LOW-COST BENEFIT OPTION FRAMEWORK

ADVISORY COMMITTEES REPORT

May 2022

Table of Contents

1. Introduction 10

1.1 Low-cost cover policy options 11

2. Feasibility Analysis: Target Market and Eligibility 14

2.1 Defining eligibility 15

2.2 Group coverage and employment restrictions 16

2.3 Affordability constraints 16

2.4 Value to members, employers and the economy 17

2.5 Anti-selection and selective movement 18

2.6 Underwriting provisions 19

3. Needs Analysis: Benefit design and pricing 22

3.1 Proposed benefit design framework 22

3.2 Costing of benefits 24

3.4 Solvency 27

3.5 Evidence-based medicine, Protocols and Formularies 28

4. Legislative reform: Legal, Compliance and Governance 28

The section sets out the regulatory implications of LCBOs being accommodated under insurance regulations or the Medical Schemes Act 28

4.1 FSP regulations 28

4.2 Demarcation of insurance products 29

4.3 Consumer Protection and Complaints 32

4.4 Managed Care 33

4.5 Non-Healthcare Expenditure 33

4.6 Governance Framework 34

4.8 Proposed Legislative and regulatory changes required 35

5. Risks and Implementation 39

5.1 Environment 39

5.2 Implications of HMI Findings on the LCBO framework 41

5.3 Other challenges and issues faced by medical schemes 42

6. Key stakeholders 42
7. Summary of Recommendations 43
8. Annexures 46

Table and figures

Figure 1: Income distribution and medical scheme membership 46

Table 1: Households with at least one family member on medical aid by monthly income 14
Table 2: Medical scheme coverage and expected LCBO take-up rates across lower-income individuals 15
Table 3: Summary of the proposed underwriting to be applied to LCBO members 21
Table 4: Estimated cost of LCBO products per life per month (PLPM) 25
Table 5: Summary of benefit package proposals 27
Table 6: Summary of solvency requirements 27
Table 7: Governance requirements and oversight bodies 34
Table 8: LIMS recommended benefit package 47

Executive Summary

The ministerial task team on social health insurance launched the LIMS consultative process in 2005 to gain insights from a range of stakeholders on ways of extending medical scheme coverage to lower-income formal sector workers. The main recommendations from the LIMS process were that LIMS should be open to any formal sector employee or self-employed person who earns less than R6 500 per month, in 2005 terms, and their dependents. The report also suggested that employers and employees should each make a 50% contribution to the premium and that the government would subsidise LIMS membership contributions. In terms of the benefits package, the LIMS minimum benefit package would provide cover for acute and some chronic outpatient or ambulatory care, but members would be expected to obtain in-patient care from public hospitals. Furthermore, cover for PMBs would be limited. To address the issue of anti-selection in the LIMS, it was recommended that an income threshold be legislated to create a demarcation between higher- and lower-cost LIMS options. However, low-cost options would not cover any form of private hospitalisation.

In 2015, the Council for Medical Schemes (CMS) issued a Circular that considered introducing a guideline to allow medical schemes to introduce Low-Cost Benefit Options (LCBOs) in response to the growing number of working South Africans who did not have medical scheme coverage due to affordability constraints. To facilitate this, the CMS intended on approving LCBOs in registered Medical Schemes by means of exemptions as contemplated in section 8 (h) of the Medical Schemes Act, 131 of 1998 (Act). As such, industry stakeholders were invited to assist in developing a set of comprehensive guidelines underpinning the framework for the CMS and Council to consider such exemptions.

LCBOs are medical scheme benefit options tailored to meet the affordability constraints and pressing healthcare needs of lower-income families who wish to purchase private healthcare cover. It is envisioned that by improving access to affordable private health cover, South Africa can accelerate its progress towards universal health coverage (UHC) and enhance healthcare accessibility. Furthermore, LCBOs can alleviate pressure in the public healthcare system and allow resources to be redirected to the poor.

Low-income households place greater value on out-of-pocket benefits than in-hospital benefits, and this is supported by the recent proliferation of primary care products that short-term insurers offer. These insurers operate in the market with an exemption from the Medical Schemes (MS) Act and provide cover to over 1

million beneficiaries. Considering this, the Council for Medical Schemes has brought together a committee of industry stakeholders and experts to deliberate on the best policy reforms that address the issue of introducing LCBOs within medical schemes while also considering how best to regulate existing primary care products.

The work of the committee has been divided into four workstreams; (1) the market and affordability, (2) the benefits and pricing, (3) the legislative and compliance and (4) the risk and implementation workstreams. The first workstream is concerned with defining the target market for the LCBOs in a manner that doesn't encourage anti-selection and selective movements across the medical schemes industry. The main recommendation of this workstream is that the LCBOs should be targeted toward employed individuals who cannot afford medical scheme cover in its current form. These individuals should ideally join under group cover to limit anti-selection with incentives in place to encourage buy-ups as people's affordability and needs change. The second workstream is concerned with designing a product that is affordable and attractive to the target market. The main recommendation from the workstream is that the LBCOs focus exclusively on primary healthcare; thus, be exempt from covering PMBs and exclude private hospitalisation.
Moreover, this package would be the minimum base package, allowing beneficiaries flexibility to buy up. The third workstream concerns the legal and compliance issues that must be considered when implementing policy reforms. The main recommendation from this workstream is that the proposed reforms must be implemented in a way that doesn't limit consumer choice or reduce their financial risk protection. Furthermore, the workstream has highlighted the significant legislative considerations that would prolong the implementation of LCBOs (i.e. changes to the Medical Schemes Act (MSA)). The last workstream concerns the risks inherent to the movement of products from the insurance industry to a medical scheme environment. These risks include the legislative and compliance risks and the financial risks associated with implementing the LBCOs.

Definitions

1. Medical schemes are regulated by the Medical Schemes Act and are subject to regulatory oversight by the Council of Medical Schemes ("CMS"). They are non-profit organisations and belong to their members. Medical schemes operate through the collective pooling of high and low risks and may not discriminate between individuals based on age or health status.
2. A health insurance policy is a binding contract issued by an insurance company to an individual. The policy can be sold by an insurance company in terms of the Long-term or Short-term Insurance Acts and is subject to regulatory oversight by the Financial Sector Conduct Authority ("FSCA") and the Prudential Authority ("PA"). The policy promises to pay for certain stated benefits when the individual is ill or injured. The individual pays a certain premium related to age, health status or income. Specific types of exclusions may also be built into a policy, which can have the effect of limiting who the policy can be sold to.

Abbreviations

1.	BHF	Board of Healthcare Funders
2.	DENOSA	Democratic Nursing Association of South Africa
3.	EBM	Evidence-Based Medicine
4.	EDL	Essential Drug List
5.	EML	Essential Medicine List
6.	FAIS Act	Financial Advisory and Intermediary Services Act
7.	FSP	Financial Services Providers
8.	FWA	Fraud Waste and Abuse
9.	GP	General Practitioner
10.	HFA	Health Funders Association
11.	HH	Household
12.	HMI	Health Market Inquiry
13.	HPCSA	Health Professionals Council of SA
14.	HSACF	Health Sector Anti-Corruption Forum
15.	ICPA	Independent Community Pharmacy Association
16.	LCBO	Low-Cost Benefits Option
17.	LIMS	Low Income Medical Schemes
18.	LJP	Late Joiner Penalty
19.	LTIA	Long Term Insurance Act
20.	MCO	Managed Care organisation
21.	MSA	Medical Schemes Act
22.	NDoH	National Department of Health
23.	NEHAWU	National Education, Health, and Allied Workers' Union
24.	NHCPA	National Healthcare Professionals Association
25.	NHE	Non-Healthcare Expenditure
26.	NHI	National Health Insurance
27.	NHLS	National Health Laboratory Services
28.	NPA	National Prosecuting Authority
29.	OHSC	Office of Health Standards Compliance

30. OOP Out of Pocket
31. PHC Primary Health Care
32. PMB Prescribed Minimum Benefits
33. REF Risk Equalisation Fund
34. SA South Africa
35. SADA South African Dental Association
36. SAMA South African Medical Association
37. SAMED The South African Medical Technology Industry Association
38. SAPC South African Pharmacy Council
39. SARS South African Revenue Services
40. SASA South African Society of Anaesthesiologists
41. STIA Short Term Insurance Act
42. TCF Treating Customers Fairly
43. UHC Universal Health Coverage
44. US United States

REGULATORS AND PROFESSIONAL ASSOCIATIONS

1. Chiropractic Association of South Africa (CASA)
2. Childhood Cancer Foundation South Africa (Choc)
3. Council for Medical Schemes (CMS)
4. Directorate for Priority Crime Investigation
5. Financial Sector Conduct Authority (FSCA)
6. Office of Health Ombud (OHO)
7. Health Professional Council of South Africa (HPCSA)
8. Hospital Association of South Africa (HASA)
9. Human Science Research Council (HSRC)
10. Independent Community Pharmacy Association (ICPA)
11. Medical Research Council of South Africa (MRC)

12. National Department of Health (NDoH)
13. National Health Laboratory Services (NHLS)
14. Democratic Nursing Organisation of South Africa (DENOSA)
15. Office of Health Standards Compliance (OHSC)
16. Pharmaceutical Society of South Africa (PSSA)
17. Prudential Authority (PA)
18. South African Council for Social Service Professions (SACSSP)
19. South African Dental Association (SADA)
20. South African Dental Technician Council (SADTC)
21. South African Medical Association (SAMA)
22. South African Pharmacy Council (SAPC)
23. South African Society of Anaesthesiologists (SASA)
24. Special Investigating Unit (SIU)
25. The Allied Health Professions Council of SA (AHPCSA)
26. The Council for Health Service Accreditation of Southern Africa (COHSASA)
27. National Health Research Ethics Council (NHREC)

1. Introduction

This report sets out the deliberations of the following work streams based on meetings held from March to October 2021:

- Market and affordability
- Benefits and pricing
- Compliance and legal governance
- Risk and Implementation

Low-Cost Benefit Options (LCBOs) aim to enhance healthcare accessibility and accelerate progress towards universal health coverage (UHC) in South Africa. Establishing an LCBO framework is consistent with the development path of numerous other middle-income countries at similar points of economic progress. By enabling lower-income earners to purchase private cover, pressure on public funds can be alleviated, allowing public resources to be directed to the poor.

LCBOs are medical scheme benefit options tailored to meet the affordability constraints and pressing healthcare needs of lower-income families. It is envisaged that LCBOs will operate within medical schemes and abide by social solidarity principles, including community rating and open enrolment. LCBOs will have specific benefit regulations that focus on providing cost-effective primary care and will be exempt from PMB obligations.

LCBO benefit structures can be developed consistent with the principles of current primary healthcare insurance products within a social solidarity framework. Market studies have demonstrated that low-income households place greater value on coverage for out-of-hospital benefits than for in-hospital benefits[1]. This evidence is supported by the recent proliferation of primary care insurance products, which are highly valued by employers and employees alike.

Insurers currently offer primary care products and operate in the market with an exemption from the Medical Schemes (MS) Act. These products typically provide coverage for primary healthcare services and are largely offered on a group basis[2]. This allows for greater productivity in the workplace while remaining within the

[1] World Bank (2007), Private Voluntary Health Insurance – Friend or Foe

[2] FIA conducted research amongst 5 primary health insurance providers representing more than 200 000 families and found that 92% of coverage was via an employer.

affordability constraints of lower-income employees. Employer subsidies make these products affordable and accessible to lower-income employees who traditionally pay for private healthcare out-of-pocket or rely on the overburdened State for care.

1.1 Low-cost cover policy options

With the current proliferation of primary care products in the market, various reform options are available. Three possible reform options discussed in the work stream are:

- Eliminate cover
- Introduce LCBOs within medical schemes under the Medical Schemes Act
- Continue with insured primary care products under the Demarcation Regulations of the Insurance Act

The intention is to ensure a fair regulated environment where financial risk protection is enhanced, access to universal healthcare is expanded, and consumers are protected. A key outcome must be a structure whereby these products' policyholders (existing and new) will not be unconstitutionally regressed.

The implications of these options are discussed below:

a) Eliminating cover

Eliminating the current cover offered through exempted insurance products would mean that all 502,000[3] lives currently on primary care products would depend on the public sector for care as they cannot afford the current medical scheme cover. This will lead to an additional burden for the State. Alternatively, these lives may purchase care on an out-of-pocket basis from private providers. This is not ideal, given that out-of-pocket (OOP) payments are the most regressive form of healthcare financing. Further, by eliminating these products from the market, employer subsidies will be forfeited, resulting in a loss of funding to the healthcare system, and not only would existing covered lives need to fund any private care access on a regressive out-of-pocket basis, but access to prepaid cover for a broader group of lower income earners would be denied.

[3] Per CMS presentation January 2020

It is important to note that the Constitution speaks to access to health care. Important provisions that speak to members of medical schemes, including those on LCBOs, affirm the democratic values of human dignity, equality, and freedom.

In this context, with emphasis on Section 27 (1) in that "Everyone has the right to have access to health care services", it goes without saying that Medical Scheme and Healthcare Insurance, including the availability of Low-Cost Benefit Option/s (LCBO/s) plays a vital part in supporting that this fundamental human right is protected and exercised by the citizens of our country.

b) Introduce LCBOs within the Medical Schemes Act (MSA)

This option is most complementary to the NHI transitional framework as it ensures products operate within the principles of social solidarity. LCBOs also intend to focus on providing access to primary care, which is consistent with NHI objectives. Medical scheme members also have access to the medical scheme tax credit. The MS Act stipulates that members may not have duplicate membership, which is essential for protecting LCBOs from adverse selection and arbitrage.

Primary Care products are currently regulated under the Prudential Authority and the FSCA. Whilst transitioning primary care products into the LCBO framework may allow for greater policy cohesion between traditional medical scheme products and LCBOs, it may also pose a potential risk of destabilising the Medical Scheme environment. Transitioning to an LCBO may enhance oversight of the healthcare funder market and improve consumer confidence.

Considerations of discontinuing health insurance in favour of the Low-Cost Benefit Option include that there will need to be a transitional arrangement which allows for the continuation of cover for existing policyholders on exempted products. This could consist of guaranteed acceptance without underwriting for a defined transition period, such as six months. This will ensure that older policyholders and those with chronic conditions are not disadvantaged. An automatic process would have POPIA and consent implications, so a facilitated process with necessary communication to policyholders to support informed decision-making would be required.

Policyholders (both groups and individuals) will need to be notified in line with Rule 19 of the Policyholder Protection Rules (Short-Term) provisions. As no alternative insurance cover will be available, the industry will need to engage with the Financial Sector Conduct Authority (FSCA) before the cancellation of these policies.

Upon the finalisation of the PMBs applicable to LCBOs and the definition and registration of the benefits, the changes to benefits and or contributions payable to the LCBOs will need to be assessed relative to the range of Primary Health Insurance products which cover a spectrum of care and a spectrum of contributions allowing for different needs and affordability even within the low-income employees market. It is, however, not envisaged that the proposed minimum benefits set out in this document will result in any significant number (if any) of current benefits not being accommodated.

As mentioned above and detailed in this submission, the risk of downgrading onto an LCBO is a significant risk to the existing Medical Scheme environment. The unprecedented downgrades from more comprehensive options to cheaper alternatives have been an underlying trend for some time. Downgrades are generally led by the young and healthy. The impact on the underlying and remaining risk pools on more comprehensive options has driven up costs, leading to further downgrades.

A declining Medical Scheme base results in higher costs, making it less attractive to younger and healthier citizens, especially where affordability is a challenge.

Therefore, careful consideration of the systemic effect of introducing an LCBO is required to ensure that the existing medical scheme risk pool is not adversely affected.

c) *Continue with insured primary care products under the Demarcation Regulations of the Insurance Act*

Without a detailed LCBO framework, this option is a feasible alternative. However, regulation by exemption for a closed group of for-profit insurers is unfair and may create uncertainty for all stakeholders in the market as exemptions are not guaranteed. There would therefore need to be provisions made in the Demarcation Regulations of the Insurance Act for these products, including the various benefit, pricing, underwriting and other rules.

There is also an anti-selection risk associated with the products straddling regulatory environments as policyholders can purchase medical scheme and primary care cover, creating arbitrage opportunities destabilising the medical scheme risk pools. This would need to be accommodated in the regulatory definitions.

2. Feasibility Analysis: Target Market and Eligibility

The Market and Affordability work stream has defined the LCBO target market as employed people and their dependants who cannot afford medical scheme cover. Importantly, LCBOs are not intended to serve as complementary cover to current medical scheme members. Research indicates that at least 41.5% of South Africans utilise private healthcare services out-of-pocket. The CMS discussion document of March 2019 suggests that medical scheme membership remains constrained in lower-income groups. Evidence from the General Household Survey (GHS) 2019 shows significant potential to expand medical scheme cover to households earning between R8 000 and R18 000 a month. For example, as shown in Table 1, only 32.8% of households in this income bracket have at least one family member on medical aid. In comparison, 67.9% of households with a monthly income greater than R18 000 have at least one family member on medical aid.

Table 1: Households with at least one family member on medical aid by monthly income

	Household income <R8000	**Household income R8000 - R18000 per month**	**Household income R18,000+**	**Total**
No of households	6,451,195	2,080,051	2,207,583	10,738,830
% of total households	60.1%	19.4%	20.6%	100%
% with at least one family member on medical aid	21.8%	32.8%	67.9%	33.4%

Source: GHS 2019

Analysis of the GHS and Finscope data shows that the target market is estimated to be between 2.5m to 4m people. Table 2 shows the expected LCBO take up by income bracket.

Table 2: Medical scheme coverage and expected LCBO take-up rates across lower-income individuals

Income bracket*	Average income	No of individuals	% on medical scheme	Expected LCBO take-up	Expected LCBO market
No income	R-	3,743,230	4.3%	2%	74,865
R1 - R1,081	R541	11,612,543	2.3%	1%	116,125
R1,082-R2,162	R1,622	12,250,698	2.9%	1%	122,507
R2,163 -R3,244	R2,704	6,008,707	6.8%	2%	120,174
R3,245 -R6,489	R4,867	9,230,164	4.4%	3%	276,905
R6,490 -R8,652	R7,571	3,297,487	10.9%	5%	164,874
R8,653 - R10,815	R9,734	2,528,740	18.0%	15%	379,311
R10,816-R12,978	R11,897	1,644,133	22.6%	20%	328,827
R12,979 -R18,386	R15,683	2,860,013	38.1%	25%	715,003
Total		53,175,715	7.3%	4.3%	2,298,591

Source: Finscope 2018, *Income brackets have been adjusted for inflation to 2020 terms

2.1 Defining eligibility

One mechanism to define eligibility is to use an income threshold below which individuals are eligible. The challenges with this approach include:

- It is almost impossible to accurately measure household income which is an accurate indicator of affordability
- Definitions of income vary across sectors and employers
- Setting an income threshold that is too low creates a risk of developing an unintended "missing middle". These lives will not be able to afford medical scheme cover but will also not be eligible for LCBO cover.

- On the other hand, an income threshold set too high will lead to buy-down risk undermining medical scheme risk pools.

Given these challenges, an income threshold for defining eligibility is not recommended. Instead, the work stream recommends alternative mechanisms for defining eligibility. These measures include tailoring the benefit design and pricing structure of LCBOs to ensure the product is attractive only to the intended target market. As discussed below, this will ensure LBCOs remain affordable to lower-income individuals, while protecting the sustainability of both the traditional medical scheme and LCBO risk pools.

2.2 Group coverage and employment restrictions

Experience from traditional medical scheme options shows that the extent of anti-selection is higher amongst those who join individually than those who join on a group basis. Restricting membership to compulsory groups will mitigate against anti-selection for a more sustainable risk pool, resulting in more affordable contributions.

While this restriction may be beneficial in determining a sustainable risk pool, compulsory groups may meet resistance from employers and individuals. A proposed solution is to apply price differentiation based on whether group membership is voluntary or mandatory.

Given the advantages that LCBOs afford the employer (in terms of improved health and productivity of employees), employers may subsidise coverage, which will allow for greater affordability of cover. By subsiding coverage, employers can also benefit from tax advantages, e.g., benefits paid for other risk covers such as group death or disability. In addition, those in formal employment can benefit from the medical tax credit, further enhancing accessibility.

There are concerns that an individual/retail market is required, but this may not be feasible initially and may need to be priced separately and have additional risk management measures. It is noted, however, that over 90% of current coverage is on a group basis.

2.3 Affordability constraints

The target contribution range is R150 to R300 per beneficiary per month to ensure affordability for this market. As discussed above, the benefit design is critical to ensure contributions remain within this range to preserve affordability.

Given the low uptake of medical scheme products below the tax threshold, we expect a significant portion of the LCBO target market to be eligible for the tax credit. Members earning above the tax threshold (R7,275 per month in 2021/22) will receive this tax subsidy, equivalent to R332 for the main member and first dependent and R224 for additional dependents in 2021/22. These 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.

We do note that those earning below the tax threshold cannot benefit from the tax credit, and policymakers could consider additional forms of subsidy to improve the financing progressivity of the market.

Employer subsidies will further enhance access and encourage compulsory membership to ensure a viable risk pool. Any balance is funded by members, but this should be minimal to create appreciation and awareness.

2.4 Value to members, employers and the economy

Value to members (and employers) should be measured regarding health outcomes. This can be facilitated with a benefit design centred on primary and preventative care. In addition, the benefits of wellness assessments can encourage early diagnosis and health management to improve longer-term health outcomes. While consideration must also be given to including accident and emergency cover in the benefits package, this must be weighed against affordability constraints of members, as well as knock-on impacts on anti-selection against traditional medical scheme options.

Reimbursement and delivery models are also essential to delivering value – mainly where contractual provisions address quality of care and appropriate access levels. This includes the use of networks to manage costs and channel proper care.

Communication and education are essential components of delivering value by ensuring members know the benefits they can access and can access appropriately – there is a role for intermediaries in communications and benefits access.

Product complexity needs to be avoided as far as possible in line with the HMI recommendations regarding standardised benefit definitions and benefits templates that are easy to understand.

Management of care is critical for ensuring appropriate access to benefits and containing costs, so a more nuanced approach to evaluating NHE is required.

Qualitative studies can be used to understand perceptions of value; however, these need to be tempered with a realistic cost approach to be helpful.

2.5 Anti-selection and selective movement

The price differential between LCBOs and traditional medical scheme options creates a significant risk for anti-selection and selective movement risk. Such selective movements include:

- Members of traditional medical scheme options buy down to LCBOs. These members are likely to have higher utilisation than existing LCBO members.
- Members of LCBOs buying-up to traditional medical scheme options only when the need arises.

Such selective movements will negatively affect the claims experience of both risk pools, requiring higher contribution increases across the scheme. This will, in turn, impact the accessibility and sustainability of the scheme.

The work stream has identified the following risk mitigation tools to protect LCBOs and traditional medical scheme options from anti-selection:

- As discussed above, limiting eligibility to those employed, or allowing for differential pricing based on a group (compulsory or voluntary) or individual membership.
- Risk equalisation across all medical schemes will limit each scheme's individual exposure to anti-selection.
- The separation of the LCBO risk pool from traditional medical schemes. The following options are available:
    - Setting up LCBOs as separate medical schemes. This will require complex eligibility definitions to be incorporated in the Medical Schemes Act and rules for movement between these schemes and other medical schemes.

- Establishing LCBOs under short-term insurance (consistent with the current approach to demarcation products, but with benefit regulation by CMS). There is precedent for maximum benefit rules and social solidarity principles to be incorporated into these regulations. The risk of policyholders purchasing medical scheme cover on an arbitrage basis remains with this option.

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

2.6 Underwriting provisions

This section details the underwriting provisions that limit anti-selection effects should LCBOs be set up as medical scheme options.

There is a risk of adverse consequences of people moving freely between benefit options (i.e., traditional medical scheme cover and LCBOs) and in and out of cover if people can make such decisions based on their health status. This is because:

- Healthier lives can choose to buy low-cost cover and then move to more comprehensive cover and participate in benefits they have not been funding – this escalates the cost of comprehensive cover.
- The target market for LCBOs is expected to have a better health status (a younger and lower (actual) prevalence of chronic conditions (noting that some may be undiagnosed) than the existing medical scheme lives and therefore, their levels of utilisation are expected to be lower. If LCBOs need to be priced for the higher utilisation levels of existing medical scheme lives, the cost of cover may be unaffordable for the target market.
- Members who are part of a compulsory group cover are likely to have lower cost levels than a group of individuals who have elected to purchase cover since it is more of a spread of risk across the pool.

These factors mean that rules around the movement of members are necessary to ensure that the cost of cover is affordable for the target market.

Waiting Periods

Waiting periods protect the existing risk pool from people joining the scheme only when a healthcare need arises, claiming for healthcare services provided and then leaving the scheme again. Adequate waiting

periods to prevent such anti-selection is vital for keeping cover affordable and sustainable across existing medical scheme options and LCBOs.

Currently, medical schemes can apply the following waiting periods:

- Three months general waiting period (in specific circumstances)
- 12-month condition-specific waiting period (in specific circumstances)

LCBOs should also maintain the above 3- and 12-month waiting periods. However, waiting periods should not be applied to lives joining an LCBO where they have proof of previous similar cover (via an exempted insurer or a medical scheme). Product providers would have the option to waive waiting periods for certain benefits (e.g. primary care consultations). Waiting periods currently apply to dental and optometry benefits for existing exempted products, and some are applied to chronic cover as well.

Late Joiner Penalties

The MS Act provides for late joiner penalties (LJPs) to encourage members to join earlier and contribute to the risk pool and to protect existing members and is also necessary to protect the LCBO risk pool. LJPs should be applied to individuals based on the age at entry, and no maximum age at entry may be applied. The scheme may waive LJPs for groups at its discretion, which is likely to become more feasible as the risk pool develops. Application of late joiner periods are discretionary in terms of the MSA and regulations

Creditable Coverage / Maximum and Minimum Benefits

Since LCBOs will provide limited coverage, membership in the LCBO will not count towards creditable coverage of traditional medical scheme options. This is necessary to mitigate against anti-selection, where members move between less comprehensive LCBOs to more comprehensive traditional options as their needs change. Such behaviour would negatively affect the sustainability of both the LCBO and traditional option risk pools.

Movement between medical scheme options

Normal underwriting as provided for in the MS Act, may be imposed should a member on an LCBO select to upgrade to the other benefit options offered by a medical scheme, except where the upgrade is as a result of a change in circumstances as contemplated in section 29A(6)(a) and (b). As per the above provisions,

medical schemes may waive these requirements, which will likely become more feasible as the risk pool develops. This provision is consistent with the current situation if a primary care policyholder joins a medical scheme.

There must be clear movement rules between benefit tiers to protect both risk pools. In particular:

- Buy-ups – should be considered a pathway to more comprehensive cover but noting the risk for anti-selection if there is a two-way movement. It is suggested that underwriting applies only to benefits not included in LCBO minimum benefits.
- Buy downs – should be discouraged but may be necessary where there is a loss of employment. So underwriting should apply (general waiting period) unless there is a change in employment as provided for in the Medical Schemes Act.

Table 3: Summary of the proposed underwriting to be applied to LCBO members

	Late Joiner Penalties	**Waiting periods**
New LCBO lives	Yes*	Yes*
Lives buying down from other medical scheme options to LCBOs	No	Yes, unless there is a change in employment
Lives buying up from LCBOs to other medical scheme options	Yes*	Yes, for benefits not covered by LCBOs

* can be waived for groups

The Compliance and Legal Governance workstream is of the view that the underwriting provisions can only be dealt with appropriately and effectively once the LCBO product and benefit design is established and agreed to by the broader Advisory Technical Committee.

3. Needs Analysis: Benefit design and pricing

Benefit design is essential to ensure products reach the correct target market and remain within their affordability constraints. Benefit design can also be a risk mitigation measure to protect medical schemes from anti-selection and selective movements. This is particularly important given that anti-selection and selective movements from traditional options to LCBOs and vice versa will escalate the cost of coverage for both products.

Exemption from the Prescribed Minimum Benefit (PMB) provisions

PMBs are one of the main contributing factors that make medical scheme cover unaffordable to lower-income individuals. For example, the CMS Annual Report of 2020/1 notes that the cost of the PMB basket in 2020 was R866 per average beneficiary per month. This amount does not include any provision for non-healthcare costs or primary care coverage. Given the high cost of PMBs and the affordability constraints of the lower-income market, a separate regulatory framework is required to inform the LCBO benefit design. Importantly, this would require LCBOs to be exempt from PMB provisions applicable to traditional options.

The LIMS task team recommended that these more affordable products should offer a reduced package of benefits. This minimum package of benefits would focus on private primary healthcare and not provide private hospital benefits. The reasons for excluding hospitalisation are that they are expensive but also that LCBO products need to be adequately differentiated from "full" medical scheme cover. The makeup of the minimum package was informed by research aimed at identifying what the target market would be willing to pay for and, on the understanding that low contributions can only buy limited benefits, which benefits have a higher priority than others. It turned out that respondents placed more value on primary healthcare services such as GP and pharmacy benefits than on private hospital cover, with some exceptions such as maternity. They also valued private emergency medical evacuation services.

3.1 Proposed benefit design framework

The workstream, therefore, proposes the following benefit design for LCBOs:

- Exemption from the current PMB provisions

- Focus on primary and preventative health care in a separate set of minimum benefits for LCBOs indicated in new regulations under the MSA
- Limited chronic cover. The scheme may add a limited chronic cover at their discretion after a thorough risk assessment. It is proposed that this be achieved by requiring all LCBO products to adhere to the primary care Essential Medicine List (EML) utilised in the public sector.
- Exclusion of private hospital. Any option covering hospital services would need to comply with PMBs to prevent arbitrage against the provisions of the MS Act.
- No reimbursement of public sector hospital costs: the target market currently accesses public hospitals, and it would be unfair to charge them for this without any change in their access. All hospital coverage is therefore not covered.
- Ideally, the LCBO benefits should be congruent with the PMBs, which should be considered part of the current PMB review.

To optimise healthcare delivery while providing members with improved choice and access, the benefit design could include the features below: The benefits listed below are proposed as a minimum. Funders offering LCBO products will therefore be at liberty to provide more comprehensive benefits should they choose to, subject to the hospital exclusion noted above.

- A nurse referral/ gatekeeper system as a minimum requirement,
- Capitation with unlimited access to GPs after following referral pathways
- GP networks based on efficient providers
- Acute and chronic medication incorporating the primary care Essential Medicine List (EML) utilised in the public sector, with its attendant standards of care.
- Chronic disease management at the primary care level to reduce demand for hospitalisation services
- Basic radiology and pathology based on a formulary. The formulary that was developed during the 2015 LCBO consultative process is proposed as an appropriate list.

The cost of including optometry and dentistry is estimated to render LCBO products unaffordable to lower-income markets (refer to section 8 on costing). It is proposed that funders be encouraged to include these

benefits in more comprehensive LCBO products while enabling primary healthcare access to very low-income families through offering the minimum set of benefits contemplated above.

A focus of the benefits package on primary healthcare will allow products to be more appealing to the target market while ensuring that contributions remain affordable to the lower-income market. Importantly, a primary healthcare focus is in line with the NHI objectives. If implemented effectively, it can improve population health and reduce demand for expensive hospital services to enhance healthcare efficiency.

By ensuring the product has a strong primary care focus, LCBOs will be unappealing to sicker lives who require extensive hospital benefits and those currently on medical scheme cover. This will mitigate against anti-selection to enable the product's affordability to lower-income households.

Schemes may consider including accident and emergency cover in the benefits package. However, including these benefits may encourage anti-selection against traditional medical scheme options. Inclusion of such benefits should, therefore, only be done at the discretion of the scheme after a thorough risk assessment. Good benefit design will help limit loss-making primary health care.

The workstream noted that excluding private hospital cover from the LCBOs is not equivalent to dumping on the State since:

- The product is targeted at lives who are already dependent on the State for hospital cover (and primary care cover)
- The coverage of primary care benefits will alleviate the pressure on the State to provide these benefits

There has been some deliberation regarding coverage of maternity and childbirth costs. Ante-natal cover can be accommodated in the benefits proposed above. However, the risk of neonatal expenses makes the cost of including maternity in the minimum benefits prohibitive. It is noted that some exempted products include a cover but excludes high-risk pregnancies. This is not consistent with principles of value in coverage and fair treatment. Therefore it is recommended that the initial set of minimum benefits does not include childbirth cover, but this can be reviewed as more data emerges and if contracting leads to limitations on risk.

3.2 Costing of benefits

The costing of the proposed minimum package and potential supplementary benefits has been performed based on various assumptions. Key assumptions include that

- mainly lives that are presently uncovered will take up LCBO products (in other words, that migration from current medical scheme cover to LCBO products will be minimal); and
- products will be sold to individuals and groups where it would be compulsory for all members in a group to participate.

The cost of providing cover on a non-compulsory basis (either to a non-compulsory group or to individual lives) is projected to be materially higher than the figures presented below, depending on the level of anti-selective behaviour exhibited by non-compulsory lives. Therefore, funders should be allowed to differentiate pricing between compulsory and non-compulsory lives, where the latter includes individual lives. This is envisaged to provide a financial incentive to employers to consider the mandatory cover to their employees, enabling wider market adoption.

The costing presented below is provided as an indication only and is subject to several assumptions, including the nature of the covered population, managed care protocols, selection criteria and contracting provisions about provider networks, geographic area, etc. Funders contemplating developing LCBO products should develop their costings, as the circumstances and appropriate costing assumptions will differ from one instance to another.

Benefit levels

An indicative range of risk costs is provided, with a lower and higher estimate in each case.

***Table 4*: Estimated cost of LCBO products per life per month (PLPM)**

	Nurse as the first point of entry	**GP as the first point of entry**
Primary healthcare	R62 to R70	R75 to R85
Acute medication	R3 to R10	
Chronic medication	R16 to R21	
Basic radiology and pathology	R3 to R5	
Emergency transportation	R3 to R6	
Total for minimum package	**R87 to R109**	**R100 to R124**
Dentistry	R17 to R25	
Optometry	R12 to R14	
Total inclusive of dent/optometry	**R116 to R151**	**R129 to R166**

We note that the cost of provision of dentistry and optometry is high and potentially increases the risk cost of LCBO products by as much as 40%. It is therefore recommended that dentistry and optometry be encouraged but not mandated as a minimum package.

The above figures represent risk costs only. Non-health expenditure (NHE), including administration, managed care, marketing & distribution, broker commission, and reserve building, need to be added to these figures. A reasonable range for these costs could be considered as (per life per month):

- Administration: R30 – R50
- Managed care: R20 – R40
- Marketing and distribution: R5 – R10
- Commission: R30 – R50 ongoing, and consideration could also be given to a sign-on fee to facilitate member education.
- Reserve building: see below

This level of costs is very low considering that the nature of services (e.g. membership enrolment, customer service, communication) is not directly linked to benefit level. A Rand amount cap on NHE is likely to be more feasible than the existing caps defined as a percentage of contributions and can be incorporated into the regulatory framework.

In crude order of magnitude, it is envisaged that the lowest mandated product, with a nurse as the first point of entry, could reasonably be offered in the region of R130 to R200 per life per month, depending on the nature and extent of non-health expenditure. These figures fall well within the scope of the current tax credits to which members of medical schemes are entitled. 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.

Table 5: Summary of benefit package proposals

Benefit package	Current proposal (minimum package)	2015 proposal (minimum package)	LIMS 2005
GP/primary care	✓(restricted to networks)	✓	✓ (restricted to networks)
Pathology and radiology	✓ (basic) *	✓	✓
Dentistry	None	None	✓(2 visits /annum)
Optometry	None	✓	✓ (1 visit/annum)
Emergency services	✓	None	✓ (to public hospitals; to a private hospital only in cases of emergency)
Medicines	✓ (chronic & acute EML) *	✓ (None for chronic; EML for acute)	✓ (chronic & acute EML)
Chronic Diseases Management	✓	None	None
Hospitalisation	✓ (Public sector)	None	None

* on a formulary basis with reference to Standard Treatment Guidelines and health technology assessment

3.4 Solvency

Table 6: Summary of solvency requirements

Solvency requirements	Current proposal	MSA	2015 proposal	LIMS proposal	Other
Provisions	10% in respect of LCBO contributions could be stipulated and adjusted according to RBC principles.	25%	25%		RBC

Regulation 29 of the Act prescribes that the minimum accumulated funds of the medical schemes should be at least 25% of gross annual contributions. The principles of risk-based capital, which have been under consideration for some time, note that the stochastic (high volatility) risk associated with primary care coverage is significantly lower than coverage, including hospital (catastrophic) cover.

Increasing the solvency requirement drives up membership contributions disproportionately, which negatively affects the increase in the number of members entering a medical scheme. A lower solvency requirement for LCBO cover would contribute to keeping contributions affordable. For example, a solvency requirement of 10% in respect of LCBO contributions could be stipulated and adjusted according to RBC principles.

3.5 Evidence-based medicine, Protocols and Formularies

Evidence-Based Medicine (EBM) aims for the ideal that healthcare professionals should make "conscientious, explicit, and judicious use of current best evidence" in their everyday practice. The practice of evidence-based medicine uses systematic reviews of the medical literature to evaluate the best evidence on specific clinical topics (evidence synthesis). The evidence is then translated into practice by medical practitioners who select treatment options for specific cases based on the best research, patient preferences and individual patient characteristics (knowledge translation). Evidence-based medicine practitioners engage in life-long learning and are committed to the continuing education of professionals and patient communities.

The CMS must ensure that schemes base their formularies and protocols on evidence-based medicine. This is provided for in Regulation 15H relating to managed care protocols and Regulation 15I regarding formularies. Currently, a sample of the protocols and formularies employed by MCOs or schemes providing their managed care services are reviewed for compliance with the requirements.

4. Legislative reform: Legal, Compliance and Governance

The section sets out the regulatory implications of LCBOs being accommodated under insurance regulations or the Medical Schemes Act.

4.1 FSP regulations

The Financial Advice and Intermediary Services Act 37 of 2002 (FAIS Act) regulates the rendering of financial advisory and intermediary services to customers. The FAIS Act's main objectives are to protect consumers' interests and professionalise the financial services industry.

The General Code of Conduct for Authorised Financial Services Providers and Representatives (General Code of Conduct) is made under section 15 of the FAIS Act. The General Code of Conduct sets out general requirements for Financial Service Providers, for instance, to act honestly, fairly, and with due care and skill. It further sets out specific responsibilities, for instance, record keeping and safe keeping of funds. The Fit and

Proper requirements determined in section 6A of the FAIS Act refer to the adviser's experience, qualifications and knowledge, personal character qualities such as honesty and integrity, and the meeting of continuous professional development requirements.

The current framework in which financial service providers ("FSPs") are regulated sets out the regulatory landscape that governs FSPs and demonstrates the effective, enough, and inclusive regulatory environment within which FSPs operate and are regulated by the applicable regulatory authority.

There are primary and subordinate legislation that govern FSPs, their remuneration, ability and competency, the obligations to protect its customers and ongoing obligations (such as financial soundness, compliance, disclosure obligations and reporting obligations, to name but a few) under the Financial Advisory and Intermediary Services Act 2002 together with the General code of conduct for authorised Financial Services Providers and their representatives as well as the Fit and Proper requirements.

4.2 Demarcation of insurance products

It is imperative that products operating under this framework are amended to address the concerns raised while developing the demarcation regulations in the Short-term Insurance Act and Long-term Insurance Act. In particular, the products should abide by social solidarity principles, with greater standardisation in benefit design.

The Demarcation Regulations issued in terms of section 72 of the LTIA and section 70 of the STIA, respectively (the "Demarcation Regulations"), created a framework in terms of which insurers could provide "health insurance products" to the market. These products constitute the "business of a medical scheme"; however, the products are demarcated by the Minister of Finance as "insurance products" in the Demarcation Regulations.

A possible approach is to add a contract description to the Demarcation Regulations, specifically within the STIA demarcation (which includes LCBOs). These will then be designated as short-term insurance products in Schedule 2, non-life insurance business (class 14) of the Insurance Act and regulated within the financial services regulatory framework.

This approach will have the consequence that any person who wishes to provide LCBOs must be a licensed insurer in section 25 of the Insurance Act, 2017 (Act 18 of 2017) (Insurance Act). To be licensed, a comprehensive application process and minimum capital requirements are required.

Regulation 70 of the Insurance Act provides the process to be followed if this option is exercised:

"70. Regulations relating to certain classes of insurance business are set out in Schedule 2.—*(1) The Minister, despite the definition of "business of a medical scheme" in section 1 (1) of the Medical Schemes Act, 1998 (Act No. 131 of 1998), may make regulations identifying a kind, type or category of contract as an insurance policy that may be entered into under the—*

(a)risk class of life insurance business in Table 1 of Schedule 2;

(b)accident and health class of non-life insurance business in Table 2 of Schedule 2; or

(c)the travel class of non-life insurance business in Table 2 of Schedule 2.

(2) Regulations under subsection (1)—

(a)must be made only—

(i)in consultation with the Minister of Health;

(ii)after consultation between the National Treasury, the Prudential Authority and the Registrar of Medical Schemes established under the Medical Schemes Act, 1998; and

(iii)after having regard to the objectives and purpose of the Medical Schemes Act, 1998, including the principles of community rating, open enrolment and cross-subsidisation within medical schemes entrenched therein;

(b)must provide for insurers to submit specified information on any product within a kind, type or category of contract referred to in subsection (1) to the Prudential Authority and the Registrar of Medical Schemes within any specified timeframes; and

(c)may provide for matters relating to the design and marketing of any product within a kind, type or category of contract referred to in subsection (1)."

For the LCBO as primary healthcare to fall under the insurance framework as in being considered an insurance business, the Minister must make regulations identifying it as such, although meeting the definition of "business as a medical scheme". National Treasury makes the regulations together with consultation with the department of health. Currently, what is identified as an insurance business despite meeting the definition of "business as a medical scheme" is:

Short-term (non-life):

- Medical expense shortfall (difference between costs and what medical aid paid);
- Non-medical expenses covered as a result of hospitalisation (purpose to cover non-medical expenses);
- HIV, Aids, Malaria testing and treatment;
- International travel insurance; and
- Medical emergency evacuation or transport.

Long-term (life):

- Non-medical expense cover as a result of hospitalisation;
- Frail care (cost of the expense of assistance for daily activities);
- HIV, Aids, Malaria testing and treatment;
- Medical emergency evacuation or transport.

The proposed LCBO will not fall to any of these mentioned here that was classified as insurance by the Minister. Should the LCBO be offered as an insurance product and wish to be captured under the protection of customers (e.g. PPRs), there would need to be regulations bringing the LCBO into the insurance framework.

Once this has been done, due to the classification of the product under the insurance framework, all the existing protections afforded to policyholders will apply to these products. The Policyholder Protection Rules is far-reaching, and a strong regulatory framework for the conduct of insurers' business ultimately leads to better outcomes for policyholders.

The Policyholder Protection Rules afford customer protection throughout the product lifecycle in that there are rules that deal with general rules in respect of fair treatment, product design, advertising, and disclosures, as well as claims/complaints and the termination of policies.

Any party who wishes to provide advice or intermediary services in respect of LCBOs on behalf of an insurer would be subject to financial service legislation.

Health Insurance products co-exist with medical schemes to strengthen the National Health Policy. Policyholders reduce the burden on the public health system, and policyholders receive no tax rebate or allocation. Their contribution to health insurance products is voluntary and a key instrument to secure financial risk protection and an individual's constitutional right to insure.

The diverse offering, size and growth of health insurance policyholders indicate and support the need for such products. Furthermore, low-income earners cannot afford to achieve financial risk protection by joining medical schemes due to affordability. The LCBOs need to offer a real and legitimate alternative to low-income earners.

Mechanisms will also need to be implemented to mitigate against the current anti-selection risk that these products pose to medical schemes, as the movement of members between these products and existing medical scheme options can destabilise both risk pools and drive up the cost of cover.

Alternatively, the LCBOs can be accommodated under the Medical Schemes Act, as shown in 4.8 below.

4.3 Consumer Protection and Complaints

Implementing the LCBO will ensure the promotion of fair treatment and equitable access to private healthcare and protect the interests of its members. The LCBO could adopt the current complaints procedure by the CMS, where complaints by providers are sent to the CMS and complaints with regards to advice provided can be directed to the FAIS ombudsman.

The CMS should also progress measures to support medical schemes to manage fraud and wasteful expenditure. Ultimately any abuse and wastage of funds by a select few impacts other members of medical schemes and leads to an increase in premiums. Furthermore, the CMS should promote the development by the industry of a code of conduct to ensure that fair practices are voluntarily adhered to and maintained, as well as develop guidelines for the industry of specific ways in which fairness in the treatment of beneficiaries can be enhanced – including possible developments to the model rules for LCBOs.

Demarcation regulations and the Policyholder Protection rules apply more to Insurers (as product providers), and FAIS applies to FSPs (brokers) selling insurance and medical scheme products. TCF principles apply to both.

4.4 Managed Care

Due to LCBOs needing to be affordable, it would be beneficial if the schemes entered into agreements with managed care organisations. Managed care organisations can assist LCBOs by lowering the costs of healthcare services provided through the management of care rather than limiting benefits. This would involve offering immediate healthcare solutions to members, supported by information and guidance. Alternative reimbursement models should be encouraged to promote a patient-centric approach to coordinating and managing primary care with a focus on quality health outcomes. Providing managed care services can also add to the appeal to the LCBOs as the members will receive support to access quality healthcare services at an affordable rate. Quality assessment and reporting is critical and require transparency.

4.5 Non-Healthcare Expenditure

The CMS guideline for Accredited Administrators tables the process to be followed for third-party administrators and self-administered medical schemes. As defined in Regulation 15, managed care services must be provided in terms of the MS Act and Regulations and aligned to the registered scheme rules.

These will apply to LCBOs. The CMS should also ensure expedited and effective implementation of administrator-accreditation procedures (including suspension and withdrawal where appropriate).

Concerning any cap on the cost of administration, there should be due regard to a reasonable level of non-healthcare expenses measured in Rand terms rather than as a percentage of contributions, given the low total contribution and base cost of administration services.

4.6 Governance Framework

Governance decisions should be taken following the members' interests rather than being influenced by commercial interests. The legal parameters of the powers of trustees derive primarily from two sources: the common law, as it has been amplified through the King Report, and statute, in this case, the MS Act.

As indicated in Chapter 1, the governance framework in the context of insurance is thoroughly regulated in terms of various sections in the Insurance Act.

We set out below the governance requirements and regulatory oversight bodies regarding financial services legislation and the MS Act.

Table 7: Governance requirements and oversight bodies

Insurance Act (financial services regulation framework)	**MSA**
Chapter 5 of the Insurance Act sets out the governance framework that insurers need to adhere to Chapter 6 – financial soundness Chapter 7 – reporting and public disclosures	Chapter 4 – medical schemes and the registration thereof Chapter 5 – rules of medical schemes Chapter 7 – financial arrangements (financial soundness) Chapter 9 – powers of the Registrar
Twin Peaks model of regulation introduced by the FSR Act (market conduct) Prudential Authority and FSCA	CMS

4.8 Proposed Legislative and regulatory changes required

The following amendments to the MS Act and regulations are proposed should the LCBOs be accommodated under the medical scheme legislative framework. All other provisions of the MS Act would continue to apply.

A. Amendments to the Medical Schemes Act

We propose the following amendments and additions to the MSA to accommodate the proposed LCBO framework. Underlined words are the additions.

i. Amendment to Section 1

By the addition of the following definitions after the definition of *'general waiting period'* –

"LCBO" means the Low-Cost Benefit Option created by a medical scheme in terms of the rules;

ii. Amendment to Section 29(1)

This amendment allows for the contextualisation of the introduction of subparagraph (oA).

1. By the Amendment of Section 29(1)(o) as follows –

"(o) The scope and level of minimum benefits that are to be available to beneficiaries <u>in general</u> as maybe prescribed".

Scope intends to cover both minimum and maximum benefits

2. By the addition of Section 29(1) (oA) as follows –

"(oA) The scope and level of minimum benefits that are to be available to beneficiaries of LCBOs as may be prescribed".

This amendment and the previous ones distinguish between PMBs and LCBO Minimum Benefits.

3. By the addition of a new subparagraph as follows -

"(v) The time by when member may change benefit options".

This amendment permits group pricing differentiation in addition to differentiation based on income and number of dependants, as is the case with subparagraph (i).

2.4 By the Amendment of subparagraph (n) as follows –

"(n) The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions -

(i) on the basis of income or the number of dependants;

(ii) in respect of LCBOs, also on the basis of the number of members on a group, the level of subsidy in respect of any group and the extent to which a person is compelled to join the group; and

(iii) but may not differentiate on any other basis including age, sex, past or present state of health, of the applicant or one or more of the applicant's dependants, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependants other than for the provisions as prescribed."

iii. Amendment of 29(3)

This amendment allows for LCBOs to be created for defined groups.

By the Amendment of Section 29(3)(c) as follows –

"*(3) A medical scheme shall not provide in its Rules –*

(a) for the exclusion of any applicant or a dependant of an applicant subject to the conditions as may be prescribed, from membership except for -

(i) a restricted membership scheme as provided for in the Act; or

(ii) a restricted group of members on an LCBO as defined in it rules where the restriction on such a group is based on the identity of the employer, the category of employment, the prescribed income threshold or such group as may be designated by the Registrar.

iv. Amendment to Section 29(A)

This amendment enables schemes to impose waiting periods in respect of upgrades (to address anti-selection where this is deemed necessary).

By the insertion of a new subsection (4) as follows –

"(4A) Notwithstanding subsection (4), a medical scheme may impose a general condition waiting period of 12 months on any member who wished to migrate from an LCBO to any other benefit option or from any other benefit to an LCBO."

Can be linked to a change of employment

v. Amendment to Section 33

This amendment excludes LCBOs from section 33(2), which relates to options being financially self-supporting but preserves this requirement at the scheme level.

4. By inserting the following words at the commencement of subsection (2) – *"Except for LCBO's……."*.

5. By the insertion of a new subsection (2A) as follows –

"(2A) The Registrar shall not approve an LCBO unless the Council is satisfied that such benefit option

(a) includes the minimum benefits as may be applicable to LCBOs; and

(b) *will not jeopardise the financial soundness of the medical scheme.*

B. Amendment to the Regulations

i. Amendment to Regulation 4(2)

A medical scheme that provides more than one benefit option may not, in its rules or otherwise, preclude any member from choosing or denying any member the right to participate in any benefit option offered by the medical scheme, provided that a member or a dependant shall have the right to participate in only one benefit option at a time and, in the case of LCBOs, the member meets the eligibility requirements.

ii. Amendment to Regulation 7

6. The addition of new definitions before the definition of "*prescribed minimum benefit*" is as follows-

"*LCBO minimum benefits*" means the benefits contemplated in Section 29(1)(oA) and consist of the diagnosis, treatment care and the cost of the treatments specified in Annexure C;

"LCBO Network Provider" means the health care provider (or group of providers) selected by a medical scheme as the preferred provider (or providers) and with whom it has contracted to provide to its members with diagnosis, treatment and care in respect of one or more LCBO minimum benefits at a rate as may be agreed between them;

iii. Insert new Regulation 8A and 8B

This amendment allows the scheme to set its upper reimbursable limit.

By the insertion of new regulations after Regulation 8.

"(8A) In respect of LCBOs, the rules of a medical scheme may provide that any diagnosis, treatment and care may be obtained from an LCBO network provider and if so, the rules -

(i) may make provisions for co-payments by members and their beneficiaries in the case of non-use of LCBO Network Providers, provided that such co-payment may not exceed 20% of the contracted rate of such providers; and

(ii) shall in the case of involuntary use of an LCBO network provider, indicate the maximum level above the contracted rate that the scheme shall reimburse non-LCBO Network Providers."

(8B) For purposes of regulation (8A), "involuntary use" of an LCBO Network Provider bears the same meaning as set out in Regulation 8(3).

Need to consider the impact on the cost of the cover of providing for non-network providers

iv. Amendment to Regulation 11

Such creditable coverage for LCBOs does not apply to PMB benefits not covered by LCBOs.

v. Amendment to Regulation 29

The amendment of sub-regulation (2) is as follows –

"(2) Subject to sub-regulation (3), (3A) and (3B), a medical scheme must maintain accumulated funds for the accounting period under review, which may not be less than 25% of gross annual contributions excluding contributions in respect of members on LCBOs plus 10% of gross annual contributions in respect of members on LCBOs.

5. Risks and Implementation

5.1 Environment

The market in which such products operate is an essential consideration in their design and costing. Some of the factors that need to be considered under the current environment are as follows:

- Burden of disease
- NHI policy framework
- Social context
- Macro-economic outlook
- International experience
- The challenge of extending coverage to vulnerable groups is ensuring TCF principles are adhered to.

- Primary strategies for addressing these include:
  - Modifying eligibility criteria to protect the target market
  - Promoting awareness of schemes and benefits
  - Ensuring that contribution levels are affordable
  - Accessible enrolment
  - Improving healthcare delivery mechanisms to promote efficient delivery of quality care
  - Improving management and organisation of medical schemes to manage related risk.

The CMS discussion document of March 2019 noted the following features of global approaches:

- Mandatory membership for formally employed was a key mechanism for sustainability.
- Income-based contribution (with a cap) is used to promote affordability.

- Tripartite contribution models (member, employer and government subsidy) ensure accessibility of cover.
- Differential benefit packages are essential for appropriate segmentation of the market.
- There are ongoing challenges with informal sector coverage
- There is a crucial role for private voluntary health insurance (PVHI) in supporting the health system.
- The proposed structures support a focus of public resources on vulnerable segments of the market
- It is essential to avoid OOP expenses
- Properly regulated coverage and risk pooling can improve UHC while publicly funded coverage is expanded
- The paper concludes that mandatory cover is more viable for formal sector employees (noting the importance of group cover principles for affordability). Low-income cover usually focuses on more predictable coverage.
- There are learnings from ObamaCare in US regarding benefit differentials, financial risk protection and cover mandates.

5.2 Implications of HMI Findings on the LCBO framework

The Health Market Inquiry made several findings and recommendations in its report of September 2019.

- Buy down effect /impact.
  - **HMI FINDING:** movement of members from the 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.
- Product simplicity and Choice optimisation/standardisation of benefit options
  - **HMI recommendation** to have one standardised benefit package, along with the introduction of a RAM which would remove the fragmented risk pools within a scheme and equalise risk across schemes.
  - A RAM must consider the different risk pools for LCBOs and other medical scheme benefits.
- Base benefit package
  - A risk adjustment mechanism is implemented for all schemes to offer a comprehensive base benefits package.
- Risk selection and cream skimming
  - **HMI recommendations**: The need to remove schemes' incentives to compete on risk factors such as age and instead encourage schemes to compete on value for money and innovative models of care.
  - LCBOs would operate on a community-rated basis per the MS Act's provisions with no maximum age at entry.
- Standardised measurement of quality health outcomes at a benefit option level (demonstration of value for money and financial risk protection)

5.3 Other challenges and issues faced by medical schemes

The introduction of the LCBO framework poses several risks to medical schemes. These include:

- Buy-down risk: If existing medical scheme members buy down to LCBO options, the cost of existing benefits will increase. This is because those with lower claims costs will likely buy down, leaving a risk pool of higher-cost lives on the existing options. In addition, the utilisation levels of existing medical scheme members are likely higher than the new lives, which are the LCBO options' target market. Adding these lives to the LCBO risk pool will increase the cost of LCBO cover. To manage this risk, the framework needs to include:
    - Benefit differentiation especially excluding private hospital cover
    - Group cover principles which limit the risk of individual anti-selection
    - Underwriting is applied to buy-ups and buy-downs to limit the risk of individual anti-selection (while still providing the opportunity for moving between options)

- Financial soundness: Adding new lives to the medical scheme risk pool will dilute existing solvency levels; however, adding an onerous reserve loading to LCBO contributions will impact affordability for a remarkably price-sensitive market. There is also significantly lower stochastic risk associated with primary care cover that does not include hospitalisation risk (i.e. lower variability of claims per person and low risk of high-cost claims). Therefore, a lower solvency requirement can be motivated for such options and a level of 10% is suggested.

- Cross subsidisation – The MSA requires benefit options to be financially sound and financially self-supporting. Social solidarity is also imperative for ensuring cover is accessible; cross-subsidies may support this. For LCBOs, this may include considering a marginal costing approach (i.e. costing for direct costs only and not overall scheme expenses) to ensure affordability. This requires sound and careful management.

6. Key stakeholders

Critical stakeholders in the implementation of the LCBO framework are:

- Members and beneficiaries – those who have previously been unable to afford medical scheme cover and will have an opportunity to purchase cover for primary care benefits.
- Medical scheme trustees – are responsible for sound risk management of medical scheme risk pools and will need to ensure that all benefit options are financially sustainable and the introduction of LCBOs does not have adverse consequences on the financial soundness of existing benefit options.
- Employers – may provide subsidies to employees for cover on a group basis and can ensure lower cost of cover by making cover mandatory. The employer benefits from the productivity benefits of employees accessing care and health management for themselves and their dependents.
- Unions – need to ensure fair treatment of employees and optimal access to benefits.
- Healthcare providers – benefit from pre-payment/pooling for treatment rather than relying on patients to fund treatment on an out-of-pocket basis. Will need to ensure that reimbursement is on a reasonable basis that is affordable to the target market and that there are appropriate treatment pathways in place.
- Managed Care Organisations
- Administrators
- Medical schemes
- Health insurance policyholders
- Health insurance companies
- Industry bodies (FSCA, PA, SARB, NDoH, HFA, BHF, BIAC, SAMA, DENOSA, HPCSA, ICPA, SAPC, African Unity, CHOC, FIA, Medicheck)
- 3rd parties (Brokers, underwriting managers)

7. Summary of Recommendations

The workstream recommendations can be summarised as follows:

- The target market for LCBO coverage is lower-income employees and their dependents.
- While an income level of R18 000 per month is considered appropriate for defining the target market, an income-based eligibility criterion is not recommended.
- Benefit differentiation is crucial to ensure that the target market is reached and that the existing medical scheme risk pool is not adversely affected. This includes:

    - A set of minimum benefits for LCBOs focused on primary care
    - No private hospital covers so that existing PMBs are not undermined
    - Limited chronic cover in the minimum benefits with some scope for schemes to offer more cover if they elect to.

- Principles of group cover are also crucial to ensuring affordability and promoting a tripartite funding model. It is noted that over 90% of current coverage is on a group basis. It is recommended that contributions can be differentiated according to:
    - Individuals (on age at entry for viability)
    - Voluntary group
    - Compulsory group

- To ensure the cost of cover remains affordable and is not adversely impacted by adverse selection, consideration must be given to managing the movement between options. These provisions should use the existing provisions of the MSA as far as possible.
    - Buy ups – these should be considered a pathway to more comprehensive cover but noting the risk for anti-selection if there is a two-way movement. Underwriting is suggested on benefits not included in LCBO minimum benefits.
    - Buydowns – these should be discouraged but may be necessary where there is a loss of employment. So underwriting should apply (general waiting period) unless there is a change in employment.
    - Risk equalisation should be considered part of implementation for the whole medical scheme environment.

- These recommendations should be considered in the context of recommendations from the other workstreams on:
    - The benefit structures
    - The legal framework
    - Implementation considerations

There should also be a transitional period whereby all existing beneficiaries of exempted products have an opportunity to join an LCBO (suggest six months). It is also noted that the risk pool needs to accumulate critical mass before covering older lives (>65) can be considered. So these are not included in the initial target market.

The workstream has noted that over 500 000 lives are already accessing coverage despite the market constraints and limitations due to the closed group of insurers permitted to offer cover. We estimate that an additional 2.3 million potential new lives will enter medical schemes. We note that underwriting and group restrictions are necessary to protect schemes from anti-selection and selective buy-down risk. Mandatory membership should be implemented only once the system is more than enough. This is not a consideration that can be addressed at this time but should be contemplated as part of the LCBO review.

Minimum benefits serve the purpose of protecting consumers by ensuring that their primary care needs are covered. Maximum benefits are required to ensure that LCBOs do not become a mechanism for bypassing the existing PMB requirements and potentially misleading consumers concerning the extent of hospital and chronic cover. The purpose of LCBOs is to provide affordable cover for low-income earners; this needs to be kept in mind when the benefits are considered.

8. Annexures

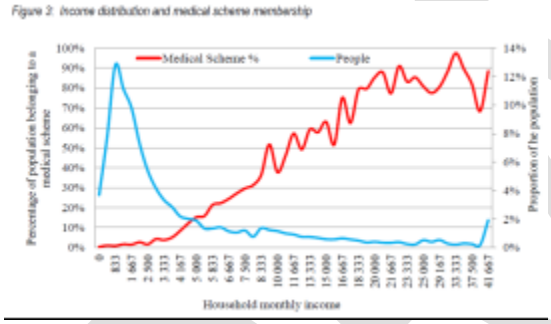
Annexure 1: Summary of key findings from previous Discussion Documents

CMS Discussion Document (March 2019)

The CMS Discussion document of March 2019 included the following key conclusions:

- Econometric analysis indicates 100 000 low-income households (<R6000) will take up cover
- The increasing threshold to R16 000 gives 299 968 – 382 269 households
- Based on benefits package cost of R400 – R800
- Stagnation of medical scheme membership growth reflects affordability constraints

Figure 1: Income distribution and medical scheme membership



LIMS Consultative Process

Table 8: LIMS recommended benefit package

LIMS package of essential services (stated as requiring refinement)	
SERVICE	**BENEFIT ENTITLEMENT**
GP consultations	• Consultations, a minimum of: three GP visits for M + 0.[93] six GP visits for M + 1. eight GP visits for M + 2. ten GP visits for M + 3. 12 GP visits for M + 4. • A maximum of 12 GP visits per family per annum. • A formulary comprising a limited set of procedures to be performed in GPs rooms. • An additional minimum of three GP visits per annum per beneficiary who has one or more LIMS PMB conditions. • It is assumed that most LIMS options will contract with DSP GP networks, and are likely to offer unlimited GP consultation benefits. • GP networks may utilise nurses and other service providers, but the package must provide access to GPs where this is required.
Pathology and radiology investigations	Ordered by GP, subject to a defined formulary.
Dental consultations	A minimum of: • two dental visits per beneficiary per annum for basic conservative and restorative dentistry. • No cover mandated for advanced dentistry or dentures, with some upper limit on number of visits, as for GPs.
Optometry	A minimum of: • One eye test per 24 months. • One pair of spectacles every 24 months, subject to clinical criteria and a formulary. • LIMS schemes may elect to impose reasonable financial limits, as well as protocols related to lens prescriptions. • A basic frame should, however, be covered in full.
Medicines	A minimum of: • A defined formulary (LMP) for acute and chronic medications, based on the health department's essential drug List, with suitable modification where this list is considered to have gaps. • Unless otherwise specified or defined as chronic medication, reimbursement of individual medicines may be limited to four courses per annum. • Medicines which would typically require a specialist diagnosis prior to prescription are not included in the LMP formulary (but may be covered).
Emergency transport to a public hospital (or private hospital in cases of a life-threatening emergency)	
Maternity care services	a. Not mandated as part of minimum package.
Specialist benefits	b. Not mandated as part of minimum package.
Hospitalisation	c. Not mandated as part of minimum package.

Summary of key recommendations from the LIMS consultative process:

- LIMS should be open to any formal sector employee or self-employed person who earned less than R6 500 per month in 2005 and their dependents.
- New schemes and new benefit options within existing schemes would be registered as LIMS schemes.

- Employers and employees would each make a 50% contribution to the premium, and the employees' share should not exceed 5% to 8% of household income.
- The report proposed a LIMS benefits package that would provide for acute and some chronic outpatient care, and LIMS members would be expected to obtain in-patient care from a public hospital at no cost;
- The LIMS schemes would be kept entirely separate from other medical schemes, with a risk-equalisation Fund (REF) to promote cross-subsidies within the LIMS environment. Still, no cross-subsidies between LIMS and other medical schemes would be allowed.
- The cost of funding the PMBs presented a significant obstacle to extending medical scheme coverage to low-income households. The study also proposed that a LIMS benefit package, if implemented, should be narrower than the PMBs

Circular 9 of 2015 – LCBO guiding principles

Broad principles guiding the development of the LCBO

- Protecting risk pooling - the existing medical scheme risk pool should not be undermined or fragmented.
- Benefit design – Proposed benefits in LCBO are based on affordability of the intended target market, cost-effective and evidence-based healthcare provision and responsiveness to market preferences.
- Continuation of care –out-of-network care
- Solvency protection – The statutory solvency requirement of the MSA should be maintained
    - 2015 CMS guidelines
- A mandatory minimum set of benefits
- Network arrangements
- The income threshold for eligibility
- Capping of broker fees (exemption)
- Employer group cover in the first year (incremental approach)
- No co-payments
- Stakeholder concerns
- Consistency with policy agenda
- Potential to further fragment medical scheme risk pools

- Revision of PMBs
- Non-health expenditure (NHE) – In evaluating the value proposition of any suggested product, the affordability of the proposed contribution must also ensure that the level of NHE is brought to a proportionate level to ensure that the benefits provided are optimised.
- Marketing –The framework's purpose is to expand coverage to persons who have not previously been members of a medical scheme (referred to as the previously uncovered market). It is essential to ensure that the marketing of the LCBOs should be targeted at the previously uncovered market and that they are not misled into believing they are purchasing a more comprehensive product than is the case.
- Underwriting – the impact of late joiner penalties on those previously excluded by economic disadvantage.
- Policy objectives of open enrolment, community rating, consumer protection, non-discrimination and expanding risk-pooling need to be demonstrably furthered

The role of private voluntary cover is discussed as a mechanism for cover until expansion can be afforded. It is particularly noted that catastrophic cover is difficult to sell to low-income households who do not perceive the value of this cover.

This suggests that regulations are needed to address the challenges of anti-selection and cherry-picking, and incentives to foster risk and income cross-subsidisation within and across risk pools are necessary. A universal basic package is encouraged as it reduces uncertainty, simplifies choice and facilitates the transfer from one policy to another. In addition, if the government intends to make the private voluntary cover more affordable to lower-income groups, it can consider providing subsidies. However, the choice of subsidies raises the concern of shifting funds from the public sector to subsidies.

The document states that mandatory health insurance for those working in the formal sector is a more economically viable option than voluntary health insurance for providing cover to low-income households working in the formal sector.