
December 2022 - March 2023	Submission of Guidelines to National Treasury and Department of Health
April 2023	Feedback from National Treasury and NDoH
January 2024	Phase 1 Structure Changes
January 2025	80% alignment expected
January 2026	100% alignment expected
Transitional Periods	
April 2023 – December 2023	Admin, Marketing, Awareness and Sensitisation
2023 – 2025	Current Insurer to Trust (not-for-profit entity)

Table 3: Implementation and Risk Roll-Out Plan

Implementation	**Expected Period**
Product finalisation, to launch date.	36 Months
Insurer to Trust (not-for-profit entity structure), transfer issues to be dealt with.	12 Months
Stakeholder engagement – Employers, Unions and Service Providers/Insurers to be consulted on the "final product."	12 Months
Contracting and Administration – Define, engage and contract with service providers.	12 – 36 Months
Interrogate and install an administration IT system.	12 – 36 Months
Employ Marketing Team: Teach them about your product and agree on how and when the information will be shared with Stakeholders, Service Providers, doctors, brokers and the public. Agree with a marketing team on project deadlines, deliverables and penalties for non-delivery. (This will ensure that they stay on the timetable.)	12 – 18 Months
Design requirements for documentation (hard copy/electronic etc.) Training, completion, storage (POPIA) etc.	12 – 18 Months
Training and accreditation: Set standards, timelines and requirements for Internal training. Provide training, including broker training on bringing new members and public awareness and training on what they can do for themselves and "How to" guides.	18 – 36 Months, ongoing.
Phase one of product change: 80% align the product to final requirements.	24 – 36 Months

4. RISK ASSESSMENT

Following the initial Risk Assessment submission in September 2021, risks have been consolidated into five major risk categories to focus on immediate threats. Suggested controls to mitigate the risks (Mitigation Column) have been proposed in the below table, along with the potential rating.

	Major Risk Category	Risk	Description	Contributing Factors	Findings	Mitigation	Probability	Impact
1.	Solvency	Minimum number of lives to be covered.	CMS has suggested a minimum number of 6000 members to ensure sustainability. A lack of adhering to this guideline can result in higher volatility and possibly deregistration.	1. Poor benefit design. 2. High/unaffordable premiums.	Of the 29 schemes with less than 6000 members, 26 (90%) are restricted schemes.	Restricted schemes are not a concern as limitations regarding income base, anti-selection, non-healthcare expenditure etc., are controlled by the employer and do not affect the member.	**Low**	**Low**
2.	Solvency	Risk-Based Solvency Requirements	Risk-based solvency requirements were discussed between workstreams and stakeholders, and it was agreed that the statutory solvency requirement of the MSA should be maintained. Workstreams proposed to lower solvency requirement from 25% to 10% for LBCOs.	1. Impact on Risk Pool 2. Legislation surrounding solvency. 3. Actuary calculations at the time of calculating and economic influences.	Stakeholders suggested that medical schemes could be allowed to reduce the minimum reserve amounts by 5%, and this amount could be earmarked for the LCBO for the first three years, allowing the medical schemes to align with the current LCBOs or create new options.	Detailed calculations to substantiate such a reduction on the minimum accumulated funds as per Regulation 29.	**Very High**	**Very High**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

3.	Risk Pool	Reserves that need to be built.	To avoid insolvency or liquidation, medical schemes need to guarantee that available earnings can support and strengthen the future financial position, including a potential loss in book size due to the transition or even potentially the claims following the additional lives covered. The claims reserve is a reserve of funds set aside by the company/medical scheme for the future payment of incurred claims that have not yet been settled.	1. Exiting of Binder Agreement. 2. Claims pre-migration. 3. The intrinsic value of the premiums established in the migration. 4. High solvency requirements. 5. Segregation of Regulations guiding risk appetite. 6. Non-healthcare Expenditures.	The Financial Soundness Framework for Insurance Groups was established by the Prudential Authority in July 2018, whereas the risk-based solvency framework for the Council of Medical Schemes is currently under review.	1. Transitional Period 2. Consolidate regulations related to the Risk Appetite framework. 3. Framework for Non-healthcare expenditures needs to be clarified.	**Very High**	**Very High**
4.	Risk Pool	Implications of Underwriting on Reserves.	Based on reserves and risk pool management, a large portion of the insurance policies has been managed through underwriting. As a result, the migration to medical schemes may affect the reserves and ability to convert.	1. Industry forecast on the effect of underwriting adjustments in the foreseeable future. 2. Financial unintended consequences related to claims.	There should be a transitional period where all claims related to pre-migration amendments are resolved under the Insurance Act and through the Insurer. Industry guidance of claims management to cross-subsidies benefits will reduce the risk of higher claimed PMB benefits against under claimed benefits.	• Underwriting only on additional benefits on buy-up. • Buydowns linked to employment status. • Demarcation has already eliminated roadblocks to underwriting. • MSA there is no underwriting unless buying up. • Defined Risk Appetites	**High**	**High**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

5.	Risk Pool	Claims and Exiting Binder Agreement	Claims before migration need to be resolved; whether this will be done during or before the transition period needs to be decided. Considering the effects of these claims on the risk pool at the time of pay-out and the lack of compensation to the risk pool.	1. Exiting Binder Agreement. 2. Member Choice. 3. Solvency of Scheme. 1. Level of Claims outstanding at the point of migration.	Regulations defined under financial bodies include the FSG1 Standards by the Prudential Authority for Health Insurance and The Risk-Based Solvency framework is defined by the Council of Medical Schemes, for Medical Schemes. The risk of two different governing bodies defining the rules and processes around the risk pool is severe, and the probability of impediments occurring is most certain.	Workstreams and stakeholders should be aware of the risks related to the established and unestablished frameworks, and that established frameworks have had the opportunity to mitigate potential risks.	**Very High**	**Very High**
6.	Risk Pool	Buy down risk	**The m**ovement of members from more benefit-rich and costly options to the lower cost, less benefit-rich options. This causes fragmentation in the risk pool, affecting the sustainability of schemes. Particularly if the members' buying down' are considered relatively low-risk in the original benefit-rich option and comparatively high-risk in the new low-cost option. This movement would serve to worsen the risk profile of both options.	1. The lower cost of LCBO cover may encourage buy-downs 2. Marketing of LCBOs may not be clear regarding lower benefits	A transitional period relating to late joiner penalties and underwriting restrictions can be considered.	• Lives Buying down from other medical scheme options to LCBOs unless there is a change in employment. • Lives buying up from LCBOs to other medical scheme options for benefits not covered by the LCBO.	**Medium**	**Medium**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

7.	Risk Pool	Employer medical scheme contributions	Risk transfer is a common risk management technique that allows the risk to be shifted or shared between parties; by considering the employer groups' roles in the LCBO, the workstreams can transfer or reduce the risks related to the risk pool, non-healthcare expenditures and PMBs.	1. Decision to apply tax subsidies. 2. Employer groups and Union contributions to discussion documents. 2. Voluntary versus Compulsory.	A proposed solution is to apply price differentiation based on whether group membership is voluntary or compulsory; ultimately, this will disperse the funds in the risk pool between individual and employer group members.	• For members who earn below the tax threshold, it is conceivable that an employer would be willing and able to subsidise all or part of a contribution of this order of magnitude. • Employer groups would obtain tax rebates under the MSA Act.	**Medium**	**Medium**
8.	Product Design	Target Market Eligibility and Out of Pocket Sustainability.	The current market LSM is middle to lower for those members of LCBOs, considering adjusted regulations to suit the medical scheme environment. The LSM would not be able to sustain the increase in premiums required to cater for the adjusted regulations.	1. Current household income stats. 2. Unemployment ratio. 3. Negotiations regarding regulations related to migration from LCBO to Medical Scheme.	Eligibility will not be income-based due to the lack of a transparent and reliable threshold. Instead, the product design (specifically the exclusion of private hospitalisation and the focus on primary care) will ensure that only individuals who value and prefer these products take them up.	Tax credits would cover a significant proportion of the current cost of exempted product contributions. This implies that the cost of cover would have a limited effect on a member's disposable income.	**Medium**	**Medium**

	Major Risk Category	**Risk**	**Description**	**Contributing Factors**	**Finding**	**Mitigation**	**Residual Probability**	**Residual Impact**

9.	Product Design	Minimum Product Benefits	As each LCBO plan will be uniquely designed, there needs to be a baseline plan that ensures that regulations related to customers (pre-migration) are maintained and adhered to and amendments to the regulations post-migration.	1. PMB exemption 2. NHI Comparison 3. Medical Scheme Key Plans Costing - Risk Appetite	The minimum product benefits would need to exclude PMB cover and private hospitalisation for them to be affordable to the target market. However, this would require regulatory amendments.	• Transitional period in implementing PMB exemptions regulations. • Product sample testing. • Implementation of Managed Care. • Exclusion of Private Hospital Cover. • Essential Medicine List.	**Very High**	**Very High**
10	Prescribed Minimum Benefits (PMBs)	Costs associated with PMBs and defining benefits.	Insurance companies/medical schemes will be required to revisit their listing of PMBs and the **costs associated** with the premiums, claims, and benefits and the PMBs that must be included as per Medical Scheme Act, Regulation 8.	1. Price Fixing 2. Variation to PMB listings	PMBs were defined during the demarcation period and structured in the "Exemption Framework and Principles for LCBOs" in 2015; further discussions on the changes to PMBs have been conducted but must take into consideration the framework provided in 2015; the risk lies with the necessity to define the PMB's, to understand what amendments would affect the MS Act.	• A review of the medical schemes amendment bill to provide for scaled-down PMBs for LCBOs. • Exclusion of private hospital. • Tax subsidies offered through medical schemes will alleviate the pressure of costs incurred. • Defining of Risk Appetite.	**Medium**	**Medium**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

11	Regulatory	Accreditation of Brokers and Broker Fees.	Requirements of accreditation according to Section 65 of the Medical Schemes Act and the implications of lower premium commission structure.	3. FSCA Fit & Proper requirements. 4. Industry turn-around period for broker applications following migration. 5. Financial implications relating to application fees and/or potential fines regarding submission timeframes. 6. System development and guidelines.	Loss of brokers could result in loss of sales for the organisations; the above solutions reduce the impact of the management of the broker fees on the broker. However, discussions with brokerages should also be conducted to identify further complications that may occur from the solutions provided by the stakeholders and workstreams.	• To ensure members access appropriate advice, the broker commission should be subject to a Rand cap rather than a % limit. • Consideration could also be given to a sign-on fee to facilitate member education. • Charge once-off marketing for signing up new members due to the high initial cost to the broker. • Pay the broker fees and not the Scheme.	**Medium**	**Medium**
12	Regulatory	Fraud, Waste & Abuse.	Effects of fraud on the risk pool, particularly in the early developmental stages of the **risk pool**, following the migration and exiting of Binder Agreements.	1. Redefined or undefined regulations by the FSCA and Medical Scheme Act. 2. The effects of economic and social grading alternately impact the increase of fraud.	Many healthcare providers would be more than willing to service LCBO patients at a reduced fee. Still, suspension of payments in terms of Section 59, as implemented currently, could lead to severe cash flow problems that could make it unsustainable for healthcare providers to service these patients.	Increasing fraud through provider claims, under the assumption that providers tariffs are not limited but merely guided according to the Health Professions Act, Tariffs need to be considered when developing the PMBs to reduce the risk of overcharged claims from providers. "Waste & Abuse"	**Medium**	**Tolerable**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

13	Regulatory	Discrimination	Underwriting, elderly etc., and anti-selective behaviour. Late joiner, waiting periods, medical status or termination.	1. Industry benchmark regarding late joiner fees. 2. LCBO Regulations versus regulations of Medical Scheme regulations. 3. The overall industry's ability to cater for members who cannot absorb the late joiner fee. 4. Ensure that LCBOs do not create an anti-selective channel to full PMB cover to bypass existing LJP provisions.	Framework relating to the health insurance products offered under the Demarcation Regulations includes changes to the Medical Insurance environment.	Under Demarcation, medical Insurances no longer decline members based on age, medical status, termination, or any form of discrimination.	**Low**	**Medium**
14	Regulatory	Segregation of Regulations and Acts.	The transition from Insurance to Medical Scheme will affect the governance framework and subordinate administration and must be implemented effectively and without delay.	1. Change in regulations and frequency of the change. 2. The implications of the change in the regulations and legal framework. 3. Length of period taken to define regulations and the implications of decided implementation deadlines. 4. Inability to conform.	Mitigating this risk would require a defined deadline, alongside the willingness to accept that further amendments will be required; determining when and how these amendments will be implemented will alleviate the potential strain on developing a framework within a dictated timeline.	3 Options were presented to Stakeholders: 1. Setting up LCBOs as separate medical schemes. 2. Establishing LCBOs under short-term insurance (consistent with the current approach to demarcation products, but with benefits regulations by CMS). 3. LCBOs are set up within medical schemes, but there are strict underwriting criteria restricting selective movement from traditional options to LCBOs and vice-versa.	**Very High**	**Very High**

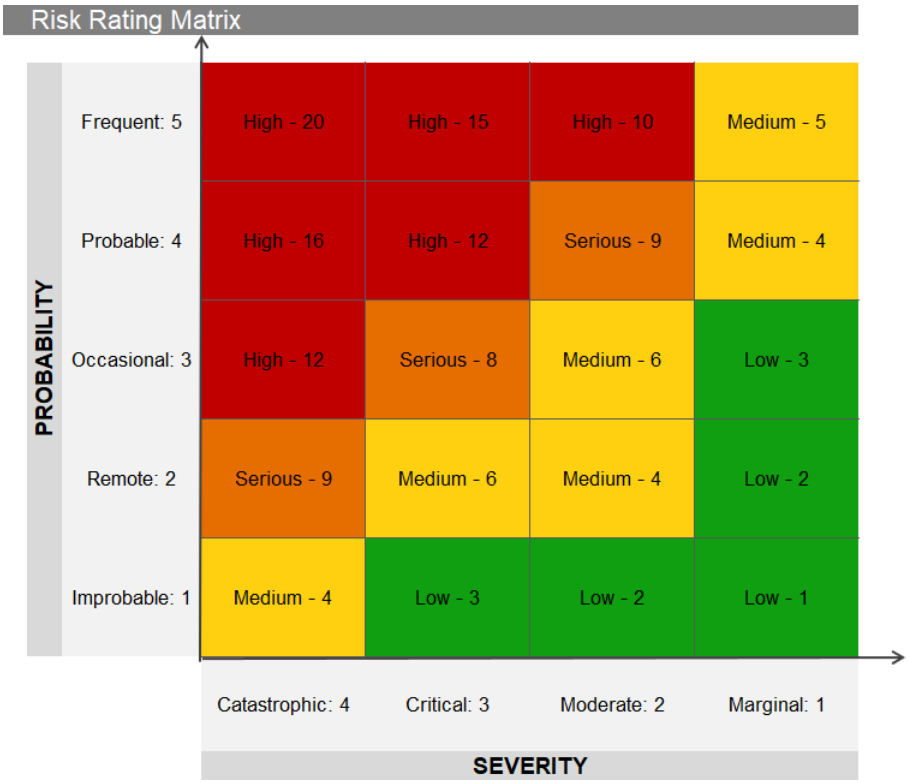
	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact
15	Regulatory	Exiting Binder Agreements	Insurance companies rely on the risk pools sustained by the insurers and are bound by criteria defined in the Binder Agreement. When insurance companies migrate from insurance to medical Schemes, the insurance company will need to develop independent risk pools to ensure solvency.	1. Unintended consequences result from exiting the binder agreement and implications on the risk pool. 2. Existing Non-healthcare expenses and effects of it on building the risk pool.	1. Binder Agreements are based on underwriting criteria vastly different from MSA. 2. Transitional period where all existing beneficiaries of exempted products have an opportunity to join an LCBO. 3. Members must be given a choice, which could result in book loss.	Substantial actuarial calculations are required to mitigate the financial implications of the shortfall when exiting Insurers Binder Agreements.	**Very High**	**Very High**
16	Regulatory	Insurer to MSA Transfer	Members will be required to transfer their existing policies to the new outlined benefits. Regulations regarding the transition between insurance and medical Scheme and the implications on existing policies have not been defined; however, this risk is to identify potential risks if policyholders must cancel their policy and then reapply.	1. Amendments to Legislation 2. Member Choice 3. Unintended consequences from exiting binder agreement.	Transfer of business to medical Scheme or whether existing policyholders will be required to make new applications. There are POPIA and consent implications of the former process.	1. Appropriate risk-based solvency requirements. 2. Amnesty period of policyholders of exempted products.	**High**	**High**

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact

17	Regulatory	Complaints Process	The complaints process needs reviewing; a simple claim for R100 can take five months, which will not be feasible for members who fall within the LCBOs eligibility.	1. Process defined by MSA 2. Process defined by FAIS	Many healthcare providers would be more than willing to service LCBO patients at a reduced fee. Still, suspension of payments in terms of Section 59, as implemented currently, could lead to severe cash flow problems that could make it unsustainable for healthcare providers to service these patients.	• CMS should consider finalising the industry's Charter and Codes of Good Practice. • Transitional period where all claims related to pre-migration amendments are resolved under the Insurance Act and through the Insurer.	**Medium**	**Medium**
19	Regulatory	Policyholder Protection Rules: FSCA Cancellation and Transfer Options.	Members will need to be notified in line with the provisions of Rule 19 of the Policyholder Protection Rules (Short-Term). In this transition, they will be given the option to cancel their policy or move it. This raises a risk that members will have no other options and members cancelling, resulting in a loss of books.	1. Propensity of decision-making in consumer product choice and understanding. 2. Consumer experience and related TCF conditions. 3. Adherence to regulations and related Acts. 4. Defined timeline to make the transition by the regulators.	Guaranteed acceptance without underwriting for a defined transition period such as six months. The FSCA does not believe that the exempted products fall under the Insurance Act and therefore are not bound to the PPR Rules.	Options Include: 1. Setting up LCBOs as separate medical schemes. 2. Establishing LCBOs under short-term insurance (consistent with the current approach to demarcation products, but with benefit regulation by CMS). 3. LCBOs are set up within medical schemes, but there are strict underwriting criteria restricting selective movement from traditional options to LCBOs and vice-versa.	**High**	**High**

The following risks were below the threshold (low severity, low probability). However, they have been included below:

	Major Risk Category	Risk	Description	Contributing Factors	Finding	Mitigation	Residual Probability	Residual Impact
1	Market Value Proposition	Employer medical scheme contributions	Small to Medium entities provide contributions to members on LCBOs. Increased premiums may negatively affect SMEs' contributions due to the strain of the current economic environment. Effect both employees and the schemes.	1. SME sustainability and growth. 2. Industry annual increase rate. 3. Economic status.	Tax subsidies are offered through medical schemes; this will alleviate the pressure of costs incurred by employees.	Define what regulation will govern this. (National Treasury to Clarify)	**Tolerable**	**Tolerable**
2.	Financial	Late Joiner Penalties	The implications of policyholders having to pay a late joiner penalty because moving to an LCBO, which falls within the MSA regulations, can result in loss of book.	1. Economic stability of members. 2. Actuarial calculations relating to premiums and disbursements. 3. Late Joiner penalty is at the discretion of the Scheme.	If there is an exit from the partnership of insurers and the risk pool, by having the late joiner penalties, schemes will be able to sustain the risk pool, especially for members with pre-existing conditions.	1. Decisive agreement on underwriting late joiner penalties. 2. Late joiner is governed by the MSA and is discretionary.	**Low**	**Low**
3	Financial	Statutory Fees	Increase and addition of fees applicable to the registration of the Scheme and its subsidiary bodies (Administrator, MCOs, Broker accreditation etc.), license fees, and renewals.	1. Change in regulations related to fees. 2. Undefined guidelines. 3. Revoking of accreditation or declining of applications. 4. Insurance entities migrating to LCBOs unable to take on additional financial expenses.	Non-healthcare expenses must form part of the entity's Risk Appetite.	Non-healthcare expenses are monitored by the Council of Medical Schemes and are reported quarterly and annually.	**Low**	**Low**


Risk Rating Matrix
PROBABILITY
Frequent: 5
Probable: 4
Occasional: 3
Remote: 2
Improbable: 1
High - 20
High - 15
High - 10
Medium - 5
High - 16
High - 12
Serious - 9
Medium - 4
High - 12
Serious - 8
Medium - 6
Low - 3
Serious - 9
Medium - 6
Medium - 4
Low - 2
Medium - 4
Low - 3
Low - 2
Low - 1
Catastrophic: 4
Critical: 3
Moderate: 2
Marginal: 1
SEVERITY