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DEPARTMENT OF HEALTH

NO. 5872 **17 February 2025**

CALL FOR PUBLIC COMMENT ON THE COUNCIL FOR MEDICAL SCHEMES' LOW-COST BENEFIT OPTION REPORT

I, Dr Pakishe Aaron Motsoaledi, MP, Minister of Health, hereby invite comments from interested parties on the Low-Cost Benefit Option (LCBO) Report ("the Report") prepared by the Council for Medical Schemes and submitted to the Minister of Health..

The CMS presented the LCBO Report which includes recommendations to the Minister of Health. I understand that the report was concluded after extensive consultation and participation by various stakeholders in the development of the reports and the proposals. I am advised that the final report was not shared with stakeholders before submission to the Minister of Health.

Following a review of the Report's proposals and recommendations, I have made the following observations firstly the benefits being proposed for the LCBOs are less than the current benefits package offered at no charge by the public healthcare system. It is thus difficult to reconcile why a low-income earner (the target group for this package) would purchase such a package when the same is available for free or at a nominal charge from the State. Additionally, employers will likely be called on to contribute towards an LCBO package that is inferior in benefits and more expensive than the same service offered by the public healthcare system currently.

Secondly, the proposals are not supported by any research linked to the specific sector of the population that believe these products offer a real value given the minimalist benefit package and significant cost.. Often these products are presented as "medical scheme like products" and only after the client attempts to access the benefits do they experience problems and then realise that their benefits are very limited.

Thirdly, the "low-cost benefit option" proposal was developed by the private healthcare sector with the purported objective of offering a package of services at an affordable rate for low-income earners. Implicit in this objective is for such a service package offering to be comprehensive. In order to offer a comprehensive benefit package at a lower cost would necessitate a significant deviation from the current private health sector pricing models i.e. focusing on higher levels of efficiency and lower profit margins by private healthcare providers and administrators for a comprehensive set of benefits. Unfortunately, the proposal presented in the report, which I understand was a collective effort of the private healthcare sector, seems to not focus on efficiencies nor lower profit margins but instead just reduced benefits to maintain the current exorbitant pricing structure. The offering in effect is a "Low-Cost Low Benefit" proposal rather than a low-cost comprehensive benefit proposal. Comments are

invited with evidence of why the LCBO package cannot provide a comprehensive package of benefits through lower unit prices.

Fourthly the LCBO package proposed in the report lacks detail on exactly what services will be offered or the quantity of each benefit e.g. the number of consultations permitted etc. This information is important for consumers so they have a clear understanding of the LCBO. Permitting this level of vagueness may lead to the development and sale of products with minimal benefits.

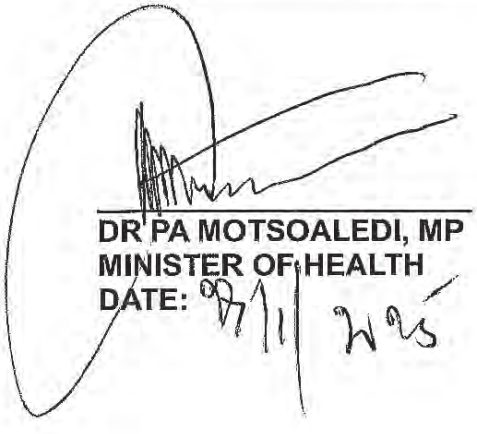
Fifthly, the National Health Insurance Act sets out a clear pathway towards universal health coverage and the reforms that are envisaged. There is no clarity on the alignment of these policy proposals with the NHI Policy.

In light of the concerns I have raised above it would be most appropriate to implement the Health Market Inquiry recommendations relating to the establishment of a basic benefit package through an amendment to the Medical Schemes Act combined with a Multilateral Price Negotiation Forum which is more likely to lead to the development of a comprehensive benefit package at an affordable premium for low-income households.

All interested parties are invited to submit comments on the recommendations in the report and on the key concerns I have raised above following a review of the LCBO report in writing. You are encouraged to substantiate your comments with evidence from the published literature or your own analysis.

Comments should be submitted electronically to LCBO@health.gov.za within 3 months of the date of this publication.

The Report can be downloaded from the website of the Department of Health at www.health.gov.za. Inquiries may be directed to Ms Mushwana (mihloti.mushwana@health.gov.za).



DR PA MOTSOALEDI, MP
MINISTER OF HEALTH
DATE: 07/11/2025

The LCBO Report can be access from the website of the Department of Health link at: https://www.health.gov.za/strategic-documents/

Recommendations and Guidelines

LCBO

LOW-COST BENEFIT OPTIONS

October 2023

COUNCIL FOR MEDICAL SCHEMES

*This report aims to clarify the **LCBO guidelines** that have been presented by the industry and makes recommendations thereof*

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- The CMS internal working committees on LCBO and staff, whose input and contributions were vital to this report.
- The Council, our governance body, for their unwavering support and for endorsing the recommendations presented in this report.
- The National Department of Health, National Treasury, Prudential Authority, Financial Service Conduct Authority, and other regulatory authorities have been actively engaged in discussions and collaborations since 2020.
- The Board of Healthcare Funders and Health Funders Association, alongside non-affiliated schemes that were integral members of the LCBO Advisory committees and technical workstreams.
- All members of the LCBO Advisory committees and Technical workstreams.
- The insurance industry, medical service providers, and advocacy groups representing consumer interests, which actively engaged in the advisory committees, and their valuable contributions have been duly acknowledged.
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- We express our gratitude to Dr. Tladi Ledibane, our proficient policy writer, for his invaluable contribution in the finalisation of this report.
- These contributions have been instrumental in the completion of this report, and we extend our gratitude to each of them.

LIST OF ABBREVIATIONS

ALT	Alanine Aminotransferase
AST	Aspartate Aminotransferase
CDL	Chronic Disease List
CK	Creatine Kinase
CMS	Council for Medical Schemes
COPD	Chronic obstructive pulmonary disease
DSP	Dedicated Service Provider
EDL	Essential Drug List
EML	Essential Medicine List
FSCA	Financial Sector Conduct Authority
GC	Gross Contributions
GGT	Gamma Glutamyl Transferase
GP	General Practitioner
HIV	Human Immunodeficiency Virus
LCBO	Low-Cost Benefit Option
LD	Lactate Dehydrogenase
LIMS	Low Income Medical Scheme
LJP	Late Joiner Penalty
MCO	Managed Care Organisation
MSA	Medical Schemes Act
NDoH	National Department of Health
NHE	Non-Healthcare Cost
NHI	National Health Insurance
NT	National Treasury
OOP	Out-of-Pocket
PA	Prudential Authority
PBPA	Per Beneficiary Per Annum
PBPM	Per Beneficiary Per Month
PEP	Post-Exposure Prophylaxis
PHC	Primary Health Care
PMB	Prescribed Minimum Benefits
PMPM	Per Member Per Month
SA	South Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
WP	Waiting Period

EXECUTIVE SUMMARY

Medical schemes and the insurance industry have introduced proposals aimed at providing benefits to individuals with low incomes. This initiative stems from a thorough and extensive engagement process within the industry that was initiated in the year 2020. Throughout this comprehensive engagement process, detailed guidelines and recommendations were meticulously formulated. These guidelines and recommendations were subsequently presented to the CMS (Council for Medical Schemes), for careful consideration and for the CMS to make recommendations to the Minster of Health.

In an effort to ensure transparency and public participation, the CMS proceeded to publish the drafted guidelines on its official website, inviting public comments and feedback. On September 14, 2022, Circular 53 of 2022 was issued, inviting the public to provide feedback and comments on the Low-Cost Benefit Option (LCBOs) framework report, along with the associated risk assessment and roadmap. Subsequently, on October 6, 2022, Circular 57 of 2022 was issued, which pushed back comment submission deadline previously mentioned in Circular 53. This extension stretched the timeframe from October 7th to November 30th 2022. Consolidated of the public comments commenced in December 2022 while thorough examination of the public feedback was initiated in January 2023.

Having collected this diverse range of public perspectives, the CMS undertook a rigorous evaluation of the proposed guidelines as presented by the healthcare industry. A meticulous analysis was conducted, aimed at critically assessing the viability, effectiveness, and potential impact of the proposed guidelines. Subsequently, these assessments were synthesized to formulate informed and well-considered recommendations, which were then submitted to the relevant government Minister for further review and consideration.

In addition to addressing the proposed guidelines, the CMS actively sought to address two pivotal questions that emerged as cornerstones of this initiative. These questions encapsulate fundamental aspects of the proposal and represent key areas of concern and deliberation:

- The necessity for medical schemes to provide low-cost benefit options.
- The fate of insurance companies currently offering primary health insurance products under the demarcation exemption framework.

This report aims to clarify the LCBO guidelines that have been presented by the industry and makes recommendations thereof. Simultaneously, it offers insightful recommendations concerning the two pivotal aspects that form an integral part of these propositions.

The extensive scope of this report encompasses a meticulous examination of the industry's consultation process, an identification of inherent limitations, and a comprehensive evaluation of the prevailing legal framework. This analysis is enriched by the inclusion of both policy and technical assessments, thereby facilitating a comprehensive grasp of the consequences and potential outcomes associated with various courses of action. The recommendations set forth by the CMS are underpinned by a rigorous assessment of the proposed package derived from the industry consultation process. The primary goal was to efficiently tackle the burden of disease by implementing measures that guarantee sufficient coverage for beneficiaries. Simultaneously, the aim was to also provide financial protection by diminishing the extent of out-of-pocket payments. Furthermore, another critical objective was to secure the long-term sustainability of public health resources.

Importantly, the CMS undertook careful consideration of the potential impact on the guaranteed Prescribed Minimum Benefit (PMB) provision, the reduction of out-of-pocket expenses, and the promotion of equitable access to healthcare. In addition to these recommendations, the CMS has also undertaken undertook the responsibility of compiling and structuring the document for submission to the Minister. This process involved aggregating all relevant information, supporting data, and analyses into a comprehensive and coherent document. This prepared document was designed to be easily comprehensible and reviewable by the Minister and other stakeholders.

The CMS advocates against the introduction of a low-income earners option. Instead, it proposes a phased discontinuation of the currently exempted products. This will be achieved through an engaged dialogue between the NDoH, National Treasury, FSCA (Financial Sector Conduct Authority), and the PA (Prudential Authority). This recommendation is preferred due to the following reasons:

- The proposed industry package lacks sufficient benefits compared to the CMS package, which fails to address the burden of disease effectively.
- There is no guaranteed reduction in the burden on state/public health services.
- The introduction of the proposed option undermines the guaranteed Prescribed Minimum Benefit (PMB) dispensation.
- It is likely to increase Out-of-Pocket (OOP) expenses and worsen the current challenging situation.
- The introduction of a new option for the missing middle widens inequities in healthcare access.
- The need to preserve and protect the implementation of the National Health Insurance (NHI).
- The proposed option introduces complex legal requirements, necessitating legislative changes.
- Continuing with the current exempted products will create an uncompetitive environment.

The CMS is committed to providing the Minister with well-informed and evidence-based guidelines and recommendations to facilitate informed decision-making. The ultimate goal is to ensure that the LCBO and the fate of exempted products are addressed in a manner that aligns with the broader objectives of the healthcare system, including the implementation of the National Health Insurance (NHI).

PURPOSE

The objective of this report is to provide a comprehensive understanding of the LCBO guidelines that have been put forward by the industry. Alongside this, the report furnishes valuable recommendations focusing on the two fundamental facets that are integral to these proposals. The depth of analysis covered in this report encompasses a thorough scrutiny of the industry's consultation process, the identification of inherent limitations, and an all-encompassing evaluation of the existing legal framework. The inclusion of both policy and technical assessments further enhances this analysis, contributing to a holistic comprehension of the repercussions and potential results linked to different strategies and approaches. Additionally, the report presents an analysis of public comments regarding the framework and benefits package outlined in Circular 53 of 2022.

Furthermore, based on prior research, technical analysis, and policy analysis, the report provides recommendations addressing the following key questions for the Minister of Health's consideration:

- The necessity for medical schemes to offer an LCBO product and
- The decision regarding the currently exempted products operating under the demarcation regulations.

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METHODOLOGY

The research method that incorporates document analysis, analysis of secondary data, stakeholder engagement, and public comment analysis is often referred to as a mixed-methods approach. This approach combines qualitative and quantitative research methods to provide a more comprehensive and nuanced understanding of a research topic or issue. Each of the mentioned components contributes to a well-rounded exploration of the subject matter. The report delineates how each component fits into the mixed-methods approach:

- **Document Analysis:** This involves examining various types of documents, such as reports, policies, memos, and other written materials, to extract relevant information and insights. Document analysis is a qualitative method that helps researchers gain an in-depth understanding of existing information, trends, and perspectives related to the research topic.
- **Analysis of Secondary Data:** Secondary data analysis involves using data that was collected by others for a different purpose. Researchers analyse existing datasets, surveys, or research findings to extract valuable insights. This quantitative method can provide statistical information, trends, and patterns related to the research question.
- **Stakeholder Engagement:** Engaging with stakeholders—individuals or groups who have a vested interest in the research topic—is a qualitative method that aims to capture diverse viewpoints and experiences. This involvement helps researchers understand different perspectives and potential impacts of their research. Stakeholder engagement involved interviews, focus groups, or surveys.
- **Public Comment Analysis:** Analysing public comments collected through various platforms, such as official websites or public forums, is a qualitative method that captures public opinion and feedback on a particular issue. This analysis provides insights into how a wider audience perceives and responds to the topic under investigation.

The report also considered a comprehensive review of the following, among other relevant documents:

1. CMS circulars and publications, Government publications, and other relevant sources.
2. In addition, the study reviewed outputs of stakeholder engagements before 2019 related to developing an LCBO framework.
3. Stakeholder analysis on the input and comments received on Circular 53 of 2022 and
4. Lastly, presentations were made by various business units at the CMS to solicit the CMS perspective and position.

PREMISE

Pillars of The Medical Schemes Act

The Medical Schemes Act No. 131 of 1998 ("MSA") was promulgated to address challenges resulting from the response of the medical schemes market to the previous legislation. Under the dispensation of the MSA of 1967 and its amendments, schemes could risk-rate members individually, and they designed their benefit structures so as to attract the young and healthy (cherry-picking). Benefits offered to the elderly and the ailing were reduced. This resulted in increased pressure on the public hospitals as the elderly and ailing were 'pushed' out from medical scheme cover. The MSA brought significant changes to the operation of medical schemes. These included:

- **Open Enrolment:** Every registered open medical scheme is obligated to accept any individual who expresses a desire to become a member of the scheme. They are prohibited from exhibiting any form of discrimination against individuals seeking membership as long as these individuals are capable of meeting the required monthly membership contributions.
- **Community Rating:** Registered medical schemes are prohibited from imposing different contribution amounts on members who have selected the same plan, unless these contributions are determined based on the applicant's income level and/or the number of their dependants, and
- Prescribed Minimum Benefits (PMBs).

Currently, there are a list of 271 diagnosis and treatment pairs that must be covered in full without co-payment from the scheme member. All medical scheme options, by default have to provide cover for these diagnosis and treatment pairs. Medical schemes are allowed to impose co-payments for conditions not designated as PMBs. The MSA sought to improve equity of access to medical scheme membership with better income and risk cross-subsidisation. At the time these regulations were instituted, two other regulatory pillars were being considered as well. The first was mandatory membership to medical schemes for certain income categories and a risk equalisation fund for medical schemes. However, these were not instituted.

This section of the report delves into the operational nature of the request, taking into consideration high-level operational and legal risks. This gives an indication on whether there are existing identified or envisaged emerging risks and how these will be mitigated.

Demarcation Regulations & Demarcation exemption process

In the historical context of healthcare regulation, it is worth noting that insurance products offering healthcare services had already been in existence prior to the enactment of the Medical Schemes Act (MSA) in 1998. This pre-existing landscape laid the foundation for the emergence of a multifaceted regulatory environment, characterized by various entities attempting to navigate this intricate framework to their advantage. Such circumstances often gave rise to a phenomenon commonly referred to as "regulatory arbitrage," where organisations strategically exploited regulatory gaps or inconsistencies to operate with reduced regulatory oversight or even in an entirely unregulated manner.

In response to these intricate challenges and the need for a more coherent regulatory framework, a consensus was achieved between the Treasury and the Department of Health. This consensus delineated the distinct roles of two regulatory bodies, namely the Financial Services Board (FSB) or the FSCA on one hand, and the CMS on the other. This agreed-upon division of responsibilities stipulated that the FSB/

FSCA would be responsible for overseeing the regulation of insurance products, while the CMS would assume regulatory authority over entities engaged in the business of medical schemes.
A pivotal milestone in addressing these regulatory intricacies was the introduction of the Demarcation Regulations. These regulations played a crucial role in providing clarity and structure to the evolving regulatory landscape. They were designed to fulfil several vital objectives:

- **Referring all insurance products for regulation under FSCA:** One of their primary functions was to ensure that insurance products offering healthcare-related benefits fell under the purview of the FSCA. This was a significant step toward resolving the previously existing regulatory ambiguities.
- **Referring medical scheme products to CMS for a temporary exemption from complying with MSA:** The Demarcation Regulations introduced a framework allowing certain medical scheme products to receive temporary exemptions from specific provisions of the Medical Schemes Act (MSA). This recognition of the unique characteristics and requirements of medical schemes aimed to harmonize their operations with the evolving regulatory framework.
- **Developing a Guidance Framework for the LCBO:** The LCBO was envisioned as the ultimate destination for insurance products operating within the healthcare sector under the MSA. The establishment of a comprehensive guidance framework delineated the rules and guidelines governing low-cost healthcare benefit options, ensuring their compliance with the MSA's requirements.

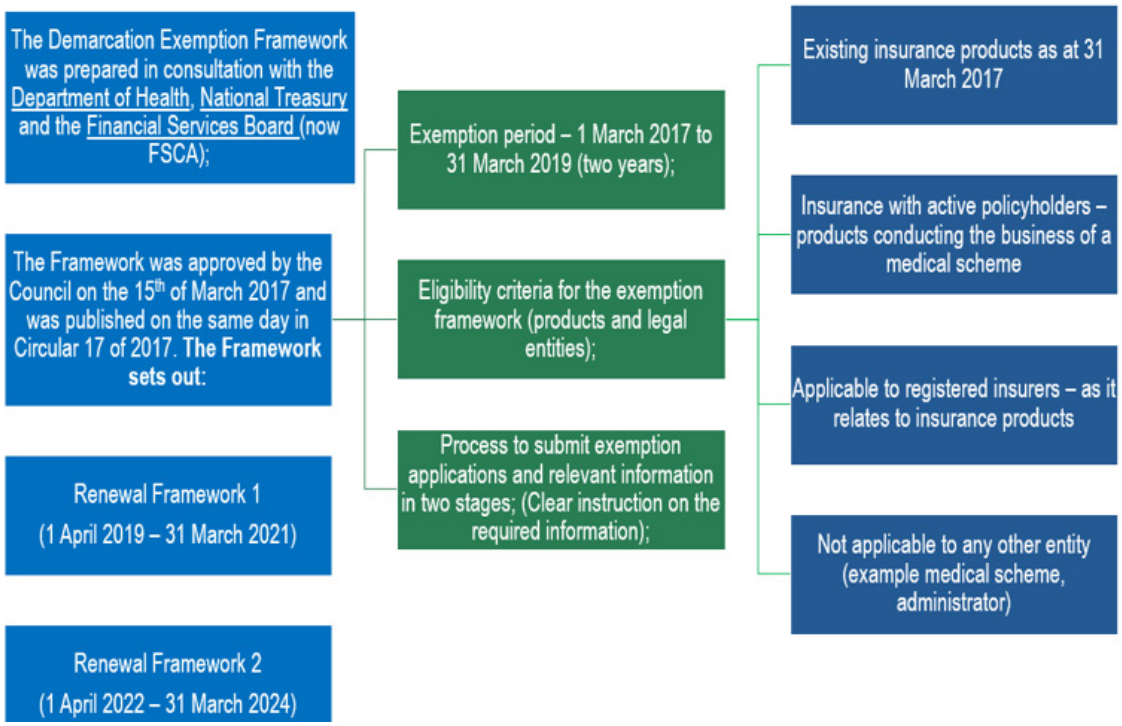
Despite these concerted efforts, the CMS remains apprehensive about schemes that continue to operate beyond the regulatory boundaries of the MSA and CMS. Such entities have the potential to pose risks to consumers and undermine the stability of the healthcare system, underscoring the importance of consistent and comprehensive regulation.

Furthermore, when the Medical Schemes Act No. 131 of 1998 was introduced, it brought about significant changes, including open enrolment, community rating, statutory solvency requirements, and the establishment of a comprehensive package known as "Prescribed Minimum Benefits (PMBs)." These changes, while intended to enhance healthcare access, led to increased medical aid costs, rendering them unaffordable for lower-income households. Insurance companies identified this affordability gap and responded by offering low-cost insurance alternatives such as primary care and hospital cash-back plans to cater to the needs of low-income individuals.

However, the popularity of these health insurance products among the young and healthy demographic began to erode the long-term viability of traditional medical schemes, as they attracted healthier members away from these schemes, leaving behind an older and more medically fragile membership base. To address this concern, consultations between the CMS, the Department of Health, and the National Treasury were initiated, ultimately leading to the commencement of the demarcation process. On December 23, 2016, the National Treasury formally introduced the latest version of the Demarcation Regulations (DR) in Parliament, with implementation set to begin on April 1, 2017. These regulations aimed to delineate and clarify the boundaries between health insurance products and traditional medical schemes, ensuring that each operates within its designated scope and regulatory framework.

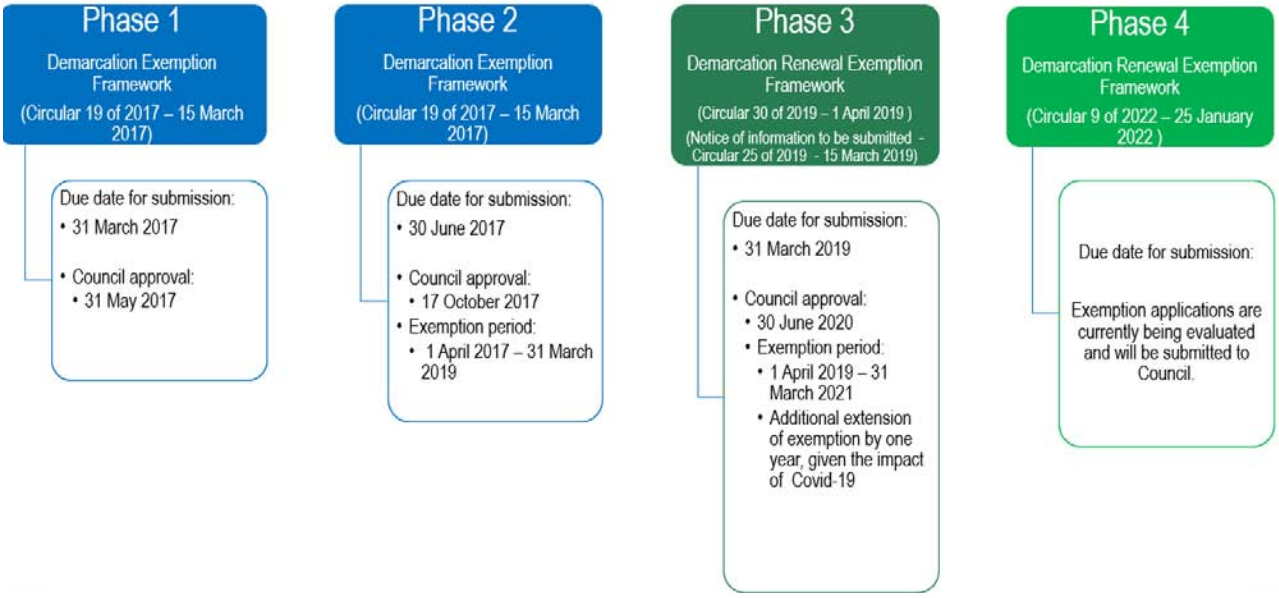
Given that the Demarcation Regulations became effective as of 1 April 2017, the policyholders on these existing health insurance policies would have been adversely affected, which meant that the policies needed to be terminated, effective 31 March 2017. Considering the impact on the policyholders that would be left without cover, an agreement was reached between the National Department of Health and the National Treasury that the CMS would develop an LCBO Guideline, and in the interim, the CMS would exempt the relevant insurers. To facilitate the exemption process, a Demarcation Exemption Framework ("framework" was prepared in consultation with the Department of Health, the National Treasury and the FSCA.) The Framework was approved by the Council on 15th March 2017 and was published on the same day by the CMS via Circular 17 of 2017. The Framework sets out the eligibility criteria for applicants. As illustrated below, two renewal frameworks have been published since the initial Framework was approved.

Figure 1: The demarcation exemption framework



The exemption applications were considered in section 8(h) of the Medical Schemes and the relevant Demarcation Frameworks. As per the 2020-year exemption, ten (10) insurers applied for exemption and based on the evaluations, it was confirmed that there were 384 589 principal members and 490 924 beneficiaries. Given that the LCBO Guideline had not been finalised, the CMS published the Demarcation Renewal Exemption Framework on 25 January 2022 (Circular 9 of 22), which provided the extension of the exemption of insurers conducting the business of medical schemes by a further two years, from 1 April 2022 to 31 March 2024. The said exemption related to the insurers conducting the business of a medical scheme without due registration. In order to protect policyholders on existing insurance products as of 31 March 2017, an exemption from compliance with the provisions of section 20(1) of the MS Act was introduced. The different stages of the exemption applications are demonstrated below:

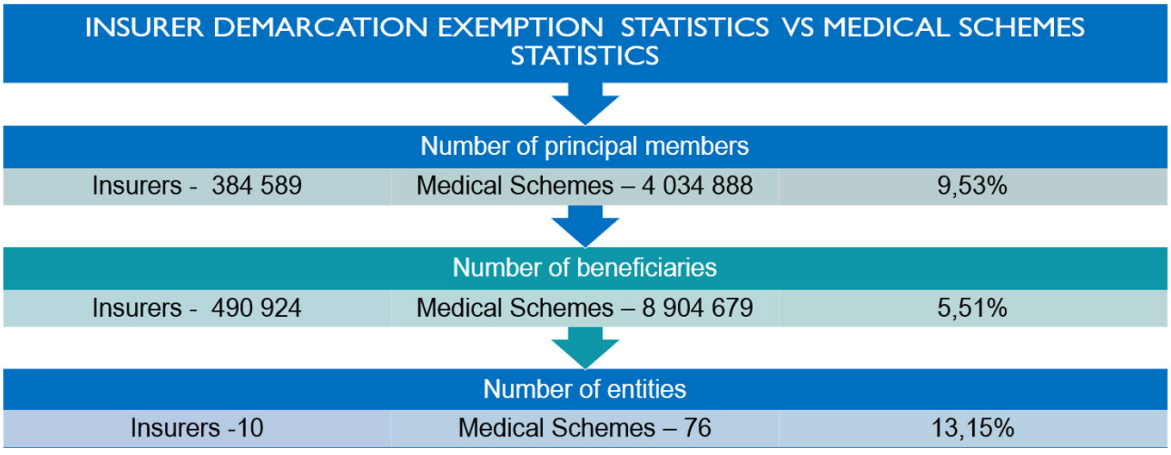
Figure 2: The demarcation exemption framework timelines



A comparison was also conducted on the number of beneficiaries of healthcare insurers and members of medical schemes. Additionally, a comprehensive analysis was undertaken to compare the number of beneficiaries covered by healthcare insurers with the membership of medical schemes. These findings shed light on the distribution of healthcare coverage in the year 2019. It was observed that principal members enrolled in healthcare insurers accounted for approximately 9.53% of the total principal members within the medical scheme landscape. These principal members are the primary policyholders responsible for initiating and managing their healthcare coverage. In terms of beneficiaries, healthcare insurers extended their coverage to approximately 5.51% of all beneficiaries within the healthcare system. Beneficiaries are individuals who receive healthcare benefits through a principal member's policy.

Registered Medical Schemes: In the same year, it was noted that healthcare insurers constituted just under fourteen percent (less than 14%) of the total number of registered medical schemes. This suggests that healthcare insurers represented a notable segment within the overall landscape of healthcare financing and coverage options. These statistics highlight the role of healthcare insurers in providing coverage to a significant portion of the population, particularly in terms of principal members and beneficiaries. While medical schemes play a vital role in healthcare financing, these findings underscore the diverse range of options available to individuals seeking healthcare coverage, with healthcare insurers serving as a substantial component of the healthcare ecosystem.

Figure 3: Key statistics: Demarcation-exempted products vs medical schemes



CHAPTER 1: HISTORICAL BACKGROUND

Summary

This chapter introduces the topic of healthcare affordability and its challenges, focusing on the escalating costs of healthcare services. It discusses the barriers to enroll in medical schemes, exacerbated by factors like high unemployment rates and rising living costs. Income inequality is a notable concern in South Africa. The chapter delves into a study by the Bureau of Market Research (BMR) indicating widening income gaps and the struggle of low-income earners to afford medical scheme contributions. The concept of LCBOs emerges as a potential solution to address affordability constraints.

The chapter further outlines the evolution of LCBOs, starting with the CMS study in 2001, which explored benefit designs for low-income earners. It highlights the need for affordable healthcare and analyses various aspects of low-cost options. The Low-Income Medical Scheme (LIMS) initiative in 2005 aimed to extend medical scheme coverage to lower-income formal sector workers. The LIMS proposal suggested employer and employee contributions to the premium, with government subsidies and protection through PMBs.

The chapter then discusses the 2015 revival of LCBO discussions by the CMS. Stakeholders engaged in a comprehensive process to establish LCBOs within the medical scheme environment, aiming to expand access and reduce the burden on the public health system. Concerns were raised about potential fragmentation and compatibility with broader healthcare reforms. The chapter highlights legislative changes and considerations required to integrate LCBOs into the existing framework while ensuring sustainability and compliance.

1.1 Introduction

The discourse within the industry revolves around the growing concern surrounding the escalating healthcare costs that have persisted over time. A prominent subject of these discussions is the mounting challenge posed by the increasing cost of healthcare. The accessibility to medical scheme enrolment remains a formidable barrier, particularly exacerbated by factors such as the elevated unemployment rate and the continuous surge in living expenses. The issue is further compounded by the pronounced income inequality that has been extensively documented in the existing literature. South Africa, in particular, stands out as consistently cited as one of the most unequal nations.

Recent findings from the BMR substantiate this concern, emphasizing that the personal income disparity among South Africans is progressively widening without any indications of narrowing. The BMR's comprehensive report underscores the severity of this disparity, drawing attention to the fact that the average gross contribution per beneficiary per month for the year 2021 within medical schemes amounted to R2,108. Simultaneously, the risk contribution income stood at R1,912—an amount that is evidently not within the means of low-income earners. A closer examination reveals that 75% of working adults in South Africa earn a monthly income of less than R5,800. This staggering statistic implies that medical scheme contributions consume a substantial portion of disposable income, sometimes surpassing the threshold of affordability.

The growing incongruity between medical scheme contributions and the Consumer Price Index (CPI) exacerbates this challenge, effectively rendering medical schemes even more financially unattainable for a significant segment of the population. In response to these formidable affordability constraints and barriers to entry, the market has witnessed the emergence of various low-cost consumer-targeted products aimed at mitigating these challenges. However, it's imperative to note that the vulnerability of low-income earners remains significant in their pursuit of adequate healthcare coverage.Many

individuals in this category face a higher risk of resorting to unregulated products due to the lack of a comprehensive legal framework governing these offerings. This pressing situation has led to the process of the development of LCBO guidelines within the medical scheme landscape. LCBOs are strategically designed medical scheme benefit options meticulously crafted to address the specific needs of lower-income families grappling with limited financial resources and urgent healthcare requirements. These options seek to strike a balance between affordability and the provision of essential healthcare services, targeting those who find themselves on the margins of the current system.

1.2 Historical context

In order to comprehensively assess the current endeavour of establishing LCBOs for low-income earners, it's crucial to delve into the historical context and previous attempts that have been made in the pursuit of developing benefit options tailored to this specific demographic. Understanding the evolution of these attempts provides valuable insights into the challenges faced, the lessons learned, and the potential paths forward.

Over time, policymakers and healthcare authorities have recognized the pressing need to address the affordability and accessibility barriers that hinder the equitable distribution of healthcare services. This recognition has led to various endeavours aimed at crafting policies and strategies to extend healthcare coverage to low-income earners who often find themselves marginalized within the conventional healthcare system. These initiatives reflect a commitment to fostering inclusivity and bridging the gap between those with limited financial means and the essential healthcare services they require.

The historical context reveals that the concept of providing healthcare benefits to low-income earners has been a recurrent theme in healthcare policy discussions. Previous attempts have explored diverse avenues, such as the introduction of specialized schemes, financial incentives, and modified benefit structures, all with the underlying aim of making healthcare more attainable to this underserved population.

However, the journey of establishing effective low-cost benefit options has not been without its challenges. Past experiences have shed light on the intricate balance that needs to be struck between affordability and the provision of comprehensive healthcare services. Previous models have encountered difficulties in reconciling the financial limitations of low-income earners with the necessity of ensuring adequate coverage for a range of medical needs. The lessons learned from these earlier efforts offer valuable insights into the potential pitfalls and considerations that must be addressed in the current endeavour.

1.3 How the LIMS/LCBO has evolved.

1.3.1 Need for Low-Cost Options and an Analysis of Benefit Designs Used in 2001

The concept of benefit options targeted at low-income earners dates back over two decades. Numerous attempts have been made to develop benefit packages geared toward low-income earners. The CMS 2001 commissioned a study titled ***"Low-Cost Options in Medical Schemes, the Need for Low-Cost Options and an Analysis of Benefit Designs Used in 2001"*** led by Shivani Ranchod, Heather McLeod and Samora Adams. The study evaluated the benefit design of low-cost options and their distinguishing features.

The market defined was the following two groups:

- Those currently not covered by medical schemes can afford the low-cost options, and
- Medical scheme members can no longer afford the benefit options they have been using and thus need a lower-cost solution.
- One of the study's key findings was that most low-cost options still cost a family of four between Rs 600 and Rs 800 per month, which was still not affordable at income levels of R3 000 and below.

The study considered Low-Cost Options in Medical Schemes, the Need for Low-Cost Options, and an Analysis of Benefit Designs Used in 2001 further explored hospital benefit offerings and found that hospitalisation benefits that most work needs to be done to develop low-cost options. Some of the challenges depicted by contracting with public health facilities included:

- Lack of offerings that engage the public sector in the provision of care.
- The barriers to contracting are high but not impossible.
- The study proposed that risk-sharing arrangements, rather than traditional fee-for-service contracts, be used for contracting with either public or private sector hospitals.
- Hospitalisation is offered in differential amenities in a public hospital.
- Specialist services in a public hospital.
- Primary care providers provide chronic medicine in a public hospital or with a strict formulary and
- Primary care is offered in private sector capitated networks.

The study highlighted the target market finding that 54% of members earn less than R 4 000 monthly. The study recommended contributions for a family of four earning less than R4 000 per month in the order of R500 per month or less to meet the goal of affordable healthcare.

1.3.2 Low-Income Medical Scheme (LIMS) in 2005

The second attempt was the Low-Income Medical Scheme (LIMS) industry-wide consultative process that took place in the 2004/2005 period. The Ministerial Task Team on social health insurance launched the LIMS consultative process in 2005 to gain various stakeholders' insights on extending medical scheme coverage to lower-income formal sector workers. Two issues mainly prompted this.

- Medical schemes expressed concerns about stagnating and declining membership levels and
- Most of the population could not afford to belong to medical schemes, which threatened the survival of the private health sector.

The outcome of the LIMS process was extensive research and consultation with health sector stakeholders to identify the major barriers to extending medical scheme coverage to low-income households and to propose solutions to overcome these barriers. The LIMS study suggested that, if implemented, a LIMS benefit package would be narrower than PMBs. The PMB package is skewed toward hospital services. However, LIMS beneficiaries would remain protected by PMBs, with the government covering the costs of providing services outside the LIMS package. The LIMS proposed that employers and employees each make a 50% contribution to the premium and that the government subsidise LIMS membership contributions.

Regarding the benefits package, the LIMS minimum benefit package would cover acute and some chronic outpatient or ambulatory care. Still, members would be expected to obtain inpatient care from public hospitals. 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 benefit options. However, low-cost options would not cover any form of private hospitalisation. Key recommendations of the LIMS consultative process were as follows:

- 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 dependants.

- 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 inpatient care from a public hospital at no cost.
- The LIMS schemes would be kept entirely separate from other medical schemes, with a separate Risk Equalisation Fund (REF) to promote cross-subsidies within the LIMS environment, but no cross-subsidies between LIMS and other medical schemes would be allowed.

1.3.3 Low-Cost Benefit Options – 2015

The CMS continuously faces an increase in applications for PMB exemptions, as it was perceived that the full PMB was unaffordable for low-income workers. In February 2015, in response to growing concerns about the affordability of medical schemes for low-income families, the CMS revisited the concept of LCBO within the medical scheme environment. A comprehensive stakeholder and industry engagement process was followed to solicit feedback and recommendations on the features of a potential LCBO framework (including benefits packages, pricing, etc.). In addition, the CMS sought to meet the demand for health insurance provided alternative insurance offerings such as hospital cash plans, primary healthcare insurance, and gap coverage. The objective of establishing LCBO within the medical schemes' environment was to:

- Expand medical scheme cover to the formally employed that are not already covered by medical schemes.
- It is also hoped that drawing more people into the private health sub-sector will lower the burden on the public health system.

Most stakeholders supported expanding access to low-income households, introducing a low-cost option and increasing the number of medical scheme members. However, concerns have been expressed about some aspects of the LCBO proposal. These were mainly around:

- **Considerations for the longer-term health sector policy agenda in South Africa.** Some stakeholders sought clarification on how the establishment of an LCBO fits into the overall long-term reform for the funding environment. The NHI proposal anticipates a diminished role for medical schemes from providing duplicate coverage to providing complementary cover.
- **Potential for further exacerbation of an already fragmented medical scheme industry.** A common concern from most stakeholders was that the introduction of LCBO in the medical schemes industry would exacerbate fragmentation and compromise the sustainability of current risk pools and
- **Revision of PMBs as an alternative option.** Some stakeholders suggested a revision of the PMBs to focus less on hospital-based catastrophic care and on primary healthcare.

Some stakeholders suggested the introduction of a low-cost PMB rather than a low-cost benefit option that is separate from the other medical scheme options. Circular 54 of 2015 details a framework and principles that allows the introduction of low-cost benefit options within the medical schemes industry. Some of the broad principles and guides that were recommended are outlined as follows:

- **Protecting risk-pooling** – the existing medical scheme risk pool should not be undermined or fragmented.
- **Benefit design** – proposed LCBO framework envisages a possible departure from the current requirement of PMB if an exceptional circumstance is demonstrated and the 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. The Framework intended to maintain the content and objective behind PMBs to the extent that affordability is not compromised and
- **Underwriting** - late joiner penalties should not be applied: The rationale for exemptions is that these people have been excluded from risk-pooling opportunities not by voluntary risk selection but by economic disadvantage.

Medical schemes that wanted to offer LCBO were to apply for an exemption from the MSA of 1998, especially since it applies to open enrolment, PMBs, and brokers. Subsequently, the published Framework was rejected by the National Department of Health (NDoH) on the basis that it did not meet the minimum requirements in terms of coverage. It was insufficiently comprehensive and did not align with health system and policy priorities such as HIV, child and maternal care.

1.4 Legislative Amendments and Implications

In the previous attempt, a significant point of the debate revolved around the potential effects and impacts on the legislative environment regarding implementing an LCBO dispensation. Such a dispensation would have required comprehensive modifications to the MSA and its regulations to seamlessly incorporate it into the existing medical scheme environment. Notably, there was a need to revisit adding a definition of LCBO in Section 1. Further considerations were made to define and adjust the parameters of Section 29(1)(o) on the scope and level of minimum benefits to be available to beneficiaries in general as prescribed.

The legislative changes had to take into account whether benefit options were or not a novel concept. This affected what Rules must include regarding "the scope and level of minimum benefits that are to be available to beneficiaries as prescribed" (s29(1)(o)). The Minister had legislative opportunities to prescribe minimum benefits for various options specified in the scheme rules.

The legislative changes also considered that medical schemes could restrict times when members could change benefit options regarding their rules. The constitutional right to freedom of association made it challenging to compel membership of groups. The MSA allowed the Minister of Health to create a wide variety of regulations that could cater for all the issues raised by the proposed amendments to the MSA.

The legislative changes also considered the position that medical schemes must be run as businesses (constitutional court) and that medical schemes could not rely on employers to finance LCBOs through subsidies or other means. Other benefit options were not allowed to directly or indirectly subsidize LCBOs. Furthermore, the amendments had to ensure that no ring-fencing of assets was permitted. LCBOs had to be sustainable, just like any other benefit option.

CHAPTER 2: NEED BY SCHEMES TO OFFER LCBOs

Summary

Chapter 2 delves into the complexities of developing low-cost benefit options within the South African medical schemes industry. It covers feasibility studies, analysis of exempted products, Bargaining Council Schemes, and the challenges posed by loss-making options. Throughout the chapter, the importance of ensuring equitable access to healthcare and maintaining financial stability within the healthcare system is emphasized. The chapter is structured to achieve the following objectives:

- ***Feasibility and Policy Analysis:*** *The chapter begins by discussing a study commissioned by the CMS in 2019 to assess the feasibility and policy options of implementing Low-Cost Benefit Options (LCBOs) within the medical schemes industry titles "DISCUSSION DOCUMENT Development of Low-Cost Benefit Options within the Medical Schemes Industry " [1] published in March 2019. The primary goal of this analysis is to understand the potential need, prospects, and appropriateness of LCBOs. The study examines stakeholder submissions, conducts regression analysis on survey data, and considers perspectives to determine the viability and implications of LCBOs.*
- ***Exempted Insurance Products Analysis:*** *The chapter then delves into an examination of exempted primary insurance products and their performance compared to traditional medical schemes. It aims to gain insights into the implications of these products operating under a different regulatory framework and their value to policyholders. The analysis considers claims ratios, expenses, and benefits to highlight the differences between exempted insurers and medical schemes.*
- ***Bargaining Council Schemes:*** *The chapter explores the unique features and characteristics of Bargaining Council Schemes, which operate within specific industries and sectors through collective bargaining agreements. The objective here is to understand how these schemes cater to their members' needs effectively and how they differ from typical medical schemes. The section also emphasizes the importance of balancing flexibility and regulation to ensure sustainable healthcare coverage.*
- ***Analysis of Loss-Making Options:*** *The chapter further aims to comprehensively analyse benefit options that are experiencing financial losses and deviating from established guidelines. The goal is to evaluate the significance of these unsustainable options and their potential impact on the overall market. The analysis considers factors such as self-sustainability, financial soundness, and the potential effects on other benefit options within a scheme.*
- ***Overall Conclusion:*** *The chapter concludes by summarising its key findings and insights. It reiterates the importance of considering equity, financial stability, and the broader goals of enhancing healthcare accessibility and affordability when developing and implementing various benefit options within the medical schemes industry.*

2.1 Development of Low-Cost Benefit Options within the Medical Schemes Industry Study

In 2019, the CMS commissioned a study to assess the feasibility of LCBOs in South Africa. The study examined twenty-one (21) stakeholder submissions, which offered inputs on the proposal for establishing the LCBO framework. These submissions formed the basis for developing a framework to analyze the appropriateness of LCBOs within the South African context. Additionally, the study utilised regression analysis on national household survey data to estimate the potential uptake of LCBOs among the target low-income group. The primary objective of the study was to:

- Undertake policy options analysis on the need, prospects, and appropriateness for an LCBO package within the medical schemes industry.
- Understand the perceptions and perspectives of various stakeholders, including the target population, regarding the LCBO package and

1 https://www.medicalschemes.com/files/extras/LCBOFullDraft29March_final.pd

- Identify additional contextual factors necessary for generating evidence and direction to determine the best course of action for the development of LCBOs.

2.1.1 Key Findings and Recommendations:

The study found that in comparison to the LIMS proposal, the implementation of an LCBO would require subsidies from employers or the government. However, the current proposals remain silent on whether a dedicated subsidy program by the government would accompany the LCBO. Given the poor performance of the South African economy, which is forecasted to persist in the short to medium term, providing additional fiscal outlays for subsidising LCBOs for low-income earners could prove to be challenging.

Furthermore, the study highlighted that an introduction of LCBOs is likely to create unfairness and introduce a new dimension of inequity in the South African health system. This stands in contrast to the value proposition of policies aimed at providing health insurance schemes for the poorer members of society. It is essential to consider these findings and recommendations carefully when evaluating the viability and implementation of LCBOs in the medical schemes industry. It is essential to consider the potential economic consequences and equity factors while devising new health financing approaches. These considerations aim to ensure that the strategies adopted are in harmony with the overarching objectives of enhancing the accessibility and affordability of healthcare services for all sections of society, particularly those belonging to lower income groups.

2.2 Analysis of the Exempted Primary Insurance Products

In 2019, the CMS commissioned a study to evaluate the performance of exempted products. The study aimed to gain insights from the analysis conducted on the data submitted by Demarcation product providers to the CMS. It specifically focused on examining the implications of these products being regulated under a different framework than that of medical schemes. The study took into account the potential impact on the medical scheme risk pool and assessed how well these products fulfilled their intended purpose and provided value to policyholders. The analysis also considered secondary data obtained from sources such as financial statements to review product value.

One of the findings of the study was that the claims ratios observed in the medical schemes sector greatly exceed those found within the exempt insurer financial structures. Assuming that demarcation products operate under a similar financial model as evident from the overall exempt insurer financial results, the findings of the study suggests that policyholders who purchase demarcation products receive significantly lower value compared to the average member within the medical scheme environment. This is because a notably smaller portion of their premium is utilised to procure healthcare benefits. The lower value received by demarcation product policyholders is influenced by a combination of higher expense ratios and profit margins, which the exempt insurers can extract due to their regulation under the Short-Term and Long-Term Insurance Acts, rather than being governed by the Medical Schemes Act.

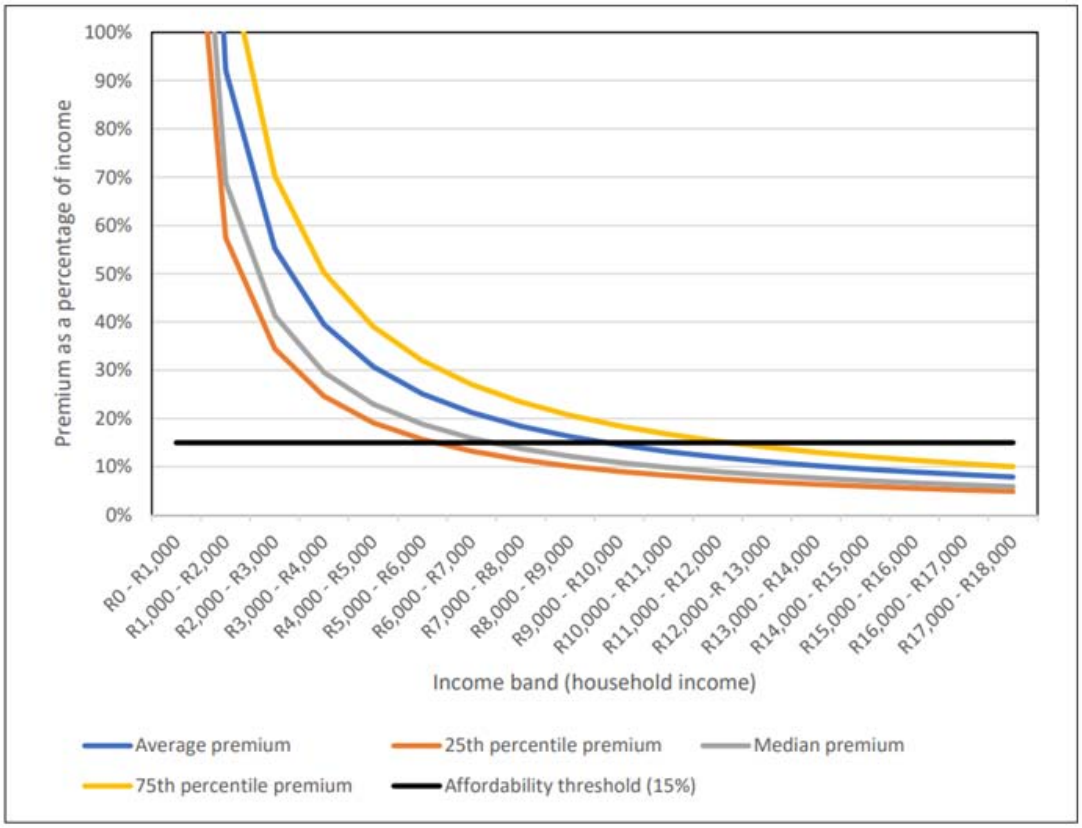
In the comparison between exempt insurers and medical schemes, the study found that the median non-healthcare expense ratio for exempt insurers is nearly six times higher than that of medical schemes. Even when excluding outliers, the maximum non-healthcare expense ratio within medical schemes remains lower than the minimum non-healthcare expense ratio within exempt insurers.

Additionally, the analysis provides a more detailed examination of the expense structures present in Demarcation products.

Moreover, aside from the significantly higher non-benefit related expenses, the exempt insurers can generate profits, whereas not-for-profit medical schemes benefit their members through retained surplus. The study further assessed affordability and considered premium levels for the demarcation products

analysed based on the information contained in marketing brochures provided by the exempted insurers. The monthly family premiums for the comprehensive insurance products under consideration vary between R638 and R3,242. On average, a family pays around R1,382 per month for such coverage. If approximately 45% of the premium is allocated to healthcare benefits, as analysed in the exempted insurer income statements, this would amount to R622 per month dedicated to funding healthcare benefits. This further highlights the limited value inherent in the benefits offered by the Demarcation products. The graph below illustrates the PAC (Personal Affordability Contribution) premium for comprehensive insurance products in comparison to income levels.

Figure 4: Comprehensive product premiums vs. income
Source: CMS Circular 82 of 2019



The data above reveals that the average premium as a percentage of income is notably high for individuals with lower income levels. This observation emphasizes that the products are not easily affordable for low-income families.

2.3 Bargaining Council Schemes

Bargaining Council schemes bear the closest resemblance to the proposed low-cost benefit options and primary health insurance products, primarily concerning lower premiums and reduced compliance requirements with the Medical Schemes Act. Nevertheless, they possess unique features that set them apart from typical medical schemes.

In Bargaining Council schemes, members often belong to specific industries or sectors, and the scheme may be established through collective bargaining agreements between employers and trade unions. This specialized nature allows them to cater to the specific needs of their members and address industry-related health concerns effectively.

Additionally, Bargaining Council schemes may offer tailored benefit packages that align with the requirements and preferences of their members. This flexibility enables them to provide targeted and cost-effective healthcare solutions, accommodating the diverse needs of their members. Furthermore, these schemes may enjoy certain regulatory exemptions or exceptions, depending on their structures and affiliations. This freedom from certain regulatory burdens enables Bargaining Council schemes to operate efficiently and may contribute to lower premium costs for members.

2.3.1 Background and Context

Bargaining councils currently operate in terms of the Labour Relations Act (LRA). However, most of the bargaining councils were established under the predecessor act, the Industrial Conciliation Act. Bargaining councils' schemes are established when employer and employee bodies (Unions) in a particular industrial sector and geographical area agree to come together to engage in collective bargaining. The LRA provides that employer and employee representative organisations within an industry or area can enter into collective agreements covering "any areas of mutual interest", and if they are sufficiently representative of the industry, the parties can approach the Minister of Labour to gazette these agreements and extend them to bind non-parties as well. A collective agreement is generally negotiated between the parties every three years and once signed, is gazetted by the Minister.

Bargaining councils have a range of powers and obligations, including the establishment of social benefit funds. Thus Section 28 of the LRA gives registered councils the power "to establish and administer pension, provident, medical aid, sick pay, holiday, unemployment and training schemes or funds or any similar schemes or funds for the benefit of one or more of the parties to the bargaining council or their members".

The number of bargaining councils has fallen from 104 in 1983, to eighty seven (87) in 1995, to fifty five (55) in 2007[2] ; to thirteen (13) by 2017[3]. The reduction in the number of bargaining councils is due to mergers of regional and sub-sectoral councils into single, larger, national councils. The number of private sector councils that currently operate at least one fund is unknown. It is estimated that, by 2007, private sector bargaining councils represented 50 000 employers covering a total of over 800 000 employees.

Table 1: Estimated Bargaining Council Coverage, 1995 and 2005

	1995	2005	2007
Total Formal Employment	8 120 279	8 039 401	8 423 000
Total BC Coverage	1 193 597	2 580 331	
Total BC Coverage (% of Total Formal Employment)	14.70%	32.10%	
Private Sector Bargaining Council Coverage	1 193 597	1 072 399	
Private Sector BC Coverage (% of Total Formal Employment)	14.70%	13.34%	800 000
Total BC Coverage (% of Total Formal Employment)		1 507 932	
Government BC Coverage (% of Total Formal Employment)		18.76%	

2 Budlender, D., & Sadeck, S. (2007). Bargaining council and other benefit schemes. Unpublished report by the Community Agency for Social Enquiry, prepared for the National Treasury.
3 https://www.labourguide.co.za/bargaining-councils

Table 2: Number of Bargaining Councils and Employee Coverage (public and private)

Year	Number of bargaining councils	Number of employees covered by bargaining council agreements
1992	87	735 533
1998	76	632 992
2004	48	2 358 012
2010	47	2 520 718
2013/4	44	2 505 074

(Source: Du Toit et al, 2015: 51)[4]

*Included public service

Table 3: Bargaining Council Representativity in the Private Sector

Bargaining councils in the private sector	Year	Total employers	Party Employers	Party employers as % of total employers	Total employees	Employees of party employers	Party employer employees as % of total employees	Party union members	Party union members as % of total employees
Amanzi*	2012	12	10	83%	6529	5750	88%	5074	78%
Building: B/fontein	2014	N/a	38	N/a	1285	723	56%	648	50%
Building: Kimberley	2014	50	20	40%	496	354	71%	254	51%
Building: S&E Cape*	2012	298	178	60%	6433	5359	83%	1827	28%
Building: Cape	2014	625	193	31%	13615	7129	52%	5741	42%
Building: E London*	2012	80	59	74%	1234	925	75%	418	34%
Building: N&WBoland	2014	N/a	151	N/a	2809	1528**	54%	1421**	51%
Canvas Goods*	2012	52	23	44%	734	415	57%	193	26%
Diamond Cutting*	2012	37	32	86%	1327	1213	91%	764	58%
Furniture	2012	1373	199	14%	16055	8773	55%	8133	51%
Furniture: W Cape	2012	234	149	63%	4872	4147	85%	3118	64%
Furniture: KZN***	2013	N/a	1	N/a	4126	3327	81%	2211	54%
Furniture: E Cape*	2011	58	20	34%	827	495	60%	494	60%
Furniture: SWDistrict*	2012	64	33	52%	695	477	69%	409	59%
Hairdressing	2013	2514	1520	60%	9577	5426	57%	7762	81%
Metal & Engineering	2013	N/a	2288	N/a	302796	152486	50%	186663	62%
Laundry: Cape	2013	N/a	48	N/a	1701	946	56%	928	55%
Laundry: Natal	2013	322	92	29%	5156	3241	63%	1411	27%
Leather Industry*	2013	274	119	43%	15533	10338	67%	11184	72%
Meat Trade: Gauteng	2014	N/a	767	N/a	6022	3713	62%	3296	55%
Road Freight & Logistic	2014	N/a	504	N/a	118769	48146	41%	41201	35%
Sugar Manufacturing*	2012	7	7	100%	5723	5723	100%	5199	91%
Restaurant & Catering	2013	5052	4588	91%	35370	22364	63%	20619	58%
Food Retail	2014	N/a	743	N/a	20224	18693	92%	10985	54%
Road Passenger	2014	N/a	46	N/a	23687	19778	83%	10233	43%
Motor Ferry	2013	N/a	5	N/a	2685	2000	74%	1526	57%

4 Bhorat, H., Van der Westhuizen, C., & Goga, S. (2009). Analysing wage formation in the South African labour markets: The role of bargaining councils. Development Policy Research Unit Working Paper, (09/135).

Bargaining councils in the private sector	Year	Total employers	Party Employers	Party employers as % of total employers	Total employees	Employees of party employers	Party employer employees as % of total employees	Party union members	Party union members as % of total employees
Motor Industry	2013	14548	6399	44%	246871	153026	62%	97049	39%
New Tyre Manfctring*	2012	4	4	100%	3972	3972	100%	3755	95%
Grain Corporation*	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a
C/tract Cleaning: KZN	2014	N/a	120	N/a	19313	13387	69%	N/a	N/a
Transnet	2012	1	1	100%	59694	59694	100%	45556	76%
Electrical Industry	2014	2003	1116	56%	15601	12059	77%	8004	51%
Chemical Industry*	2009	216	193	89%	72427	68169	94%	41903	58%
Wood & Paper	2013	N/a	24	N/a	32494	19739	61%	12180	37%
Fishing Industry	2014	N/a	8	N/a	2054	1783	87%	1166	57%
Clothing Industry	2014	852	270	32%	51703	26082	50%	42946	83%
Textile Industry	2014	N/a	82	N/a	14753	9677	66%	11112	75%
Civil Engineering	2013	N/a	650	N/a	80000	54453	68%	41713	52%
TOTAL					**1 207 162**	**755 510**	**62.9%**	**637096**	**52.4%******

(Source: Data provided by the Department of Labour)

2.3.2 Legislative requirements and changes in the regulatory environment

Bargaining Council funds (including medical aid schemes or "sickness funds") were established and regulated in terms of LRA, typically under the auspices of a particular bargaining council. The Labour Relations Amendment Act of 1998 was expected to usher in a new regulatory arrangement for pension, provident or medical aid schemes or funds established in terms of the LRA.

The amendment, in terms of medical aid schemes, was understood to mean that all medical aid schemes or funds established in terms of Section 28 of the Labour Relations Act of 1995 would fall under the regulatory auspices of the CMS. Bargaining Council medical aid scheme had previously been considered exempt from the Medical Schemes Act. They were, however, required to submit annual returns to the medical regulatory authority.

2.3.3 Medical and sick benefit funds

As of 1994, a total of thirty-four (34) bargaining council schemes were in operation . In 2007, a much smaller total of fifteen (15) councils indicated that they had a medical or sick benefit fund or scheme of some sort. Currently, five (5) former bargaining schemes are under the regulatory ambit of the CMS. These schemes cover an average total of 78,644, inclusive of 38,175 principal members. The schemes are either fully or partially exempted from the MSA prescripts requiring the provision of PMBs.

Table 4: Number of beneficiaries covered by former bargaining council schemes under the regulatory auspices of the CMS.

Ref. no	Name of medical scheme	Average members	Average beneficiaries
1590	Building & Construction Industry Medical Aid Fund	4,424	11,760
1271	Fishing Industry Medical Scheme (Fishmed)	1,786	4,159
1086	Foodmed Medical Scheme	10,954	18,202
1270	Golden Arrow Employees' Medical Benefit Fund	2,617	5,263
1600	Motohealth Care	18,394	39,260
	Consolidated	38,175	78,644
	Sub-total: registered restricted schemes	1,692,650	4,046,903
	Total registered schemes	4,034,888	8,904,679

The analysis of former bargaining council schemes data indicate that the covered beneficiaries are on average older than beneficiaries covered by restricted schemes (33.26 vs 31.47 years), have a lower number of pensioner (65+ years) beneficiaries (5.11% compared to 6.77% for restricted schemes); and have a low dependency ratio compared to other registered medical schemes.

Table 5: Profile of BC funds

Ref. no.	Name of medical scheme	Average age pb	Pensioner ratio (65+ years)	No. of de-pendents per member
		Years	%	#
1590	Building & Construction Industry Medical Aid Fund	27.77	1.88	1.68
1271	Fishing Industry Medical Scheme (Fishmed)	26.92	0.39	1.34
1086	Foodmed Medical Scheme	30.68	1.95	0.63
1270	Golden Arrow Employees' Medical Benefit Fund	35.38	5.67	1.02
1600	Motohealth Care	36.49	13.15	1.13
	Consolidated	33.26	5.11	1.11
	Sub-total: registered restricted schemes	31.47	6.77	1.40
	Total registered schemes	33.55	8.97	1.21

Contributions received by medical schemes on behalf of beneficiaries covered by former bargaining council schemes was R 888.63 per average beneficiary per month by the end of December 2021. This is significantly lower than the contribution made by beneficiaries covered by restricted schemes (R1,885.80 pabpm). The large difference is largely explained by the fact that former bargaining council medical schemes are exempted from the MSA PMB provisions. In 2021, the projected cost of PMBs within the medical schemes industry was approximately R1,000 per beneficiary per month. This amount exceeded the risk contribution of the majority of the bargaining council schemes, as illustrated in the table provided.

Table 6: Claims and contributions

Ref. no.	Name of medical scheme	Year risk claims ratio	Risk Contribution Income (RCI)
		%	pabpm
1590	Building & Construction Industry Medical Aid Fund	81.57	1,050.50
1271	Fishing Industry Medical Scheme (Fishmed)	81.54	463.46
1086	Foodmed Medical Scheme	48.09	152.51
1270	Golden Arrow Employees' Medical Benefit Fund	111.19	715.78
1600	Motohealth Care	91.65	1,718.78
	Consolidated	85.10	888.63
	Sub-total: registered restricted schemes	85.38	1,885.80
	Total registered schemes	81.38	1,911.95

2.3.4 Unintended consequences and short comings

The prolonged existence of negotiating council schemes has formed a two-tiered structure in the private healthcare sector, with most members enjoying the full protection of the Act and the bargaining council scheme beneficiaries unable to realise this goal.

2.3.5 What do they offer (benefit options)

The bargaining council plans are exempt from the provisions of the MSA's PMBs. Hence, various bargaining schemes benefits excluded PMBs to varying degrees. Some offer a limited selection of CDL conditions, while others offer a whole set of PMBs with a maximum monetary cap and state hospitalisation. The gradual increase of PMB coverage is one of the requirements imposed by the CMS when exempting schemes from the Act's obligations.

The LCBOs are likely to be priced at levels far lower than the current PMB exempts medical schemes, while aiming for a different population profile. There is an expectation that the bargaining council schemes will eventually fully comply with the provisions of the Act. The current PMB exempt medical schemes offer lessons on how to extend coverage to low-income groups. However, the efficiencies and effectiveness of bargaining schemes in the collection of contributions are likely not to be replicated by LCBO options, who will collect contributions from individual employees likely.

2.3.6 Conclusion

Bargaining Council Schemes operate under an exemption, which allows them to demonstrate exceptional circumstances and on condition that they progressively add PMBs on their benefit designs. One notable characteristic of these schemes is that they may provide coverage for seasonal employees, but this coverage is not guaranteed to be long-term. Additionally, Bargaining Council Schemes offer benefit packages that differ considerably from typical medical scheme options. These packages may include one or a combination of benefits such as Pension benefit, Provident benefit, medical benefit, Sick pay, Disability, Sick funds, and leave. These distinctive features enable Bargaining Council Schemes to cater to the specific needs of their members and industries, providing tailored and comprehensive healthcare solutions. However, it is essential to carefully consider the potential implications of such exemptions and benefits to ensure equitable and sustainable healthcare coverage for all beneficiaries. Policymakers and stakeholders must strike a balance between flexibility and regulation to foster effective healthcare delivery within the Bargaining Council Scheme framework. Additionally, learning from the experiences of these schemes can provide valuable insights for developing inclusive and responsive healthcare policies and benefit options for diverse segments of the population.

2.4 Loss-Making Options

The primary objective of this section is to undertake a comprehensive analysis of benefit options that are currently experiencing financial losses and deviating from the established guidelines stated in Section 33. The central focus is to evaluate the significance of unsustainable benefit options in relation to the introduction of new options in the market. Although the MSA does not explicitly endorse the consolidation of benefit options, it confers upon the Registrar the authority to withdraw benefit options that are financially unsound. This authority can be exercised through diligent inspection, thorough investigation, or upon the receipt of a report that highlights the inherent instability of these options from a financial perspective. Adhering to Section 33(2) of MSA, it is imperative that benefit options align with the following set of guidelines:

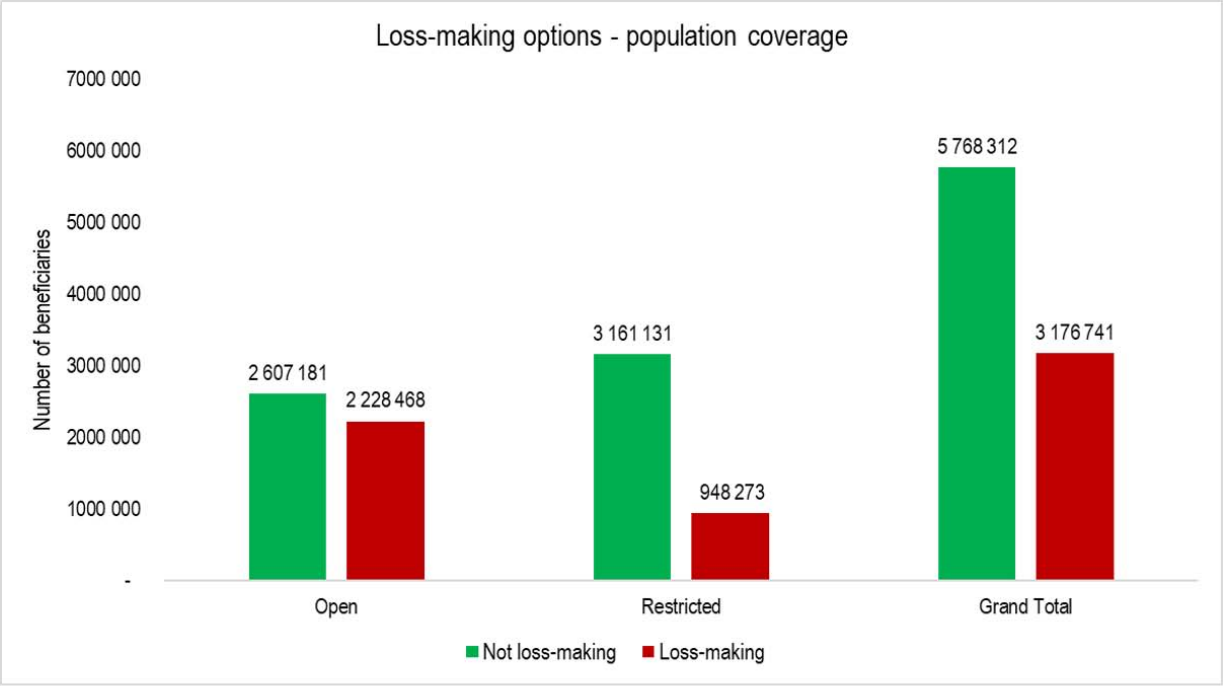
(b) be self-supporting in terms of membership and financial performance.
(c) be financially sound; and
(d) not jeopardise the financial soundness of any existing benefit option within the scheme.

Although the MSA does not explicitly outline the requirement, it is deemed essential that an option should have a minimum of 2,500 beneficiaries in order to be considered self-supporting according to Section 33 (2)(b) of MSA. Additionally, the option must demonstrate profitability at the operational level. Furthermore, Regulation 2(3) stipulates that a minimum number of 6,000 members is required for the scheme as a whole.

Seventy-two (72) medical schemes have been registered as of December 2021.
Among these, fifty-four (54) medical schemes were identified as having benefit options that incurred losses during Q4 of 2021/22. However, these loss-making options did not pose a threat to the overall sustainability of the respective medical schemes. Out of the fifty-four (54) schemes, seventeen (17) were open schemes, while thirty-seven (37) were restricted schemes. As of 31 December 2021, there were a total of two hundred forty nine (249) registered benefit options (excluding EDOs). Notably, out of the total registered benefit options, a significant number of twenty seven (127) options were facing financial losses. Specifically, within these loss-making options, ,sixty (60) were identified within restricted schemes, while sixty-six (66) were present within the open scheme environment.

The figure presented below provides an overview of the distribution of beneficiaries across loss-making and non-loss-making options. Surprisingly, almost half of the beneficiaries (46%) in open schemes are enrolled in loss-making options, whereas only 23% of beneficiaries in restricted schemes are affected by such options. Collectively, loss-making options encompass 36% of the total beneficiary population.

Figure 5: Distribution of beneficiaries by options stratification (Loss vs. Not loss-making)



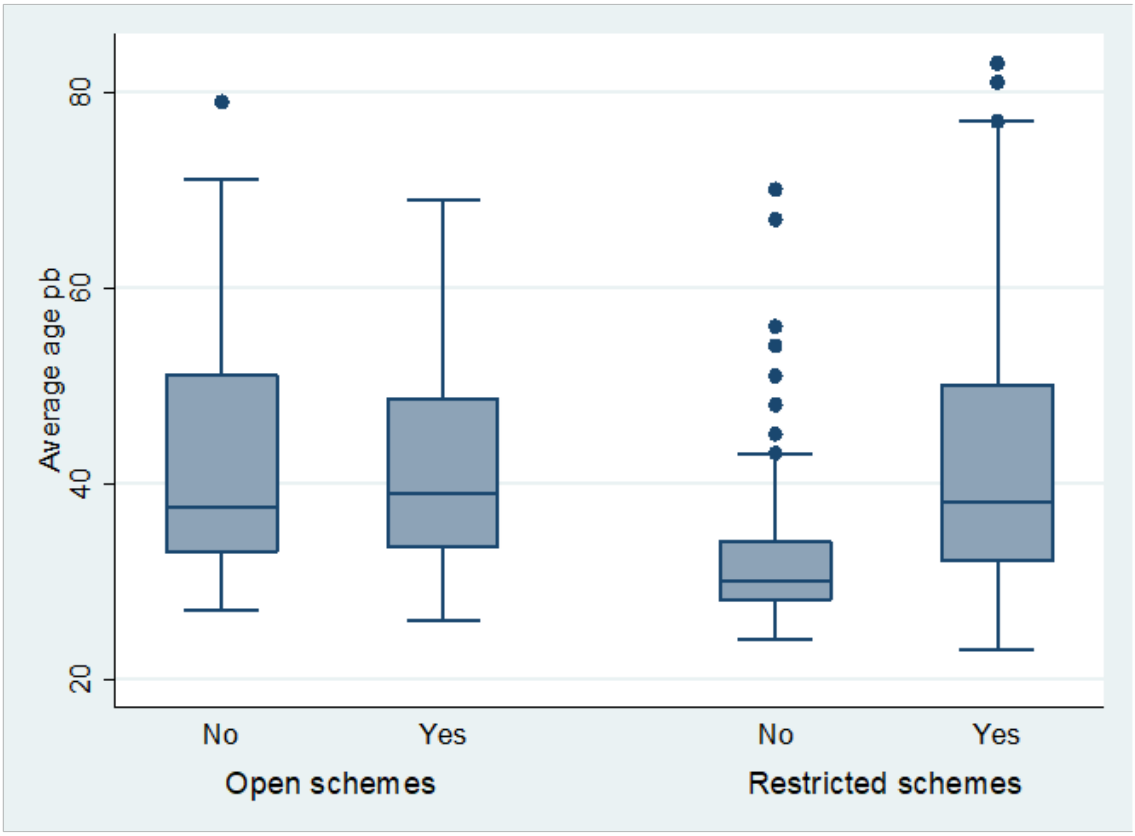
The figure depicted above illustrates that loss-making options encompass a significant portion of the beneficiary population, accounting for over one-third. This indicates a substantial number of individuals affected by these options. Additionally, loss-making options are distinguished by several factors, including a higher average age among their members and an elevated prevalence of chronic conditions (see Table 7 below). In response to this situation, schemes have submitted plans outlining the measures they intend to implement to ensure compliance and rectify the financial losses.

Table 7: Demographic characteristics of benefit options stratification (Loss making: Yes/No)

Benefit Option strata	Beneficiaries	Average age pb
No	5 768 312	36.9
Yes	3 176 741	42.1

The Box-and-Whisker plot presented in Figure 6 displays the distribution of loss-making options based on their respective benefit option names. In open schemes, the average age between loss-making and non-loss-making options did not exhibit a significant difference, ranging from 26 years to 79 years. However, within closed schemes, the average age of beneficiaries was notably higher in loss-making options compared to non-loss-making options. In closed schemes, the average age of beneficiaries also varied between 26 years and 79 years. Additionally, the graph highlights a considerable number of restricted options that feature outliers, indicating a significantly older age profile among these options. In the context of absorbing an older age profile, employers contribute or subsidize premiums to accommodate the healthcare needs of older employees. This is because older individuals often require more comprehensive medical coverage and may have higher healthcare expenses. The employer contribution helps ensure that the restricted medical schemes can sustainably provide adequate benefits to older beneficiaries. Employer groups provide healthcare expenditure subsidies to attract and retain top-quality employees. While loss-making options may raise concerns under Section 33(2)(b), it is important to emphasise that the spirit of the Medical Schemes Act promotes cross-subsidisation rather than risk rating. It is crucial to consider the principle of "first do no harm" when deciding to close loss-making options. Implementing such a measure may trigger a detrimental cycle where cross-subsidisation is weakened, leading older individuals to opt for cheaper options like hospital plans. This could dilute the effectiveness of cross-subsidisation and have unintended consequences.

Figure 6: Box-and-Whisker plot showcasing the strata of benefit options by average age (Loss making: Yes/No) by scheme type



Loss-making options exhibit distinct demographic profiles, with a significant number of these options catering to beneficiaries who have a high prevalence of chronic conditions and an older age profile. These options provide comprehensive coverage and attract high contributions due to the specific characteristics of the beneficiaries, including offering full PMB coverage. These factors differentiate them from the proposed benefit package by the industry and the offerings in currently exempted products. Lastly, due to non-compliance with the MSA, these options cannot be considered as alternative solutions and are incomparable, as they provide much more extensive benefit offerings.

2.5 Efficiency Discount Options (EDOs)

Efficiency in medical schemes often involves strategies to reduce costs while maintaining the quality of healthcare services. One such approach is through efficiently discounted options. These options aim to provide cost-effective healthcare coverage while ensuring that beneficiaries receive the necessary medical care. The underlying rationale behind this approach lies in the enhanced efficiency of the designated network of healthcare providers, with the resultant savings in operational costs being transferred to the scheme members. A study case was conducted by Willie (2019) examined the value proposition of GEMS EVO, an EDO that necessitates specific dispensation from the CMS. The study's findings revealed promising outcomes in terms of cost-efficiency and enhanced care coordination within the healthcare system. Notably, the study reported a substantial reduction in overall health expenditure, exceeding 20%. This reduction was particularly noteworthy in the realms of hospitalisation and specialised medical services, and the statistical significance of these findings underscores their credibility. Additionally, there was a nearly 20% decrease in specialist visits.

The success story of GEMS EVO can be seen as a model for pioneering benefits design within medical scheme options. This includes emphasizing care coordination and establishing direct provider contracting arrangements. The experience with EVO demonstrates the potential to optimise healthcare delivery while simultaneously curbing costs, offering valuable insights for future innovations in healthcare benefit structures. Despite achieving cost savings in terms of premium expenses, the adoption and utilisation of EDOs by beneficiaries within medical schemes have not witnessed a substantial increase. The following graph illustrates the trajectory of covered lives over a specified period, shedding light on this trend. While the reduction in insurance premiums has undeniably improved the affordability of EDOs, it is worth highlighting that the adoption of these choices among beneficiaries has not experienced a substantial increase. This suggests that besides the potential financial benefits, there are likely other factors at play influencing beneficiaries' decisions concerning their healthcare coverage preferences.

The table illustrating the progression of covered lives during this specified timeframe provides valuable insights into the utilisation patterns of EDOs within the context of medical schemes This table shows that the number of lives covered relative to parent benefit options increases from 29% to 30% over nearly a decade between 2014 and 2021. Further in-depth analysis is imperative to gain a comprehensive understanding of the underlying factors contributing to this trend. Moreover, there is a need to develop strategies aimed at increasing the attractiveness and utilisation of EDOs among beneficiaries. It is important to note, however, that EDOs offer the same level of coverage as their parent options and are inclusive of PMBs. Consequently, they provide a more comprehensive but relatively costlier healthcare coverage solution compared to the proposed low-cost benefit option design.

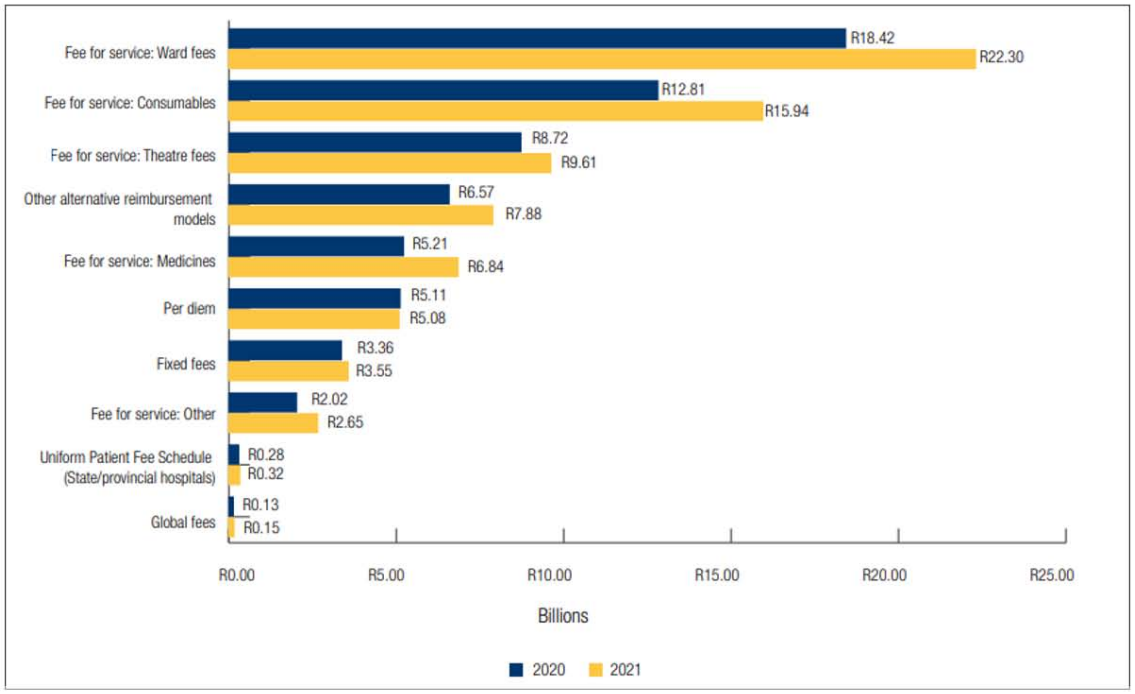
Table 8: Number of EDOs and lives coved between 2014 and 2021

	2014	2021
Number of EDOS benefit options	42	66
Number of lives covered EDO	433 234	980 039
Number of lives covered non-EDOS	1 482 603	3 253 462
% f lives on non-EDOs	29%	30%

2.6 Innovation on Cost of Healthcare: Alternative Reimbursement Models

The lack of innovative approaches in formulating alternative reimbursement models within the context of medical schemes is a significant concern, demanding an intensified level of examination and in-depth exploration. Innovative solutions are indispensable for effectively reducing costs and bolstering the financial sustainability of these schemes. Traditional fee-for-service reimbursement models persist as the prevailing paradigm within medical schemes. This is illustrated in Figure 7, which delineates various reimbursement models for hospital benefits. Notably, the expenditure on hospital services, remunerated on a fee-for-service (FFS) basis, escalated to R57.34 billion in 2021, marking a substantial 21.55% increase from the R47.17 billion recorded in 2020. Within this spending, nearly 64.39% is allocated to ward fees, theatre fees, and consumables, while expenditure on medicines constitutes merely 9.20% at R5.07 billion. However, these models, which compensate healthcare providers based on the volume of services they render, may not inherently foster cost-effective or high-quality care. This situation necessitates the exploration of alternative reimbursement paradigms that deviate from this well-entrenched framework.

Figure 7: Reimbursement methods for hospital services (2020–2021)
Source: CMS Industry report (2022)



One promising alternative is the introduction of value-based reimbursement models, which depart from the conventional quantity-driven approach. These models focus on remunerating healthcare providers based on the quality outcomes of care, potentially leading to superior patient results and more judicious resource utilisation. Nonetheless, comprehending the intricacies of implementing value-based models within medical schemes requires in-depth research to unravel both their challenges and advantages. Expanding the spectrum of alternatives, capitation models emerge, suggesting a fixed fee per patient as the basis for reimbursement. These models emphasise the importance of care coordination and preventive healthcare services. Despite their potential, it is noteworthy that they remain underutilised within the realm of medical schemes. This underscores the need for research to assess their efficacy and adaptability across diverse healthcare settings.

Additionally, risk-sharing models are gaining prominence, involving the shared distribution of financial risks and rewards between payers (such as medical schemes) and healthcare providers. These models are designed to foster cost control and improve healthcare quality. However, research endeavours are imperative to identify and overcome the obstacles that hinder the implementation of these models, tailoring them to meet the unique requirements of medical schemes. The realm of payment mechanisms also offers opportunities for innovation, including bundling payments for episodes of care and integrating telehealth and digital health services. These innovative strategies have the potential to enhance care delivery and elevate the patient experience while exerting control over costs. Furthermore, patient-centred reimbursement models empower patients to make informed choices and offer them a portion of the cost savings when they opt for cost-effective care options. Research is crucial to explore the feasibility of implementing such models within the specific context of medical schemes. As the reimbursement landscape evolves, it is essential to consider its impact on healthcare providers' incentives.

The absence of innovative reimbursement models can inadvertently influence the incentive structures for healthcare professionals, necessitating alignment with the overarching goals of medical schemes, which encompass delivering high-quality care at more economical costs. Regulatory and policy considerations play a significant role in the implementation of these alternative reimbursement models. Research should delve into the challenges presented by the regulatory environment and policy landscape, identifying the necessary adjustments to facilitate the adoption of innovative models.

Moreover, the impact of alternative reimbursement models on patients is a critical aspect to scrutinize. This entails an examination of their effects on patient access to healthcare services, satisfaction levels, and the ultimate outcomes of their healthcare journeys. Lastly, a fiscal perspective is paramount. Evaluations are necessary to assess the cost-effectiveness and efficiency of these alternative reimbursement models, comparing them directly with the established traditional fee-for-service approaches, thus providing a clearer path toward optimized financial viability within medical schemes.

CHAPTER 3: STAKEHOLDER CONSULTATION

Summary

Chapter 3 of the document discusses the developments, consultations, and considerations related to LCBOs and the Demarcation Exemption Framework in the South African healthcare industry. The chapter covers the period from 2019 to 2022 and includes extensive stakeholder engagement and consultations, as well as the progression of the LCBO framework and exemption process.

- ***Circulars 80 and 82 of 2019:*** *The chapter begins by outlining Circulars 80 and 82 released by the CMS in December 2019. These circulars detailed the CMS's initiatives regarding LCBOs and the Demarcation Exemption Framework. LCBOs were not permitted for low-income segments, and products based on the Demarcation Exemption Framework, or the Medical Schemes Act were not allowed beyond 2021. The circulars aimed to ensure equal access to care regardless of economic status and indicated that non-compliant products should be phased out.*
- ***Industry Consultations on LCBO Framework (2020–2022):*** *The CMS engaged in an extensive consultation process with industry stakeholders from 2020 to 2022. Circular 56 of 2020 outlined the outcomes of these consultations, involving various stakeholders such as medical schemes, administrators, insurers, and more. The consultations focused on themes like perpetual regulation, primary health insurance alignment, compliance with the Medical Schemes Act, and establishing LCBO Advisory Committees and technical workstreams.*
- ***LCBO Advisory Committees and Workstreams:*** *The CMS established three LCBO Advisory Committees (Insurance, Funders and Stakeholders) supported by technical workstreams. These committees addressed various aspects of LCBOs, such as market and affordability, benefits and pricing, legislative compliance, and risk and implementation. The workstreams developed draft recommendations and risk assessment reports, which were published in Circulars 53 and 57 of 2022 for public comment.*
- ***Proposed Benefit Package:*** *The workstreams' recommendations included targeting LCBOs toward employed individuals unable to afford traditional medical scheme cover. The recommended benefit package focused primarily on primary healthcare, excluding certain services like hospitalisation and PMBs. Stakeholders provided comments on the proposed benefit package, emphasizing concerns and suggestions for various components.*
- ***Stakeholder Engagement and Mapping:*** *Circular 53 of 2022 initiated stakeholder engagement, resulting in more than 200 comments from 40 stakeholders across 12 thematic areas and 52 policy issues. Stakeholder mapping categorized participants based on legitimacy, power, and urgency attributes. High-risk and Prevailing stakeholders, such as medical schemes and practitioner organisations, played significant roles in the engagement process.*
- ***Demarcation Exemption Process:*** *The chapter also covers the Demarcation Exemption Framework, which allowed insurers to operate under exemptions while the LCBO Guideline was developed. The framework set eligibility criteria and renewal timelines for exempted insurers, and subsequent circulars extended the exemptions. Challenges related to proper reporting and the sustainability of bundled insurance benefits were noted.*
- ***Challenges and Considerations:*** *Challenges in the process included reconciling insurance products with medical scheme operations, proper reporting for insurance products, and ensuring the sustainability and affordability of LCBOs.*

The chapter provides a comprehensive overview of the evolution of LCBOs, stakeholder input, and the development of guidelines and recommendations to enhance healthcare provision and access for low-income earners in South Africa. It highlights the complex interplay between regulatory frameworks, stakeholder dynamics, and the need for sustainable, inclusive healthcare solutions.

3.1 Introduction

In December 2019, the CMS released Circulars 80 and 82 of 2019, which outlined its initiatives and the offices position regarding LCBOs and the Demarcation Exemption Framework. Circular 80 of 2019 outlined the CMS's plans regarding LCBOs and Demarcation Products. It specified that no LCBOs would be permitted for low-income market segments in the future. Additionally, products based on the Demarcation Exemption Framework and/or the Medical Schemes Act would not be allowed beyond 2021. This circular echoed the position of Council contained in the Exemption Framework that exemptions pertaining to primary health care products will only be granted to primary healthcare products which were already in existence when the Exemption Framework first came into operation and which were already registered with the FSCA, the then FSB. These exemptions were grated pending the development and implementation of an LCBO. Effectively, this meant that pending the development and implementation of an LCBO no other products other than those catered for in the Exemption Framework could be exempted.

The Circular also indicated that no exemptions would be granted for LCBO products within the medical scheme and healthcare insurance sectors. The CMS advised that any products not compliant with the Medical Schemes Act should be phased out before March 2021, as they would be considered illegal thereafter. Entities currently exempted under Section 8(h) of the Medical Schemes Act were requested to approach the CMS to determine the appropriate course of action for winding down these business segments.

Circular 82 of 2019 informed medical schemes and insurers that no additional exemptions would be granted for the creation of products targeting low-income market segments outside the scope of the Medical Schemes Act. This decision also included demarcation products that were provisionally exempted. Circular 82 provided a detailed report outlining CMS projects, future key activities, and an analysis of the performance of exempted products.

The two circulars elicited responses, feedback, and reactions from various stakeholders, prompting the CMS to actively engage with all key stakeholders, affected parties, and interested parties. This engagement aimed to gather additional information and identify areas of concern for further consideration.

3.2 Industry Consultations on The LCBO Framework (2020–2022)

Between 2020 and 2022, an extensive consultation process with the industry was conducted through advisory committees and technical workstreams. In August 2020, the CMS published Circular 56 of 2020, which outlined the outcomes of the consultative process with industry stakeholders, including the Minister of Health, National Treasury, FSCA, PA, medical schemes, administrators, managed care organisations (MCOs), insurers, brokers, and related service providers on the report findings of Circular 80 and 82 of 2019. The main discussion points of these engagements were:

- The CMS could not perpetually regulate by an exemption,
- The industry was concerned about the main findings of CMS' research report published with Circulars 80 and 82 of 2019,
- Primary health insurance products needed to align with regulations and demonstrate a significant degree of compliance with the provisions of the MSA and
- The CMS would pave the way for establishing Advisory Committees grouped into streams for insurance, administrators and funders. These streams would be tasked with addressing the challenges faced by primary health insurance providers in complying with the MSA and the need for medical schemes to develop options for low-income earners.

The CMS established three LCBO Advisory Committees **(Insurance, Funders and Stakeholders)** which were supported by the following four technical workstreams:

- Market and affordability –tasked with identifying the target market for LCBO products,
- Benefits and pricing –tasked with developing the minimum benefit package for LCBO products,
- Legislative and compliance –tasked with considering the legislative landscape and making regulatory recommendations on the best policy option to consider, and
- Risk and implementation workstream - tasked with identifying the risks of implementing the LCBO framework and the likely implementation timeline.

Draft recommendations for the **LCBO framework** were developed by the industry advisory committees, along with a **Risk and Implementation report**. These documents were published in **Circular 53** (August 2022) and **Circular 57** (September 2022) for public comment.

One of the key recommendations from the market and affordability workstream was to target the LCBOs towards employed individuals who currently cannot afford traditional medical scheme cover. The benefit and pricing workstream recommended that the LCBOs focus primarily on primary healthcare, which would entail exemptions from covering PMBs and the exclusion of private hospitalisation. This proposed package would serve as the minimum base package, allowing beneficiaries the option to purchase additional service packages.

The workstream focused on legislation and compliance underscored the significance of implementing the proposed reforms in a manner that safeguards consumer choice and provides adequate financial risk protection. They also emphasised the presence of notable legislative considerations that could potentially hinder the timely implementation of the LCBOs, such as potential changes to the MSA. Furthermore, the workstream responsible for risk and implementation examined the potential risks involved in transitioning products from the insurance industry to the medical scheme environment. These risks encompassed legislative and compliance aspects, as well as financial risks associated with the successful implementation of the LCBOs. (Please note that Table 9 below provides a summary of the proposed benefit package, which can be compared to the enhanced proposal put forth by the CMS).

Table 9: Proposed benefit package

Benefit package	Advisory committee	CMS recommendation (Internal Task Team)	Stakeholder comments recommendations (median recommendation)
Nurse based care	Included, no number specified	5 consultations pbpa from a DSP/network provider	**Agree, with referral to GP**
GP based care	Included, no number specified	5 consultations pbpa from a DSP/network provider	**Agree, with network arrangement**
Basic pathology	Basic	Basic pathology required to deliver acute care and defined chronic benefits . Subject to referral from DSP/network provider	**Agree, with formulary**
Basic radiology	Basic	Basic radiology required to deliver acute care and defined chronic benefits. Subject to referral from DSP/ network provide	**Agree, with formulary**
Dentistry	Excluded	Maximum of 2 consultations pbpa. Oral hygienist and dental therapists to provide comprehensive oral assessment. Includes scaling, polishing, filling (motivation - Xray).	**Inclusion at the discretion of medical scheme.**
Optometry	Excluded	Basic eye examination, basic frame & lens cover. Consultation every 2 years per beneficiary.	**Inclusion at the discretion of medical scheme**
Emergency transportation	Included	To any facility for stabilisation, then referred to public facility for further care and treatment.	**Inclusion at the discretion of medical scheme.** **Emergency transport should be offered only at primary health care level. Emergency transportation can cause confusion in terms of extent of cover, cause buy-downs and make LCBOs expensive.**
Preventative health screenings	Included	Must be included as part of nurse-based consultations: -Chronic disease management -Vaccinations -Other health screenings	**Agree**

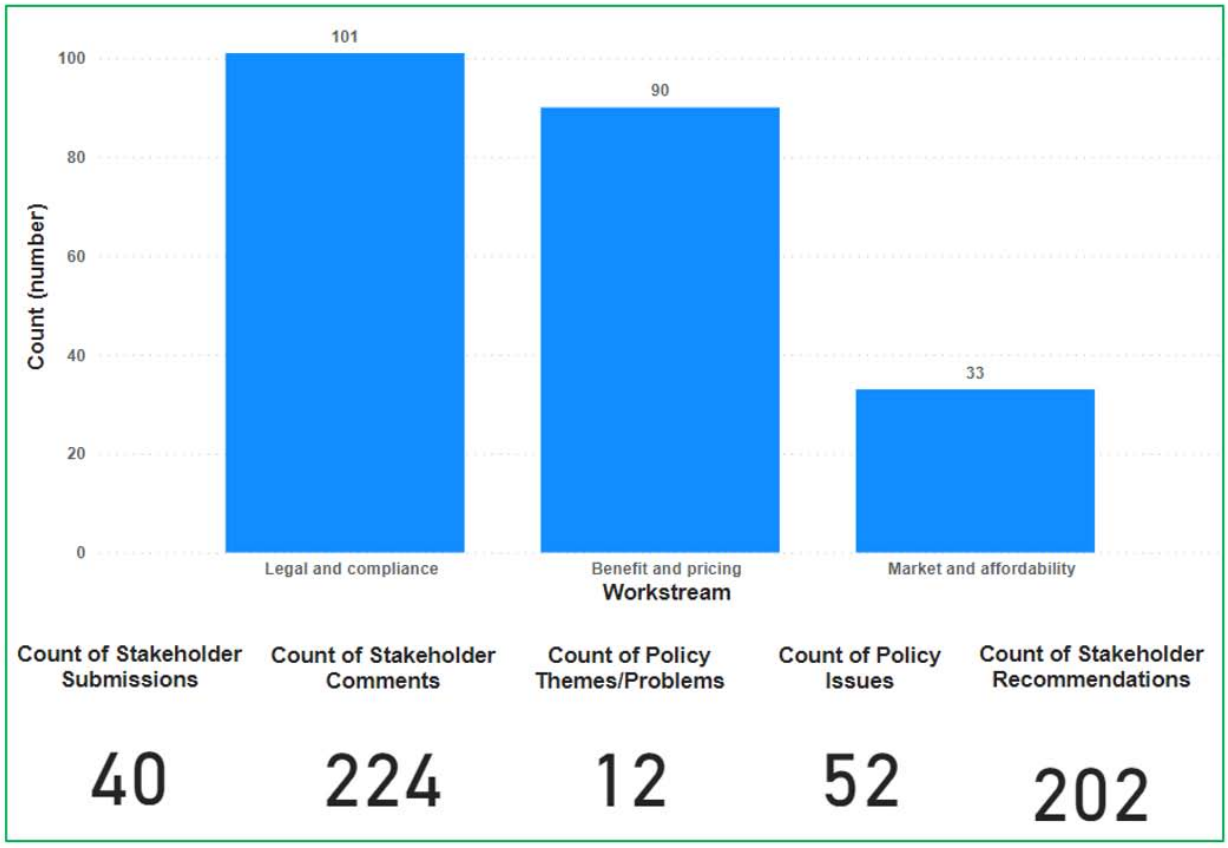
Chronic medication	Included, subject to public sector EML	Prescribed medication for limited chronic conditions at DSP/network pharmacy based on limited protocols and formularies. Must include medication cover for the following CDLs as a minimum: -HIV/TB management -Hypertension -Diabetes -Respiratory conditions (Asthma, COPD)	**Agree, subject to public sector EML**
Acute medication	Included, subject to public sector EML	Limited to prescribed medication during an acute care visit	**Agree, subject to public sector EML**
Sexual health	Excluded	Cover for Contraceptives, Rape, PEP, TB, STI. HIV management - Diagnosis and acute management.	**No recommendation**
Antenatal care	Excluded	2 consultations with Nurse or GP. 1st consult – Hb, HIV, Syphilis, RH. 2nd consultation - 20/52 ultrasound scan. Refer to State for continuation of care and preparation for delivery. Nurse, GP - p29 Guidelines for maternity care in South Africa 4th Edition 2016	**Agree, strictly for antenatal consultations and scans not for delivery or postnatal care.**
Mental Health services	Excluded	Screening by Nurse or GP. Refer to State facility for continuation of care.	**No recommendation**

Circulars 53 and 57 of 2022, published by the CMS, outline the outcomes of the consultative process that started in 2020. The key recommendation from the market and affordability workstream was that the LCBOs should be targeted toward employed individuals who cannot afford medical scheme cover in its current form. The key recommendation from the benefit and pricing workstream is that the LBCOs focus exclusively on primary healthcare and, thus, be exempt from covering PMBs and exclude private hospitalisation. Moreover, this package would be the minimum base package, allowing beneficiaries flexibility to buy additional service packages. The key recommendation from the legislation and compliance workstream was 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 significant legislative considerations that would prolong the implementation of LCBOs (i.e., changes to the MSA. The risk and implementation workstream highlighted 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.

3.3 Circular 53 Stakeholder and Comments Analysis Summary Report

Following the release of Circular 53 of 2022, a total of forty (40) stakeholders participated in the submission process, providing valuable feedback and insights. These stakeholders collectively raised more than 200 comments, addressing various aspects across twelve (12) thematic areas and fifty-two (52) policy issues (Figure 7 below). Furthermore, they offered two hundred and two (202) unique recommendations to enhance the proposed framework. Of all the workstreams, the legal and compliance workstream attracted the highest number of stakeholder comments. This observation indicates a significant level of interest among stakeholders regarding the legislative and regulatory aspects associated with the implementation of LCBO. It underscores the importance placed on ensuring that the necessary laws and regulations are in place to support the successful establishment and operation of LCBOs within the healthcare system. The engagement and participation of stakeholders reflect the broad range of perspectives and expertise brought to the table. By incorporating these inputs, the aim is to develop a robust and comprehensive framework for LCBOs that addresses the diverse needs and concerns of the various stakeholders involved. The extensive feedback received from stakeholders demonstrates the importance of collaborative efforts in shaping the future of healthcare provision in South Africa.

Figure 8: Summary of stakeholder comments



3.3.1 Key Thematic Areas

The findings within this thematic area highlight significant concerns pertaining to two main aspects:
a) the exclusion of specific services within the benefit package, and
b) the emphasis placed on PHC within the same package. Under the PHC focus, stakeholders recommended that LCBOs should exclusively deal with primacy health care.

This means that hospitalisation and PMB cover would not form part of the benefit package. The reasons for this are that offering any services above primary care will induce a buy-down effect which would put the current risk pool of schemes at risk. Moreover, hospitalisation and PMB cover would make LCBO expensive for the target population. Given that the PMB cover, and hospitalisation are part of the provisions of the medical schemes act, it is not clear how LBCOs would be given exemption from complying with these provisions.

Under Exclusions, stakeholders have recommended that several services should be excluded from the base LCBO benefit package. These include hospitalisation, parts of maternity cover relating to delivery and postnatal care, emergency services and specialist care. The reasons for these exclusions are mostly centred around concerns that it will be difficult to mitigate against adverse selection if these benefits are provided under LCBOs. Moreover, these benefits will make LCBOs significantly more expensive. In some cases, stakeholders proposed that these benefits should only be included at the discretion of the medical scheme. However, the CMS is concerned that these exclusions go against the provisions of Section 7 of the and are inherently discriminatory.

In addition to this, excluding maternity deliveries and emergency services doesn't help in improving the financial risk protection of members nor does it reduce the burden on the State as these patients will have to seek services in the public sector. Alternatively, they will be exposed to significant OOP expenditure. Therefore, the CMS recommends that benefits such as antenatal screenings and consultations as well as emergency transportation and stabilisation needs to be included as part of the base package. The CMS also recommends that there should only be one base benefit package which is standardised and easy to communicate to members as opposed to the current dispensation in the medical schemes' environment of multiple packages with discretionary offerings by schemes.

Under waiting periods, stakeholders proposed a myriad of recommendations; including imposing waiting periods of 3-and 12-months, waiving waiting periods for employer-based group membership and not allowing any member movement unless there are justifying circumstances (like loss of employment). The CMS recommends that waiting periods should comply with the MSA provisions. Furthermore, there needs to be clarification in terms of how members who are currently covered by the exempted insurers will be transitioned into the medical schemes' environment (i.e., will their exempted products membership count as credible coverage). The current provisions on waiting periods in the exempted products environment also need to be considered. In terms of member movements (buy ups or buy downs), the CMS recommends that schemes comply with Section 29(4) of the MSA. Stakeholders are interested in preventing buydowns through regulations and scheme rules, however this would need to be evaluated against what is currently provided for in the MSA under Waiting Periods/Adverse Selection. Lastly, the recommendation of employer-based group waiver needs to be considered in terms of whether this would be considered discriminatory and whether this would be an implicit form of risk rating (offering favourable conditions to individuals who join as groups vs those who join individually).

Under late joiner penalties, stakeholders recommend that penalties should be imposed in LCBOs. Specifically, they recommend imposing age entry exclusions and penalties to members who join beyond the age of thirty five (35) years old. They also recommend penalty waivers for those who were previously unemployed. The CMS recommends that schemes penalties should be implemented according to the

provisions of the MSA, however their impact on member contributions should be monitored (as they can make membership unaffordable to the intended target market). Also, the provisions of late joiner penalties under the current exempted products need to be considered as this will have an impact on members who are transitioning to the schemes' environment.

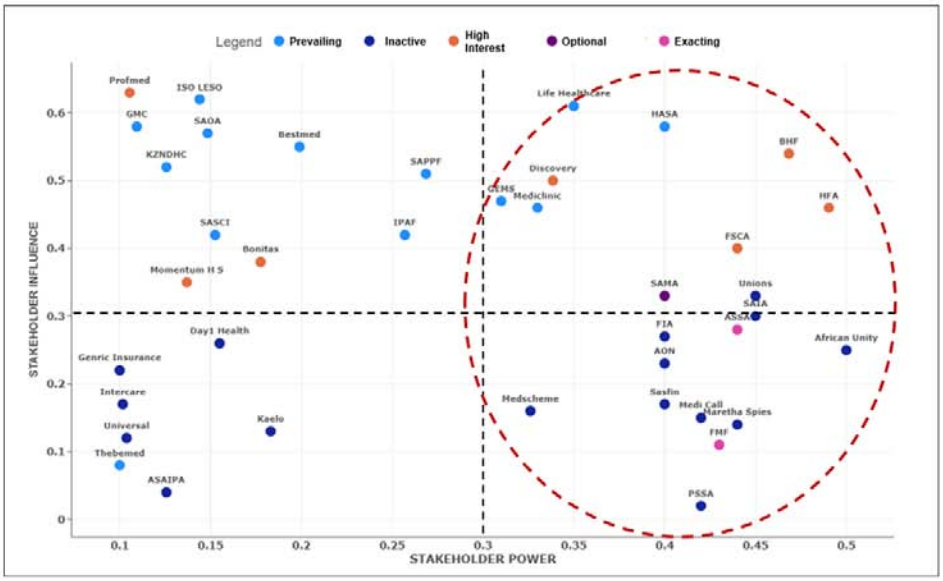
Under the target market, the key issues raised were eligibility criteria and group enrolment. Stakeholders proposed that there needs to be an explicit income-based criteria targeting employed individuals with household incomes of less than R18 000. Furthermore, LCBOs should initially be rolled out to employed individuals under group cover to mitigate against adverse selection. The CMS recommends an income-based criteria as proposed above. However more research is needed to understand other household dynamics (excluding income) that could impede the willingness to pay for medical cover. Moreover, the recommendation on group enrolment is also supported, if schemes have the necessary data and insights to roll-out cover to the entire target market. Perpetual group cover would go against the MSA and will be considered discriminatory.

3.3.2 Stakeholder Mapping

After identifying key issues and themes, the stakeholders were categorized based on three attributes:
(a) legitimacy.
(b) power; and
(c) urgency.

This categorisation aimed to assess the level of influence each stakeholder holds. Figure 8 illustrates four quadrants that provide a summary of stakeholder management strategies for each quadrant. Of relevance to this analysis are the enclosed quadrants labelled as "anticipate and meet needs" and "manage closely." These quadrants offer valuable insights into stakeholders with median opinions and provide guidance to the CMS and the Minister of Health in effectively addressing imminent risks. By focusing on these identified quadrants, decision-makers can prioritise actions that align with stakeholder expectations and address their needs. This approach facilitates a comprehensive understanding of stakeholder dynamics and enables the development of strategies to effectively engage with stakeholders and mitigate potential risks. Figure 8 serves as a valuable tool for stakeholder management, aiding in decision-making and providing guidance on key stakeholder relationships. It strengthens the capacity of the CMS and the Minister to navigate the intricate landscape of stakeholder interests while duly considering the submissions of the most influential and pertinent stakeholders.

Figure 9: Stakeholder mapping



Under the quadrants of interest, the main stakeholders have the following attributes: High risk, Prevailing, Inactive and Exacting. At a high level, Figure 8 provides a summary of stakeholder comments based on their attributes. The stakeholders categorised as High risk and prevailing contribute approximately 70 percent of the comments in the analysis. The High-risk attribute refers to stakeholders who possess power and urgency but lack legitimacy. In this case, it primarily includes medical schemes, administrators, and funder associations such as BHF and HFA. On the other hand, stakeholders categorised as Prevailing attribute type have both legitimacy and power. These stakeholders mainly comprise practitioner organisations such as GPs, specialist societies, and a smaller portion of medical schemes.

Given the significant number of comments and the potential influence of these stakeholders, the CMS recommends acknowledging their presence and influence. This recognition is crucial due to their high potential to legally challenge, appeal, or disrupt the implementation of the final recommendations that will be approved for consideration and operationalisation. It is important to carefully consider their perspectives and engage with them effectively to ensure a successful implementation process. Other stakeholders and their respective classifications are outlined below.

Table 10: Perspectives of Stakeholder Groups and classification**

	High interest	Exacting	Optional	Prevailing	Inactive	Total
Stakeholder group	11				3	14
Administrators	30					30
Funders Association	2					2
Government agency						0
Health insures					19	19
Hospital Association						3
Hospital Groups						2
Insurers Association					2	2
Intermediaries					33	33
Medical Associations			13	3		13
Medical Schemes	41			2		54
NGOs		3				3
Optometrists						1
Practitioner Society					4	21
Professional societies		10				10
Sub-Acute & Day Clinics					2	2
Unions					1	1
	84	13	13		64	210

The subsequent table illustrates the composition of the industry advisory technical workstream, delineating its key milestones and the corresponding reference dates when these milestones were successfully concluded. This depiction provides a comprehensive overview of the workstream's progress and the chronological sequence of its achievements.

Table 11: Progress update and key milestones

Workstream/Committee	Key Milestones	Completion Date	Comments
Market Affordability	Presentation and report concluded and made to the joint advisory committee meeting.	December 2021	Presentations and input to the report were provided. These are stored on the CMS website: LCBO portal
Benefits of Design & Pricing		December 2021	
Compliance& legislative framework		December 2021	
Implementation and risk		December 2021	
Advisory Committee Funders and Administration	A total of six joint advisory committee meetings were held between 2020 and 2022, with the most recent meeting taking place in August 2022.	December 2021	
Advisory Committee: Insurance		December 2021	
Advisory Committee: Member and Provider		December 2021	
Draft guidelines by the advisory committee published for public comment.	Draft guidelines, recommendations, and risk & implementation report published for public participation in September 2022. Circular 57 and Circular 57 of 2022. The industry received an update on its status through the publication of Circular 23 of 2023.	September 2022	The three circulars were published on the website.
Final draft guidelines and recommendations to Council on 30 June 2023	Proposed guidelines, and various options were presented and recommendations	30 June 2023	
Guidelines and recommendations to the Minister	Preparing and packaging the document for its ultimate submission.	July-August 2023	

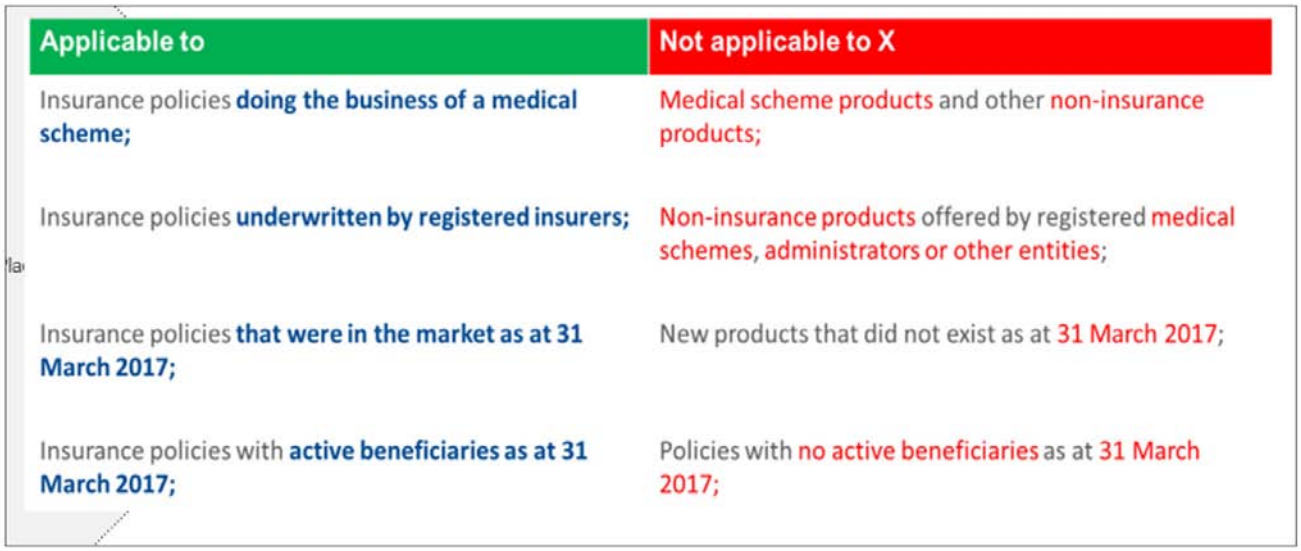
3.3.3 Demarcation exemption process and the exempted products

Considering that the Demarcation Regulations came into force on April 1, 2017, necessitating the termination of policies by March 31, 2017, this had an adverse impact on the policyholders who held these pre-existing health insurance policies. Considering the impact on the policyholders that would be left without cover, an agreement was reached between the National Department of Health and the National Treasury that the CMS would develop and LCBO Guideline, and in the interim, the CMS would consider exempting the relevant insurers. To facilitate the exemption process, a Demarcation Exemption Framework ("Framework" was prepared in consultation with the NDoH, the NT and the FSCA. The Framework was approved by the Council on the 15th of March 2017 and was published on the same day by the CMS via Circular 17 of 2017. The Framework sets out the eligibility criteria for applicants. As illustrated below, two renewal frameworks have been published since the initial Framework was approved. The following analysis delves into a comparative study, as illustrated in the figure below. It examines the insurance attributes of products related to medical schemes (pertaining to healthcare services) and subject to regulation by the CMS through the exemption framework. It also evaluates demarcation insurance products and pure insurance products, which are overseen by the FSCA. Moving forward, additional figures provide an intricate evaluation of the potentiality of unbundling the non-medical scheme aspects. Furthermore, these figures underscore the notion that the act of unbundling these non-medical components would result in their lack of sustainability.

Figure 10: Comparison of insurance products regulated by the CMS and by the FSCA

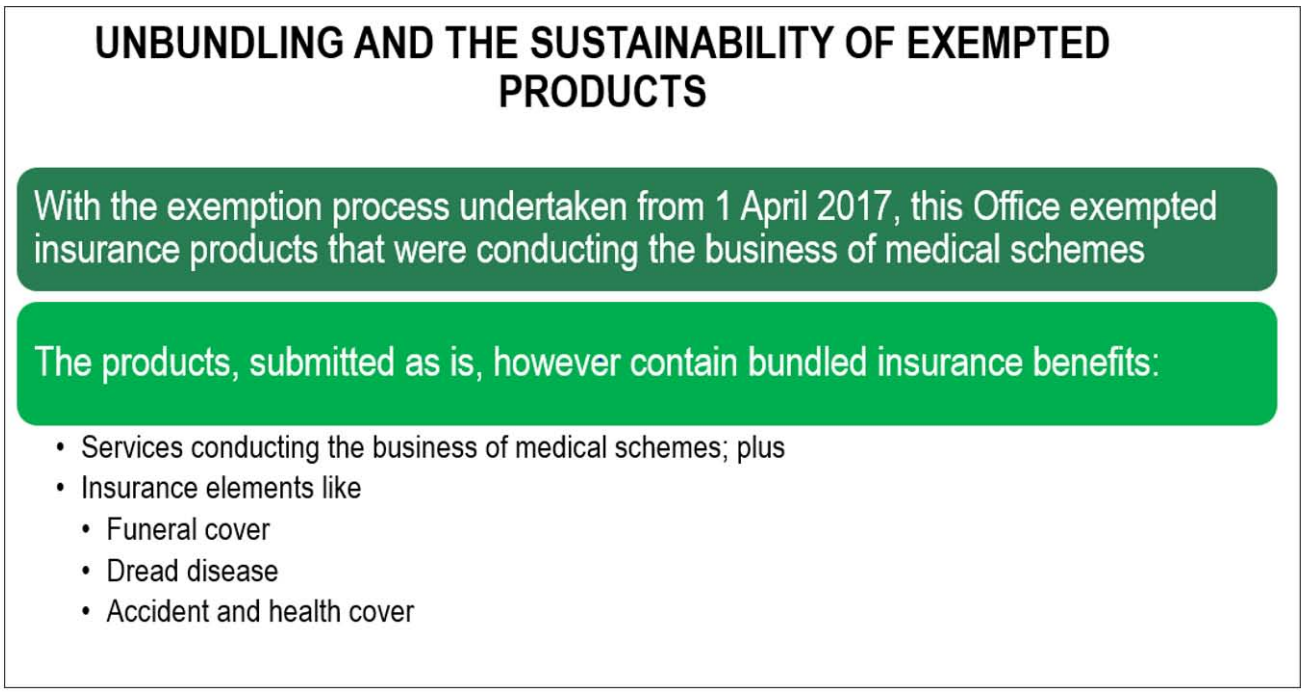
Insurance products doing the business of a medical scheme (relevant healthcare services)	Demarcation insurance products	Pure insurance products
Regulated by the CMS	X Regulated by the FSCA	X Regulated by the FSCA
Primary Care Products	X Gap Cover	X Dreaded disease/critical illness (cash lumpsum if a member is diagnosed with a stated dread disease)
Day to day products	X Hospital Cashback plan (Cash lumpsum for each day spent in hospital)	X Other insurance products not doing the business of a medical scheme
Hospitalisation product	X TB & Malaria treatment X HIV Aids (Meets the definition of the business of a medical scheme, but the burden of disease and impact on state facilities were considered)	
Comprehensive products (day to day and hospitalisation)	X Emergency Medical evacuation & transportation	

Figure 11: Outline and enablers of the exemption framework



Applicable to	Not applicable to X
Insurance policies **doing the business of a medical scheme;**	Medical scheme products and other non-insurance products;
Insurance policies **underwritten by registered insurers;**	Non-insurance products offered by registered medical schemes, administrators or other entities;
Insurance policies **that were in the market as at 31 March 2017;**	New products that did not exist as at 31 March 2017;
Insurance policies with **active beneficiaries as at 31 March 2017;**	Policies with no active beneficiaries as at 31 March 2017;

Figure 12: Effect of unbundling and sustainability of exempted products



3.3.4 Reporting challenges: Insurance products

The lack of proper reporting for insurance products, unlike medical schemes that consistently submit healthcare information, is a notable concern. These insurance products, when submitted, contain bundled insurance benefits alongside services resembling medical scheme operations. The bundled elements often include funeral cover, dread disease coverage, accident and health cover, among others. Considering the feedback received, it becomes evident that these products would not be sustainable if their insurance components were unbundled from the offerings. Additionally, the affordability of these products to policyholders would be compromised if the insurance elements were separated from the overall packages. While the insurance industry routinely engages in the bundling of products, it's essential to recognize that this practice deviates from the stipulations outlined in the MSA. The MSA, which governs the provision of healthcare services and products, imposes specific constraints and restrictions that diverge from the conventions accepted within the broader insurance sector.

Under the MSA, healthcare offerings are subject to a distinct regulatory framework, one designed to safeguard the interests of beneficiaries, ensure transparency, and maintain the integrity of healthcare service delivery. As such, it is imperative for stakeholders in the healthcare domain to adhere meticulously to the guidelines and provisions set forth by the MSA, aligning their operations with the unique requirements and standards that pertain to healthcare-related services and products. This distinction serves to underscore the importance of compliance with the specialized regulations governing the healthcare sector, emphasizing the need for a clear demarcation between practices accepted in the insurance environment and those prescribed under the MSA. Ensuring compliance with the MSA is fundamental to maintaining the integrity of healthcare provision and upholding the rights and well-being of patients and beneficiaries.

3.3.5 White labelling, primary coverage coupon, and legal regulations

It is common knowledge that medical schemes operate based on open enrolment, community rating and social solidarity principles. Over and above these principles, medical schemes are legally compelled to provide Prescribed Minimum Benefits ("PMB"). The law also makes it illegal for any person to engage in the business of medical scheme without being registered by CMS. It is for this reasons that medical schemes are required to be registered, administrators, managed care organisations and brokers are also required to be accredited. Thus, the medical schemes environment is a highly regulated space.

It follows therefore that engaging in the business of medical a scheme without due registration or following the principles of open enrollment, community rating and social solidarity is undermining the core of the business of a medical scheme. Primary health insurance was identified by CMS, FSCA, and the National Treasury [5] as harmful to the business of a medical scheme which led to the promulgation of the Demarcation Regulations. Because of the harmful effect which primary health insurance may have on medical schemes, they were outlawed unless they complied with the Medical Schemes Act or exempted from compliance by CMS.

Primary health insurance undermines the business of medical schemes because although granted exemptions by CMS, they do not comply with the principles of open enrollment, community rating and social solidarity and they are likely to attract young and healthy members away from medical schemes. Unlike medical schemes which are not for profit entities, primary health insurance companies are profit making entities driven by profit maximisation than the health interest of the policy holders.

5 National Treasury: Response to Key Issues Raised in Public Submissions on Regulations Which Give Effect to The Demarcation Between Health Insurance Policies and Medical Schemes, page 10.

During the consultation stages of the Exemption Framework with other regulators, CMS raised the possibility of prohibiting exempted insurers from signing up new policy holders as the exemption was meant to be a transitional arrangement. However, other regulators were of the view that there was no need for such prohibition. They were of the view that customers will not be interested in purchasing a product which only enjoys a temporary exemption and whose future was uncertain.

It is important to point out that since the primary health insurers were first granted exemptions in 2017, none of them have converted to register as medical scheme nor have they made any attempt to move their policy products to medical schemes or made any attempt to comply with the Medical Schemes Act. Instead, the primary health insurers have engaged in aggressive marketing of their current products to recruit more clients and grow their books, business is booming. Indeed, the CMS commissioned research showed that the rate of utilisation in these products is very low, which makes primary health insurance a very lucrative business. In our view, the low utilisation rate in primary healthcare insurance is evidence that the products attract young and healthy people and/or that they do not provide sufficient cover such that when people need cover, they are unable to make use of them due to the exclusions which in turn leave them out of pocket.

One of the tactics used by the exempted primary health insurers to grow their books is to engage in what is known as "white labelling". Basically, what they do is that an exempted entity authorizes a non-exempted entity to rebrand the exempted product and market it as its own product. This practice is in violation of the spirit of the Exemption Framework which does not anticipate for the continued marketing of the exempted products. The practice is also in violation of the expressed condition of the exemption which states that no amendments to the exempted product may be affected without the authorisation by Council. But most importantly, white labelling is a violation of the Medical Schemes Act in that it introduces a non-registered, non-accredited and a non-exempted entity into the highly regulated business of a medical scheme without the necessary authority to do so. The impression created to unsuspecting consumers and potential clients is that these entities are legally entitled to carry on the business of a medical scheme [6].

Because exemptions for primary health insurers were only given to entities which were already in existence at the time when the Demarcation Regulations came into effect, this has seen some entities come up with other tactics to try and circumvent the Medical Schemes Act. We have recently seen entities introducing vouchers for healthcare funding and CMS has taken legal action to curb this practice. It has become apparent that these entities have taken a cynical and unethical calculated risk knowing that they can take CMS' directives through appeals processes whilst they generate sufficient profits to keep their shareholders content in the meantime.

Section 8(h) of the Medical Schemes requires that exemptions must only be granted in exceptional cases. Primary health insurers were granted exemptions on the basis that their clients/policy holders would have been in a worse off position if the exemptions were not granted because it would mean that they would lose cover. However, the legality of these exemptions is in question and in order to show this point it is important that we explore two rulings issued by the Appeals Board.

The first ruling was issued by the Appeals Board in the matter between Discovery Health (Pty) Ltd v/s Council for Medical Schemes [7] ("first ruling"). This matter involved an appeal by Discovery Health against the decision of Council to deny it an exemption on the basis that when the Demarcation Regulations came into effect Discovery Health was not a registered FSP with Financial Sector Regulatory Authority ("FSCA") and therefore it was operating illegally. The Exemption Framework stated that only products which were in existence when the Demarcation Regulations came into effect would be exempted and the entities in question must have been registered with the FSCA or its predecessor, FSB.

6 See the prohibition in terms of section 21A of the Medical Schemes Act 131 of 1998.
7 Matter: DM1045 (2 October 2018)

In confirming the correctness of the decision of Council to decline Discovery Health's exemption, the Appeals Board agreed that:
"…one of the pillars of the regime of open-enrolment governing medical scheme, is the principle of cross-subsidisation. Cross-subsidisation would be undermined, and open medical schemes decimated, if there were to be other regimes in terms of which other entities conducting the business of medical scheme are allowed to pick and choose members. This happens for example where younger and healthier members are attracted away from medical schemes by other financial services providers."

The second ruling involves the Board of HealthCare Funders ("BHF") v/s Council for Medical Schemes and Discovery Life Limited ("second ruling")[8]. After the first ruling Discovery Health moved the primary health products to Discovery Life and reapplied for an exemption. Council reconsidered the application and granted the exemption to Discovery Life. BHF challenged the decision of Council to grant Discovery Life the exemption. In grating the BFH's application and setting aside the decision of Council to grant Discovery Life an exemption, the Appeals Board made very important findings.

In the second ruling the Appeals Board stated that the fact that policy holders who had bought Discovery's policies will be prejudiced by their cancellation would not on its own constitute exceptional reason to grant an exemption:
"The motivation in paragraphs 19.2.1 to 19.1.4 come down to two points. Firstly, that the enrolees would be prejudiced if the products are cancelled. This is no compelling reason to allow the practice to continue because, as it was done by this Board in its decision of 2 October 2018 when turning down a similar application by Discovery Health, the respondent would be given adequate period of grace within which to make appropriate arrangements for them. Secondly, there is nothing exceptional about DL [Discovery Life] providing the products; many insurers can and would indeed do so once an open sesame is created."

As indicated above, the primary health insurers were granted exemptions on consideration that not doing so would leave the policy holders with no cover, but the above passage makes it clear that such considerations do not meet the test for exceptional cases. Furthermore, the number of entities that were granted the exemptions also supports the view that there is no exceptional case for the exemptions to be granted.

The Appeals Board went further to make observations which questions the legality of granting exemptions to entities which are not registered as medical schemes to allow them to carry on the business of a medical scheme without due registration:
"The provisions of section 20 and section 8(h) read together, are meant to operate pre-emptively; that explains the high threshold. Lowering it would result in the emasculation of section 20, which is the pillar of medical scheme regulation regime created by the Act."

The Appeals Board also scoffed on the idea that evidence was required to prove that the operation of primary health insurances undermined the business of medical schemes by holding that such "reasoning suggests that the steed be stolen first before the stable is closed." This observation is correct, and it also aligns with what can be regarded as truite. The fact that the operation of primary health insurance undermines the business of medical scheme is an accepted fact which forms the basis of the consultations which CMS, FSC and National Treasury engaged in from 2000 and which culminated in the promulgation of the Demarcation Regulations.

In arriving at its decision to set aside the decision of Council to grant an exemption to Discovery Life, the Appeals Board also considered that the amendment to the definition of a business of a medical scheme was properly passed by parliament because it was supposed to cure a particular mischief. The mischief which the amendment sought to cure is that of primary insurers circumventing the law and

8 Ruling delivered on 28 October 2020

undermining the principle of cross-subsidisation by carrying on the business of medical a scheme without due compliance. Therefore, the law must be given effect to and not be watered down by exemptions.

In our view the decision of the Appeals Board is in line with the the Supreme Court of Appeal decision which dealt with the meaning of "exceptional circumstances" in the context of section 17 (2) (f) of the Supreme Courts Act 10 of 2013 in the case of **Avnit v First Rand Bank Trading, inter alia, as Wesbank and Wesbannk Aviation Finance [2014] JOL 32336 (SCA) at para [4],** and quoted with approval a passage from Norwitch Union Life Insurance Society v Dobbs 1912 AD 395 where Innes ACJ stated:
"The question at once arises, what are "exceptional circumstances"? Now it is undesirable to attempt to lay down any general rule. Each case must be considered upon its own facts. But the language of the clause shows that exceptional circumstances must arise out of, or be incidental to, the particular action; there was no intention to exempt whole classes of cases from operation of the general rule. Moreover, when a statute directs that a fixed rule shall only be departed from under exceptional circumstances, the Court, one would think, will best give effect to the intention of the Legislature by taking a strict rather than a liberal view of applications for exemption, and by carefully examining any special circumstances relied upon."

In line with this case, it is clear that exempting a whole category of primary health insurers will not meet the test of exceptional case. Furthermore, a strict adherence to the legislation is required rather than generous granting of exemptions.
It is clear that the threat of primary health insurance to the business of a medical scheme is bigger than it was in 2000 when the regulators started the consultation process or in 2017 when the Demarcation Regulations came into effect. This is so because the exempted entities have engaged in marketing practices that are meant to undermine medical schemes from within as opposed to when they were doing it as insurance products regulated by the FSCA. Currently, they are undermining the business of medical schemes with the approval of Council and thereby making a mockery of the amendment of the definition of a business of a medical scheme which sought to cure this mischief.

It is for this reasons that we hold the view that the primary health insurance exemptions must not be renewed when the current exemption period comes to an end or if need be, the exempted entities be granted a grace period within which to wind down their primary health products.

This report contains a chapter dealing with whether or not an LCBO should be approved. However, we wish to point out here that we do not think that the proposed LCBO solution offers a viable solution either. Our view is based on the fact that the proposed LCBO is based on the creation of a lite PMB for the have-nots, or the poor. This in our view strikes at the heart of the non-discrimination as contained in section 24 of the Medical Schemes. The LCBO proposal is also based on a premise to ringfence the LCBO risk pool such that members who buy into the LCBO will face waiting periods when they want to change to other options. This in our view cements the discrimination element and creates an impression that people who buy LCBOs are members of medical schemes whilst in actual sense they will be treated as non-members. Ringfencing also strikes at the heart of the prohibition against ringfencing options or asserts as contained in Regulation 4 (4).

The National Treasury acknowledges that the Department of Health is currently busy with efforts to introduce the National Health Insurance ("NHI") and that medical schemes and primary health insurance products are part of the challenge[9]. In our view, if primary health insurance products are part of the challenge in introducing NHI but it is illegal then it makes sense that the prohibition must be upheld. Absorbing the primary health insurance into to the medical schemes by way of exemptions or in the form of LCBOs will not do anything to easy the challenge.

9 National Treasury: Response to Key Issues Raised in Public Submissions on Regulations Which Give Effect to The Demarcation Between Health Insurance Policies and Medical Schemes, page 6: "Government is also exploring how best to provide universal coverage through National Health Insurance, and to do so in a way that minimizes costs and ensures quality care. The transition to this objective is an equally complex process and is further complicated by the existence of health insurance products operating under the LTIA and STIA as well as the current MSA framework.

CHAPTER 4 TECHNICAL ANALYSIS

Summary

This segment delves into the advantages associated with low-cost benefit options, which serve to enhance healthcare accessibility for individuals with constrained financial resources by providing essential coverage and preventive care. These options play a dual role in not only equalizing risk pools but also yielding cost reductions for all members within the scheme. Conversely, the chapter also outlines potential drawbacks linked to these low-cost benefit options, encompassing limited coverage and the potential for adverse selection, which could contribute to imbalanced risk pools. The pursuit of lower reimbursement rates may also potentially exert an influence on the quality of healthcare services provided. Additionally, Chapter 4 casts light on unintended repercussions stemming from the exclusion of critical benefits. These omissions run counter to principles of non-discrimination, undercut global health objectives, strain available resources, and shift financial responsibilities. The absence of coverage for PMBs and mental health further compounds issues related to equitable healthcare access.

This chapter delves into the historical aspiration of medical schemes to devise options tailored specifically for low-income earners. It underscores the imperative to accord this aspiration comparable attention as primary health insurance products operating under the regulatory oversight of the CMS through exemptions. The chapter formulates pivotal questions necessitating comprehensive elucidation through the Low-Cost Benefit Guidance Framework:

- *Should medical schemes be permitted to furnish options targeting low-income earners, and if affirmative, under what stipulations and ramifications?*
- *Should medical schemes be precluded from targeting low-income earners, and if so, what rationale justifies this stance and what repercussions ensue?*
- *Should primary health insurance products governed by CMS regulations persist beyond the exemption period, and what ramifications ensue? and*
- *Should primary health insurance products governed by CMS regulations be proscribed from continuing post-exemptions, and what are the full ramifications of this course of action?*

The central goal of this chapter is to ensure that recommendations effectively address the exigency for options catering to low-income earners and also attend to the destiny of exempted primary health insurance products. A prior proposal, declined due to its inability to adequately tackle disease burden and financial risk protection, is brought to scrutiny. The viability of the latest proposal in rectifying these concerns is interrogated, and its implications for stakeholders are closely examined. Although the proposal promises benefits such as potential industry expansion and contributions to National Health Insurance, apprehensions arise concerning healthcare quality, financial risk coverage, and the potential dilution of benefits. The chapter posits that the introduction of options for low-income earners does not necessarily ensure heightened healthcare quality or facilitate the transition towards Universal Health Coverage.

The chapter delves into stakeholder endorsements, highlighting support from medical schemes, administrators, and managed care organisations favouring the low-income option. In contrast, healthcare professionals voice reservations regarding potential compromises in quality and safety. On the other hand, resistance emanates from providers of exempted primary insurance products, apprehensive of heightened competition. It is argued in the chapter that the introduction of an option, absent rectification of identified issues, would be imprudent. It questions the dependency on tax credits and subsidies, contending that the implementation of inferior health products to address macroeconomic challenges should not come at the expense of public health. Conclusively, the chapter navigates the prospects of exempted primary insurance products, dissecting concerns around competition, regulatory framework adequacy, and the behaviour of involved entities. Implications spanning policyholders, assets,

external regulators, medical schemes, service providers, and healthcare entitlements are meticulously contemplated. The chapter's closing remarks reflect upon the decision to discontinue the issuance of exemptions for LCBOs, considering overarching macroeconomic factors, risk pooling dynamics, subsidy considerations, financial sustainability, and policy alignment.

4.1 Potential benefits of offering LCBOs by medical schemes

Proposed in response to industry submissions, low-cost benefit options are designed to enhance healthcare accessibility for individuals grappling with financial constraints. These options serve as a means for individuals to secure fundamental healthcare coverage, ensuring their access to essential medical services and preventative care. Characterized by their reduced premiums and deductibles, these low-cost benefit options are tailored to be more financially viable for individuals operating within limited budgets. This affordability, in turn, plays a pivotal role in alleviating the financial burden associated with healthcare expenses, thus incentivising individuals to actively seek imperative medical attention without enduring undue financial stress.

Although they may not offer all-encompassing coverage, these options prioritize the provision of vital healthcare services, preventative measures, and the management of chronic conditions. This strategic focus empowers individuals to access indispensable healthcare resources, even if their financial circumstances preclude them from affording more expansive coverage. Beyond individual benefits, the implementation of LCBOs brings about a broader positive impact. By attracting individuals who possess lower healthcare needs and a healthier profile, these options effectively contribute to the equilibrium of risk distribution within medical schemes. This harmonised distribution of risk has the potential to curtail costs for all scheme members by evenly distributing financial risks across the entirety of the membership base.

4.2 Potential pit falls of offering Low Income Benefit options by medical schemes

LCBOs have certain limitations in terms of coverage, which can be a disadvantage for individuals seeking comprehensive care. These plans may exclude specific treatments, procedures, or specialist consultations, thereby restricting the range of services available. While these options typically offer lower premiums, they often involve higher deductibles, co-payments, or out-of-pocket expenses. Consequently, individuals may need to bear a greater financial burden before their coverage limits are reached, which can be particularly challenging for those with limited financial resources. Moreover, some LCBOs may have restricted benefits or fail to encompass essential services. As a result, individuals may experience delays or compromised access to healthcare, potentially impacting their overall health outcomes. Another concern is that these options may attract individuals who consider themselves healthier or at lower risk, leading to adverse selection. This could create an imbalance within the risk pool, where the costs of providing care to higher-risk individuals outweigh the premiums collected from healthier individuals, ultimately driving up costs for the scheme. Additionally, to offer LCBOs, medical schemes may need to negotiate lower reimbursement rates with healthcare providers. This has the potential to impact the quality and accessibility of healthcare services, as providers may be less motivated to participate or may reduce the level of care provided.

4.3 Unintended consequences

The proposed benefit offering for the LCBOs currently lacks substantial coverage, with a primary focus on primary healthcare services. Several important elements of a healthcare systems such as Maternal and Childcare Benefits. Excluding maternity benefit is in contradiction with section 24 (e) of the Medical Schemes Act which states that: "The medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, gender, marital status, ethnic or social origin, sexual orientation, pregnancy, disability and state of health."
Secondly, excluding maternity benefits would undermine and contrast the overall health systems goals and the SDGs. There is evidence or intention to support SDG goal 3.1. and 3.2 stated as follows:

- **3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births.**
- **3.2 By 2030, end preventable deaths of new-borns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.**

If maternal benefits are excluded, it would mean that members would have to bear the costs themselves or rely solely on state facilities as their only available option. The inclusion of maternal benefits is vital for ensuring comprehensive healthcare coverage for individuals during pregnancy, childbirth, and postpartum periods. These benefits typically encompass prenatal care, delivery expenses, postnatal care, and related medical services. By providing coverage for these maternal healthcare needs, medical schemes support the well-being of both mothers and babies. Excluding maternal benefits would have significant implications. Firstly, it would result in members having to pay for these services out of their own pockets. This could place a considerable financial burden on individuals, especially those with limited resources or who are not adequately prepared for such expenses. Secondly, with the absence of coverage for maternal benefits, the only viable option for members may be to rely on state healthcare facilities. This could lead to increased pressure on public healthcare resources, potentially resulting in longer waiting times, overcrowding, and reduced quality of care. It may also limit the choices and control that individuals have over their preferred healthcare providers or facilities. The proposed LCBO benefit package is also limited in terms of emergency cover and other benefits that are flagged as PMBs. This is in contrast with the provisions of the MSA section:

The inclusion of PMBs in all benefit options is crucial to ensure equitable access to essential healthcare services for all members of medical schemes. PMBs are designed to protect individuals by guaranteeing coverage for a comprehensive range of conditions, diseases, and medical emergencies. By adhering to PMBs, medical schemes are obliged to provide coverage for the diagnosis, treatment, and ongoing care without imposing additional financial burdens such as co-payments or deductibles. When PMBs are excluded, it could lead to fragmentation within the healthcare system and result in a situation where certain individuals are left without appropriate coverage for necessary medical treatments. This could ultimately lead to increased reliance on the state healthcare system, creating a strain on public resources.

Moreover, excluding PMBs would essentially shift the financial responsibility onto the state, as the government would need to provide healthcare services for individuals who lack adequate coverage through medical schemes. This scenario could result in the state subsidizing the private sector, as the cost burden is transferred from the medical schemes to the government. Therefore, it is essential to maintain the inclusion of PMBs in all benefit options to ensure that individuals have access to essential healthcare services and prevent an undue burden on the state healthcare system.

The proposed benefit package also excludes mental health. Excluding mental health from the proposed benefit package overlooks the importance of including it in medical scheme benefit options. Mental health is an integral part of overall well-being, and its inclusion ensures comprehensive healthcare that addresses both physical and mental aspects. By recognising the common occurrence and impact of mental health conditions, medical schemes can reduce stigma and discrimination associated with them. Timely intervention and treatment for mental health conditions lead to better outcomes and improved overall functioning. Preventive measures and early intervention programs included in mental health benefits allow for early identification and management of concerns. Supporting mental health contributes to enhanced productivity and well-being, as individuals can better focus on their daily activities. Investing in mental health benefits can yield long-term cost benefits by preventing severe conditions and reducing the burden on the healthcare system. The inclusion of mental health benefits promotes equity and social justice by ensuring equal access to healthcare services for individuals with mental health conditions.

The inclusion of mental health as a benefit in medical scheme benefit options is of utmost importance for several reasons. Mental health is an integral component of overall well-being. Including mental health as a benefit ensures that individuals have access to comprehensive healthcare that addresses both the physical and mental aspects of their health. It recognises that mental health conditions are common and can have a significant impact on a person's quality of life. By including mental health as a benefit, medical schemes help reduce the stigma and discrimination often associated with mental health conditions. It sends a message that mental health is equally important as physical health, promoting understanding and acceptance among the population. Mental health conditions, if left untreated, can lead to worsening symptoms, functional impairment, and negative outcomes. Medical schemes offering mental health benefits facilitate timely intervention and treatment, resulting in improved mental health outcomes and overall functioning for individuals.

Mental health benefits can encompass preventive measures and early intervention programs. This can include screenings, counselling services, and access to mental health professionals, allowing for early identification and management of mental health concerns before they escalate. Supporting mental health through benefit options can contribute to improved productivity and well-being among individuals. When mental health conditions are effectively addressed and managed, individuals can better focus on their work, relationships, and daily activities, leading to enhanced overall functioning and productivity. Investing in mental health as a benefit can have long-term cost benefits.

Medical schemes play a crucial role in preventing the escalation of mental health conditions, hospitalisations, and emergency interventions by providing access to mental health services. This proactive approach leads to long-term cost savings and alleviates the burden on the healthcare system. Moreover, the inclusion of mental health benefits promotes equity and social justice by ensuring equal access to healthcare services for individuals with mental health conditions, aligning with the principle of inclusive and accessible healthcare for all, irrespective of their health condition.

4.4 Comments on The Draft Guidance Framework on the LCBO

The desire by medical schemes to provide options that are specifically designed for low-income earners is historical and must be given the same attention that is given to the fate of the primary health insurance products that are in the market and are operating under the regulatory umbrella of the CMS through an exemption from Section8(h) of the MSA. This approach is aimed at addressing the following key questions that we believe needs to be comprehensively answered through LCBO Guidance Framework, which include:

- Should medical schemes be allowed to provide options that are targeted at low-income earners? If so, under what conditions and what will be the full implications of doing so?
- Should medical schemes be disallowed from providing options that are targeted at low-income earners, if so, what is the justification for this and what are the full implications of this decision?
- **Should the primary health insurance product that are currently operating under the regulatory purview of the CMS, be allowed to continue existing beyond the current exemption period, if so, under what conditions and what are the full implications of this decision? and**
- Should the primary Health insurance products that are currently operating under the regulatory purview of the CMS be disallowed from continuing beyond the current exemption period and what are the full implications of this decision?

The answers to these questions should not be seen as mutually exclusive but should be read together in order to develop a comprehensive view of what is being recommended either for the medical scheme option or the primary health insurance products. When CMS makes recommendations to the Minister of Health every attempt will be made to ensure that they address themselves to the following issues:

- The need for medical schemes to offer an option for low-income earners and
- The fate of the primary health insurance products that are currently operating through a CMS Section 8(h) exemption.

In considering the case made by medical schemes, it is of great importance to note that the last proposal they made to the Minister of Health with respect to the provision of an option for the low-income earners was turned down. The key reasons for this decision were based on the following:

a. That the proposed package was **NOT** adequately addressing itself to the country's burden of disease
b. That the proposed package was **NOT** providing any financial risk protection for its prospective members

It is therefore important to determine whether the latest offering as proposed by the medical schemes, is correcting the identified shortfalls that led to the rejection of the previous proposals. Failure to adequately address these identified shortfalls will, in our view, lead to the same outcome after the Minister has considered the latest proposal.

The assessment of the proposal from medical schemes needs to be weighed against the current and future implications on the following key stakeholders:

- Current and prospective medical scheme members
- The medical Schemes, administrators, brokers and managed care organisations
- The medical scheme regulator, CMS and its legislative mandate
- The service providers, including professionals, hospitals, pharma and others
- The primary health insurance market and
- The conduct of the medical schemes and their associations in the period leading to the recommendations on the LCBO

This assessment will be incomplete if it ignores the current health reform initiatives including the imminent implementation of the National Health Insurance **(NHI).** The broader social and economic implications of the introduction of a LCBOs for low-income earners, will be articulated and analysed prior to the final recommendations.

4.5 Feasibility analysis of medical scheme to offer an LCBO product

This section explores a range of possibilities, including whether it is appropriate for medical schemes to offer plans specifically tailored for individuals with lower incomes. If this is deemed permissible, what criteria should be established, and the comprehensive ramifications of such a decision. MSA and the Regulations associated with it does NOT recognise or give existence to the so-called LCBOs also known as the LCBO. The reference to an LCBO Guidance Framework should not be interpreted to mean that there is a tacit approval of the LCBO, and that the Framework should merely describe how this should be implemented. The fact is, the need for the existence of the LCBO needs to be determined in the first place, before any kind of guidance on its implementation is provided. The key pertinent consideration and is:

Should medical schemes be allowed/ not allowed to provide options that are targeted at low-income earners? If so, under what conditions and what will be the full implications of doing so?

This question has been deliberately framed this way, so that all stakeholders are clear that this entire exercise is directed at medical schemes currently registered with the CMS and **NOT** to administrators, managed care organisations or brokers. There are many reasons advanced to make a case for the Minister of Health and the CMS to allow medical schemes to provide options targeted at low-income earners. The key tenet of the case is covered in the following narrative:

- The number of medical scheme beneficiaries has NOT grown significantly in the past ten years or more and this poses a sustainability threat to the medical scheme industry.
- The reason for the lack of growth in this market is since the current and prospective members of medical schemes cannot afford the current benefit options.
- The current benefit options are found to be unaffordable because the Medical Schemes Act has legislated the mandatory PMBs and
- The payment of PMBs claims by the medical schemes is compulsory and expensive. They are seen to be the main contributor to the unaffordability of the current benefit options.

The introduction of an option that has the following characteristics was seen to be the solution that addresses the “challenges “as discussed above:

- Does not comply with the MSA and the associated Regulations by ensuring that PMBs are NOT mandatory and are NOT applicable to it.
- Exists either by a permanent exemption using section 8(h), from complying with the PMBs as required by the MSA or the MSA and Regulations will need to be amended to accommodate it
- It will provide benefits that are far less than what is covered by the PMBs.
- Will become cheaper and more affordable for prospective members as a result of offering significantly reduced benefits and
- Will be targeted at low-income earners, who currently want to belong to a medical scheme, but cannot afford it at this stage.

This benefit option is expected to significantly increase the number of beneficiaries enjoying medical scheme cover and save the medical scheme industry from the threat of collapse. Depending on who you talk to, this number is estimated between four and twenty million. This narrative is also spiced with an allegation that the delay in the finalisation of the approval process for this option by the Minister of Health and the CMS is denying twenty million lives medical scheme cover, against the provisions of the Constitution.

In the aggressive lobbying for the approval of this benefit option, there have been assertions that it is a perfect benefit option to introduce in the transition towards the implementation of the National Health Insurance. In developing a comprehensive answer to the question posed, it is also important to understand, what the proposal to introduce a benefit option that is targeted at the low-income earners is silent on. The drive to provide a benefit option in order to increase the number of beneficiaries and market for medical schemes, needs to be weighed against the social costs of its introduction.

Firstly, there is no indication from the supporters of this benefit option, how its introduction will contribute to the quality of health care and the overall national health outcomes. It could be argued that if the current scheme beneficiaries are enjoying good quality healthcare, this is because they are covered for the two hundred seventy-one (271) Diagnostic and Treatment pairs as well as the twenty six (26) Chronic disease list that form the PMBs. Any attempts to dilute the cover provided for by the PMBs, should through the same reasoning, reduce the quality of healthcare services that will be provided through this new benefit option.

Secondly, the notion that you can reduce the level of benefits in an option through important exclusions, while still retaining the level of quality of healthcare, is counter-intuitive and nonsensical. This benefit option that is aimed at low-income earners, is a false promise and needs to be exposed for what it is. Unsuspecting and uninformed prospective members of these benefit options will discover at the time when they wish to enjoy these health benefits that they are not covered for important illnesses and conditions that are prevalent in South Africa.

Thirdly, the drive to increase medical scheme beneficiaries has a profit motive behind it that needs to be exposed at the outset. In terms of the MSA, medical schemes are not-for profit entities, where members make monthly contributions which are pooled, and service claims are paid through these resources. According to the same Act, schemes are allowed to out-source the function of collecting monthly contributions and paying out claims lodged by service providers to entities known as administrators. Administrators are by design and nature profit-making entities that generate their wealth through the contracts that they have with schemes. The administration fees are directly proportional to the number of beneficiaries that you administer on behalf of a scheme. This explains why they are the most vocal supporters of the benefit option designed for the low-income earners; there is money to be made! This is further supported by the observation that certain administrators have attempted to introduce a primary healthcare benefit option, despite their awareness that the LCBO is intended for medical schemes. Additionally, the existing accreditation criteria do not authorise them to function as medical schemes.

Fourthly, the recently increased and aggressive lobbying for the introduction of the benefit option aimed at the low-income earners at all costs is driven by the unhappiness that through the demarcation process, primary insurance products have been allowed to operate through an exemption by the CMS. This argument that may on the surface appear valid especially from a competition and fairness point of view, exposes the profit-making motive of this drive. The facts are that the CMS has interrogated the benefits that policy holders of these primary insurance products and has found them to be completely and hopelessly inadequate. This view has been expressed publicly in the Circulars 80 and 82 that were issued in 2019. The medical schemes as led by their administrators, wish to be allowed to go into the same pool of mud as the primary insurance products in the name of fairness and competition, if there is money to be made. The fact that the benefits that these policy holders are inappropriate, irrelevant and will not improve their healthcare quality is of no consequence to them.

It is very important to note that the proposed benefits in this option, clearly indicates that hospital admission will not be included as a benefit. Members that buy into this option are expected to seek admission in the public hospitals at their time of need. This key exclusion is to ensure that the befit option is cheap and affordable. This goes against the promise that these options will reduce the burden from the state, as a key motivation for their introduction. The targeted low-income earners are the poor as well as your young entry level workers. This group is very diverse in terms of its demographics and the burden of disease faced by them. Attempting to develop a benefit option that will provide this diverse group adequate cover is an impossible task.

Out-of-pocket expenditure is defined as that expenditure that you incur over and above what is covered by your insurance or medical scheme. In South Africa, the level of these out-of-pocket expenditures sits at R32bn according to the last Annual Report issued by the CMS in 2023. This very high level of out-of-pocket expenditure is believed to be grossly understated as the CMS, only reports on the claims that were lodged with schemes and were rejected for one reason or the other. Where claims are not lodged with the medical scheme, then they are not counted in the determination of this amount.

The out-of-pocket expenditures is experienced at an individual level and varies from a few to millions of rands, depending on the case. There is a silent group of medical scheme members who have suffered from this catastrophic expenditure as a result of healthcare funding gone awry. This phenomenon has been identified as a key contributor to the impoverisation of individuals and communities. WHO cautions against the uncontrolled imposition of out-of-pocket expenditure and has urged member states to keep this at a low level.

The relevance of the out-of-pocket expenditure in the discussion of the introduction of an option to address the healthcare needs of the low-income earners, is that very little is being said by its proponents about risk of exposure to high out-of-pocket expenditures if you buy into such an option. We argue that if your benefit option is very thin and has many exclusions, the risks of high out-of-pocket expenditures remains real and guarantees that there is minimal financial risk protection for you. The fact that the targeted market is the low-income earners, in an economy beset by poverty, unemployment and inequality is of grave concern.

It is often argued that if the Minister of Health and the CMS approve the implementation of the benefit option targeted at the low-income earners, this will expand the market, create more jobs and this will contribute to the growth in the economy. Our retort is that even in desperate times, inferior health funding product should not be allowed into the market to address other macro-economic challenges if this will be at the expense of the health of individuals and communities.

Those that believe that the introduction of the benefit option targeted at low-income earners will increase the medical scheme beneficiaries by another 20 million members are also linking this possibility with the National Treasury supporting this process through the relevant tax credits and subsidies. The CMS is at this stage, not aware if there is indeed an official commitment by National Treasury on these tax credits and subsidies. We are concerned about the retrogressive nature of these tax credits and subsidies, given that the fiscus collects through general taxes such as the Value added tax even from the indigent. The further addition of these tax credits to the medical scheme industry, will, in our view, further distort this picture. We also argue that the proponents of this benefit option need to make a case that is NOT dependent on the tax credits and subsidies, given the numerous competing macroeconomic priorities that this country is faced with.

There is a strong argument based on the economics of health that asserts that investment in health should be seen as a capital investment that ensures that over time the healthy population is productive and contributes to the growth of the economy in a sustainable way. The demand for healthcare is also seen to be a derived demand, in that when individuals demand health care, this contributes to their health in the present and the future. The argument that by providing a diluted form of health cover for low-income earners contributes to the overall health outcomes is negated by the argument espoused above.

The proponents of the introduction of the benefit option for the low-income earners also seem to be suggesting that the overall health outcomes of the population will be improved if more members of the population are migrated and provided cover in the medical schemes industry. This suggestion is often linked to the asserting that this migration is a key step in the transition towards Universal Health Coverage (UHC). Accordingly, UHC, which is the single most important health reform of our times, cannot be achieved by simply migrating as many beneficiaries into the medical scheme industry, let alone a denuded benefit option.

The myth that if you are not a medical scheme beneficiary, then you do not enjoy any healthcare cover whatsoever, needs to be challenged. The truth of the matter is that those that are not covered by a medical scheme, still enjoy cover through its funding of the Public Health sector and there is also some degree of self-funding. The quality of services in the Public Health sector is not at the level that it should be, but we all understand the contributory causes to this, which includes but is not limited to the following:

- Chronic Under-funding
- Poor Leadership and Management
- Under-staffing
- Non-compliant with Supply Chain Policies and Prescripts
- Fraud, Waste, Abuse and Corruption
- Poor infrastructure planning, development and maintenance and
- Poor planning on the acquisition of essential medicines, consumables and equipment

That said, it is worth noting that there are medical schemes that have appointed the State as a Designated Service Provider (DSP), these challenges affect all sectors because of the inter-connectedness of the system, and therefore needs to be addressed by all stakeholders in the health sector, both public and private. The poor quality of healthcare services produced by the Public Health sector and the high costs in the Private Health sector have been identified as the major failures of the South African Health System; and it is these key failures that the National Health Insurance seeks to comprehensively address.

An impression is often created that the creation of the benefit option for low-income earners within the medical aid industry is desirable because this environment is safe, well-regulated and members will be protected. The CMS agrees whole-hearted with this view, but we also need to state in no uncertain terms that the medical schemes industry cannot be seen to be an ideal environment that is without its problems and challenges. The conduct of some of the medical schemes, administrators, managed care organisations and brokers, leaves a lot to be desired as they are continuously challenging the mandate of the regulator.

The regulator is seized with the task of ensuring compliance by entities that it regulates to address major issues that are prevalent in the industry that includes, but are not limited to the following:

- Excessive and increasing out-of-pocket and co-payments in the industry
- Illegal payment of Prescribed Minimum Benefit from Member Savings
- Scheme beneficiaries running “out of funds” even before the end of six months.
- Inadequate and delayed resolution of member complaints

- Allegations that brought about the Section 59 Investigation
- Inadequate Regulatory funding
- Multiple options, poor benefit design and information asymmetry

It would therefore be imprudent to simply introduce this benefit option without considering its impact and consequences on the current regulatory landscape. A key issue to be addressed is how the introduction of this benefit option for low-income earners will impact the conduct of the funders and how this will affect the role of the CMS as a regulator.

A pivotal factor in determining whether to permit or prohibit the introduction of a benefit option catering to low-income earners within medical schemes is the assessment of its implications on various stakeholders. While the aim is to ideally achieve a mutually advantageous outcome for all major stakeholders, this goal is frequently not entirely attainable. Findings from stakeholder engagement and public comment analysis indicate that, for the most part, medical schemes, administrators, and managed care organisations tend to be largely in favour of implementing the benefit option for low-income earners. It is important to note that this stance is indicative of the prevailing collective perspective and does not necessarily represent the opinion of individual entities.

The endorsement of introducing the low-income earner benefit option emanates from the presence of mutually beneficial contractual agreements that are established and permitted between medical schemes and the diverse regulated entities. These relationships underscore the support for this proposed benefit option, as they are driven by collaborative dynamics that accommodate the interests of both parties.

The support for this benefit option by the industry association is not surprising, given that they represent the collective view of their membership. It however needs to be mentioned that apart from the two industry associations cited above, there are several schemes that are not affiliated to either the Health Funders Association (HFA) or the Board of Health Funders (BHF). Their stance on this matter and many others have been indifferent, and they have tended to defer to the formally established associations.

The attitude of the prospective beneficiaries is somewhat uncertain. When you consider the views of the schemes and related entities, they will quote significantly high numbers (30 000 quoted by the representative of the Foschini medical scheme) of prospective members who cannot wait for the approval of the benefit option for the low-income earners (below R10 000 pm). We have not had an opportunity to directly engage with the prospective beneficiaries, but we believe their support for the benefit option will be determined by their perception of the positive and negative impact of this option on their well-being. These perceptions will be influenced by their understanding of the benefit offering that this option is expected to deliver.

The attitude of the current scheme beneficiaries to the introduction of this benefit option targeted at low-income earners, is also uncertain. It can, however, be reasonably inferred that a significant number of scheme beneficiaries would at some point wish to buy down and enrol for the new option so that they can alleviate their current financial pressures, and if this is prohibited, they will be unhappy as they might perceive this restriction as taking away their rights. In order to prevent these buy-downs, the proponents of the new option have proposed some scheme rules and legislation changes, whether these will succeed in curing this potential problem remains to be seen. It should not be forgotten that the current scheme beneficiaries and the prospective beneficiaries of the new options will not be spared from the current confusion and information asymmetry that makes it very difficult to make rational choices when purchasing a medical option.

The general opposition to the benefit option targeted at low-income earners by the service providers has been established in the numerous engagements that the CMS has had with them. Their argument goes along the lines that as health professionals bound by their ethical standards, they cannot support a benefit option that promises what is essentially seen as inferior quality and compromise the safety and outcomes for beneficiaries. Health professionals argue that you can tamper with the benefits within an option up to a certain point, beyond which the quality of health care and safety of patients or beneficiaries are compromised.

Health professionals also believe that the medical schemes will bully them into signing these contracts where they will have to treat these beneficiaries to sustain their practices. When they contract to treat these beneficiaries, the volume of patients will increase, but the total revenue per patient will significantly decrease. They will in fact be holding and wrong end of the stick as they will be indirectly subsidising these benefit options, whilst the administrators will be smiling all the way to the bank. They do not see these beneficiaries as different from the highly subsidised indigent cash-paying patients that they treat below cost recovery as part of their corporate social investment.

The most vehement opponents of the option targeted at low-income earners come from the current providers of the primary insurance products that exist through an exemption by the CMS and their associated brokers. The opposition by these parties is fuelled by the current dispensation that sees them providing these products without any competition from medical schemes. The worst fear of those opposed to the introduction of the option targeted at low-income earners is that this also brings the medical schemes into this environment, who are well resources, have all the systems and processes to out-compete with them in an environment regulated by the CMS. This real threat of competition will be accompanied by the loss of beneficiaries and the associated income.

It is also worth noting that primary healthcare providers we granted exemptions under the MSA on full knowledge that this was meant to be a transitional measure aimed at having the products migrated to the LCBO which if approved would only be offered by medical schemes. Despite this, no single primary healthcare provider has managed to convert into a medical scheme and only one primary healthcare provider ever made enquiries about how to go about registering as a medical scheme. Instead of registering as a medical scheme in order to prepare for the possible implementation of the LCBO, we have seen aggressive marketing of this products and underhanded marketing gimmicks such as white labelling which are not only foreign to the medical schemes environment but also make mockery of the Demarcation Regulations and goes against the spirit of the Exemption Framework.

In our view, the purpose for this aggressive marketing is twofold; a) it is profit driven, b) it is meant to create a stumbling block for government in the event that the decision is not to approve the LCBO because the question will be “what must happen to the current policy holders”. This might ensure that the providers continue the provide these products long after the decision not to implement the LCBO has been taken in the same way that they have managed to continue these products long after they have been outlawed by the Demarcation Regulations.

4.6 Feasibility of insurance products to continue existing beyond the current exemption period.

In this section, we delve into the deliberation surrounding the potential extension of primary health insurance products currently governed by the CMS (Council for Medical Schemes) beyond their existing exemption period. If the decision to allow such an extension is warranted, it becomes imperative to establish specific criteria for this continuation and thoroughly assess the far-reaching implications of such a course of action. As we navigate the decision-making process regarding the future status of these exempted primary health insurance products, several critical issues must be comprehensively addressed:

- The competition concerns that have been raised by other stakeholders emanating from a prolonged and indefinite exemption by the CMS.
- Whether the Medical Schemes Act provides an adequate regulatory environment for these products or there is an alternative appropriate legislation
- Whether regulation by exemption and exemption in perpetuity is a desirable approach and best practice
- The conduct of the entities that were provided with an exemption to provide the primary health insurance product especially as this relates to:
    - Compliance with exemption conditions
    - White labelling
    - Protection of member interests
- Mapping the progress of the various entities to migrate into the medical scheme environment during the exemption period and
- Assessment report on the exempted products

In addition to the above, the fate of the exempted primary insurance products will have to be considered by examining the full impact of the decision to be taken will have on the following:

- Protection of the current policy holders of the primary insurance products
- The preservation and transfer of any assets that are realised.
- Regulators outside the CMS, their legislation, and mandates
- The fate of both the health and other insurance entitlements and the appropriate regulation
- The medical scheme members, medical schemes, administrators, brokers and managed care organisations and
- Service providers, including professionals, hospitals, pharma and others.

4.7 Conclusions

The decision to cease the issuance of exemptions for LCBOs by the CMS and NDoH was well-considered, taking into account various factors. These factors include ongoing strategic projects to support universal healthcare coverage and the macroeconomic and socioeconomic landscape of the country. One crucial consideration was the operational effectiveness and sustainability of medical schemes, which involve risk pooling, mandatory coverage, eligibility criteria, underwriting, risk assessments, and financial sustainability, among others.

The macroeconomic indicators in South Africa show weak economic growth, which has a direct impact on access to healthcare for medical scheme members and policyholders. The government and employer subsidies, while targeting low-income individuals, may not effectively benefit the intended recipients and could be better utilised for broader healthcare policy initiatives like NHI. The financial sustainability of medical schemes is a concern with the introduction of LCBOs, as it may lead to regulatory arbitrage and undermine existing risk pools. Administrative issues arise from the use of public healthcare facilities by private medical schemes, necessitating monitoring and potentially increasing the administrative burden for both schemes and regulators. Policy alignment and sequencing of strategic projects are essential to stabilize the medical scheme environment. The sequencing of projects, such as the PMB review and development of base benefit packages, should be aligned with national health policy goals to minimize market disruption.

CHAPTER 5: POLICY ANALYSIS

Summary

Chapter 5 of the academic work delves into the enhancement of healthcare accessibility and the mitigation of the disease burden within the South African healthcare system. The chapter covers the NHI, HMI base benefit package, PMB Review with a focus on PHC and addressing the multifaceted burden of disease in South Africa.

- ***NHI:*** *The chapter underscores the intricate healthcare landscape in South Africa, blending public and private sectors to offer comprehensive services. Challenges, including limited resources and access inequalities, have prompted the government to launch a multifaceted approach. This includes the NHI, aiming to create an equitable, efficient, and sustainable healthcare system. The NHI seeks to provide universal coverage, financial risk protection, equitable access, and improved care quality. Integration of medical schemes into the NHI framework is discussed, emphasizing alignment with holistic healthcare objectives.*
- ***HMI Base Benefit Package:*** *The HMI's exploration of the private healthcare sector has generated recommendations for enhancing competition, pricing, and access. While the HMI report covers diverse aspects, it does not specifically address the base benefit package, which encompasses crucial healthcare services. The chapter highlights the pivotal role of this package for equitable access and analyzes its alignment with the proposed LCBO package. The HMI's proposals for improved regulation and transparency have broader implications. The chapter emphasizes harmonizing the base benefit package with NHI objectives and LCBO considerations.*
- ***PMB Review:*** *Focus on PHC: The chapter delves into the ongoing review of PMBs, concentrating on PHC). The review aims to align PMBs with health policy, ensure affordability, and establish comprehensive essential healthcare benefits. The delineation and costing of PHC service packages are discussed, along with potential alignment with the LCBO benefit package. The chapter outlines the future course of the PMB review, emphasizing stakeholder involvement and evolution toward tailored, affordable healthcare solutions.*
- ***Addressing Burden of Disease:*** *South Africa grapples with a multifaceted disease burden, encompassing HIV/AIDS, tuberculosis, maternal and child mortality, violence and injuries, and non-communicable diseases (NCDs). The chapter stresses the need to address each facet strategically, focusing on prevention, treatment, and management. The goal is to alleviate pressure on the healthcare system and enhance the overall population well-being.*

Chapter 5 extensively explores key facets of the South African healthcare system, encompassing NHI objectives, the significance of the base benefit package, the ongoing PMB review, and strategies to combat the complex burden of disease. The overarching theme revolves around the aspiration for a more equitable, efficient, and comprehensive healthcare framework, catering to the diverse needs of all citizens while addressing South Africa's unique healthcare challenges.

5.1 National Health Insurance

The healthcare system in South Africa is designed to provide healthcare services to the population and consists of a combination of public and private sectors. However, it faces several challenges, including limited resources, disparities in access to care, and a high burden of disease. In response to these challenges, the South African government has undertaken various initiatives to improve the healthcare system. These initiatives include the following:

(a) implementation of the National Health Insurance (NHI);
(b) strengthening primary healthcare;
(c) enhancing health infrastructure;

The goal is to create a healthcare system that is more equitable, efficient, and sustainable, capable of meeting the healthcare needs of all South Africans. The NHI Bill, as introduced in the National Assembly (proposed section 76); explanatory summary of Bill and prior notice of its introduction published in Government Gazette No. 42598 of 26 July 2019. It has undergone extensive review and consultation processes. As of [specific date], the Bill has been endorsed by both the Portfolio Committee and Parliament. The NHI aims to address healthcare inequalities and ensure that essential health services are accessible to all individuals without causing financial hardship. Through the NHI and other initiatives, the South African government is striving to transform the healthcare system, ensuring that quality healthcare is available and affordable to every citizen. The ultimate objective is to achieve universal access to essential health services and reduce health disparities in the country. The key objectives of the NHI include:

- **Universal coverage:** The NHI seeks to provide healthcare coverage to all South Africans, regardless of their socio-economic status or employment status. It aims to ensure that everyone has access to a defined package of essential healthcare services.
- **Financial risk protection:** One of the main goals of the NHI is to protect individuals and families from high healthcare costs. By pooling resources and implementing risk-sharing mechanisms, the NHI aims to provide financial risk protection, ensuring that people can access the care they need without incurring catastrophic expenses.
- **Equitable access to healthcare:** The NHI aims to address the disparities in access to healthcare services between different population groups and geographical areas. It seeks to ensure that all South Africans, regardless of their location have equal access to quality healthcare services.
- Improved quality of care: The NHI aims to enhance the quality of healthcare services by implementing appropriate standards and regulations. It seeks to strengthen healthcare infrastructure, improve the skills of healthcare professionals and promote evidence-based practices.

The NHI Bill provides a clear outline of the role that medical schemes would play within the framework of the NHI. It envisions a single purchaser model where medical schemes would provide complementary cover for services not included in the NHI benefit package. This includes the primary healthcare component, which is a vital aspect of any comprehensive health system. However, it is important to note that the proposed LCBO benefit package and the currently exempted products have their own limitations.

These limitations include exclusions on certain essential benefits, as mentioned earlier, which are in contrast with the objectives of establishing a unified and equitable health system. Several studies have highlighted that a significant proportion of healthcare service providers are focused on the private sector, which serves only 15% of the population but accounts for half of the overall healthcare expenditure.

The NHI aims to address these inequities and imbalances by creating a single-tier health system that ensures equal access to quality healthcare for all South Africans. By integrating medical schemes into the NHI framework and providing complementary cover, the government aims to enhance the overall effectiveness and coverage of healthcare services. This approach seeks to promote a more equitable distribution of healthcare resources and eliminate disparities between the public and private sectors.

The NHI Bill embodies a holistic approach towards attaining universal access to healthcare services, diminishing healthcare disparities, and enhancing the overall health outcomes of the populace. Through the alignment of medical schemes and any related developments, such as proposals targeting low-income earners, it is essential to ensure that they do not contradict the objectives of the NHI. The government's objective is to establish a healthcare system that is more effective, sustainable and inclusive, catering to the healthcare needs of all South Africans, regardless of their socioeconomic status.

5.2 Health Market Inquiry (HMI): Base Benefit Package

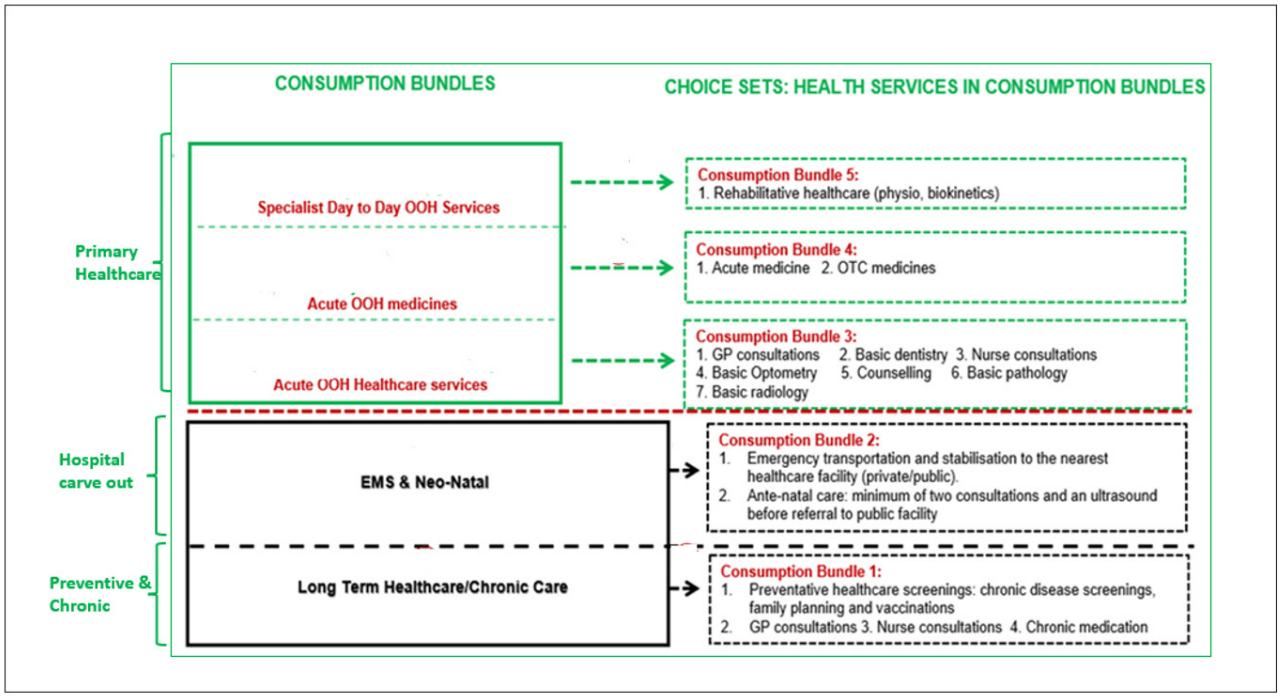
The HMI in South Africa conducted an extensive investigation into the private healthcare sector and made recommendations to address issues related to competition, pricing, and access to healthcare services. While the HMI report provided recommendations on various aspects of the healthcare system, including pricing regulations and market transparency, it did not specifically focus on the base benefit package. The base benefit package refers to the essential healthcare services that should be provided to all individuals as a minimum standard of care. These services typically include primary healthcare, preventive services, and a range of essential treatments and medications. The design and composition of the base benefit package are important considerations in ensuring equitable access to quality healthcare for all. The proposed Benefit Package outline in Table 12 is very thin on preventative services such as screening and immunisation, which are in turn covered under the revised PHC package (The comparison of the two bundles is shown in **Table 12** below).

Table 12: Comparison between the proposed LCBO minimum package and the PMB PHC package

PHC Service Package	Included as part of the LCBO minimum benefit
Preventative Services	√
Maternal Health Services	√ (very limited)
Neonatal & Child Health Services	√
Mental Health Services	**X (except for screening)**
Rehabilitative & Palliative Services	**X**
Radiological & Pathological Services	√ (basic)
Oral & Eye Health Services	√ (limited)
Procedure/Surgical Services	**X**
Essential Drugs, Devices & Consumables	√ as per the EML

While the HMI report did not specifically address the base benefit package, its recommendations aimed to improve the overall functioning of the private healthcare sector and enhance competition, which could indirectly impact the design and affordability of healthcare services, including the base benefit package. The HMI report emphasised the need for greater regulation, transparency, and collaboration within the private healthcare industry to promote fair pricing, quality care, and improved access for consumers. It is important to note that the specific details of the base benefit package, including its coverage and implementation, are typically determined through policy development and regulatory processes led by relevant government authorities, such as the National Department of Health or the CMS. The CMS has developed a draft base benefit package published in 2019 (See Research brief 4 of 2019). Figure 12 illustrates a benefit design framework that visually presents a suggested foundational benefit package. This package can be further developed and improved to align with the PMB PHC Review package, ultimately serving as a comprehensive base package applicable across all schemes. The package further distinguishes between different components of the package, namely the PHC (Out of hospital), Hospital carves out and the three service bundles; Preventative and Chronic (In hospital); the PMB benefit package non-PMB services, and Non-PMB Out-of-Hospital (OOH) services, which together form an ideal minimum package.

Figure 13: Consumption bundles: proposed base benefit package.



The CMS views the proposed PMB PHC package, and the base package outlined in Figure 12 as potential alternatives to address the need for LCBOs within schemes and currently exempted products. However, further discussions and collaboration between the NDoH and NT are required since the CMS does not register or have jurisdiction over insurance products that are currently exempted.

5.3. PMB Review: Focus on Primary Health Care (PHC)

The MSA provides for a review of PMBs every two years to ensure that PMBs remain relevant through undergoing rigorous clinical, cost, affordability, and sustainability assessments by experts and users of services. The costs of PMBs have been increasing year-on-year, placing pressure on medical schemes and more so on beneficiaries as such increases are largely transferred back to them. Following the previous review conducted on the PMBs, the CMS made submissions to the NDoH for the review of the PMB based on inputs from various committees and other stakeholders. The feedback received indicated that the previously proposed reviews lacked prioritisation of PHC and failed to adequately address the country's needs. In response, the current review process has been designed to bridge these gaps and ensure that the PMBs align with developments in the National Health Policy. The objective of the current review is to define a comprehensive package that encompasses primary health care and remains affordable for members of medical schemes.

The objective of the ongoing PMB review is to establish a comprehensive PHC service with particular emphasis on the following aspects:

- Alignment of the PMB package with development in health policy,
- Specification of a comprehensive set of essential healthcare benefits,
- Identification of actions that should be undertaken to ensure the sustainability of the package and
- Identification of measures required to ensure the affordability of the new package.

Ten (10) PHC service packages have been identified and costed down to the granular (basic building block) level based on reference price lists. These ten (10) PHC service packages are listed in Table 13

Table 13: List of PHC service benefit packages proposed for inclusion in the PMB package.

• Preventative Services	• Radiology Services
• Maternal, Neonatal and Child Health Services	• Essential Medicine List
• Rehabilitative and Palliative Care	• Medical and Surgical Procedures
• Mental Health Services	• Oral Health Services
• Pathology Services	• Eye Health Services

While ensuring alignment between the proposed PMB PHC service package and developments in National Health Policy is crucial, it is equally important to align the PMB PHC service package with the proposed LCBO benefit package. Although the LCBO benefit package represents a smaller portion of benefits compared to the proposed PHC PMB service benefits package, it is essential to highlight and analyse the key differences, mainly driven by affordability constraints. The PMB PHC service package aims to provide an ideal and comprehensive set of benefits, addressing the country's PHC health needs and the burden of disease. In contrast, the LCBO proposed benefit package is primarily focused on delivering affordable basic PHC services, resulting in the exclusion of certain benefits such as maternal and mental health, as well as rehabilitative and palliative health services. Other services offered in the LCBO benefit package are more limited or basic in nature, such as oral and eye care services, radiology, and pathology services. It should be noted that the LCBO benefit package serves as a standardised minimum package, and beneficiaries have the option to upgrade for additional required services.

In the 2023/2024 financial year, the PMB PHC costing report will be finalised, and an affordability framework and assessment will be conducted using a budget impact analysis methodology to determine the affordability levels of the PHC service package. Subsequently, scenario testing will be carried out to further elaborate on implementation parameters that could affect the costs and affordability of the service package. The draft report will be published for stakeholder comments and feedback. An update on the progress of the PMB review process was recently published (Circular 15 of 2023), outlining the progress made and the way forward. Considering that the current PMB review process has shifted its focus towards costing and introducing PHC service packages, it can be argued that this should form the foundation for establishing an affordable baseline package tailored to low-income households. Beneficiaries would then have the option to upgrade to more inclusive and comprehensive service packages based on their specific needs.

5.4 Addressing the Burden of Disease

South Africa is confronted with a quadruple burden of disease, referring to the simultaneous presence of multiple health challenges within the population. This burden encompasses four main categories of diseases and health issues that place a significant strain on the healthcare system and the well-being of individuals in the country. The first component of this burden relates to the high prevalence of HIV/AIDS and tuberculosis (TB). South Africa has one of the highest HIV/AIDS burdens globally, with a large number of people living with the virus and experiencing associated health complications. TB is also a major concern, often occurring as an opportunistic infection among individuals with weakened immune systems due to HIV/AIDS.

The second aspect is the persistently high levels of maternal and child mortality. Maternal mortality refers to the death of women during pregnancy, childbirth, or within a few weeks after delivery. Child mortality encompasses the deaths of infants and children under the age of five. Despite improvements in recent years, South Africa still faces significant challenges in reducing these rates and ensuring the well-being of mothers and children. The third burden is characterised by high levels of violence and injuries. South Africa has witnessed alarmingly high rates of interpersonal violence, including homicides, assaults, and gender-based violence. Additionally, accidents and injuries contribute to the burden, resulting in substantial morbidity and mortality.

Lastly, South Africa grapples with a growing burden of non-communicable diseases (NCDs). These include chronic conditions such as cardiovascular diseases, diabetes, cancer, and respiratory illnesses. NCDs are increasingly prevalent due to factors like changing lifestyles, urbanisation, and an aging population. The combination of these four burdens places significant pressure on the healthcare system, requiring comprehensive strategies and interventions to address each component effectively. It is essential for South Africa to prioritise prevention, treatment, and management of these diseases to improve the overall health and well-being of its population.

CHAPTER 6: LEGISLATIVE ENABLEMENTS

Summary

The chapter focuses on legal and regulatory considerations pertaining to the introduction of a LCBO framework and the discontinuation of excluded products within the South African healthcare system. It underscores the significance of aligning healthcare policies with constitutional rights, particularly the right to access healthcare services. The chapter delves into relevant legislative prescripts, including the MSA and various insurance-related statutes, outlining their implications for benefit options and regulatory authority. Central Themes:

- ***Constitutional Imperatives:*** *The chapter underscores the constitutional rights of healthcare access, highlighting Section 27(1)(a) and Section 28, which emphasize equitable healthcare provision and prioritisation of children's interests.*
- ***Legal Framework:*** *A detailed overview of pertinent legislative prescripts, such as the MSA and other insurance-related statutes, is provided. Sections 29(1)(o), 33(2), and 67(1)(g) of the MSA are explored in the context of prescribed minimum benefits and regulatory authority.*
- ***PMBs:*** *The chapter delves into the concept of PMBs, stressing their significance in healthcare coverage and the potential applicability to various benefit options, including LCBOs.*
- ***Regulatory Oversight:*** *The roles and responsibilities of regulatory bodies, including the CMS, Prudential Authority (PA), and Financial Sector Conduct Authority (FSCA), are examined. The chapter assesses their authority and potential jurisdictional overlaps.*
- ***Exemption Framework:*** *The consequences of discontinuing the Exemption Framework for Exempted Issuers and Excluded Products are explored, including potential impacts on costs, coverage, competition, and compliance.*
- ***Recommended Actions:*** *The chapter proposes a sequence of actions if an LCBO framework is favoured, including advising relevant authorities, seeking concurrence, and adjusting regulations as needed.*
- ***Balancing Measures****: The text highlights the need for mitigating potential adverse effects and ensuring alignment with constitutional rights. It emphasizes responsible decision-making and comprehensive solutions.*

The chapter provides an in-depth analysis of legal and regulatory aspects surrounding the proposed LCBO framework and the cessation of Excluded Products. It underscores the need to harmonize healthcare policies with constitutional principles, navigate intricate legal landscapes, and make well-considered regulatory choices to uphold equitable healthcare access while addressing practical challenges.

6.1 Introduction

Whichever organ of state is required to consider and address the matter of Excluded Products and an appropriate LCBO framework, it must be mindful that: Section 27 (1) (a) of the Constitution provides that everyone has the right to have access to health care services and that the state must take reasonable legislative and other measures to achieve the progressive realisation of that right; and Section 28 of the Constitution provides that every child has the right to basic health care services and that a child's interests are paramount in every matter concerning the child.

The provision of healthcare goods and services must be understood in the light of the right of access to healthcare services, guaranteed by section 27(1) of the Constitution, and the obligation on the state to take reasonable legislative and other measures, within its available resources, in order to achieve progressive realisation of this right. The state fulfils this obligation by providing healthcare goods and services and by enabling the private sector to provide healthcare goods and services, subject to the requirement that privatisation does not constitute a threat to the availability, accessibility and quality of healthcare facilities, goods and services.

These regulators have a significant role to play in the implementation of the regulatory framework. It was important to understand the role and mandate of these regulators, and to assess their effectiveness to make appropriate recommendations. The key regulators include: (a) the Council for Medical Schemes (CMS); (b) the Health Professions Council of South Africa (HPCSA); (c) the South African Nursing Council (SANC); (d) the South African Pharmacy Council (SAPC); (e) the Dental Technicians' Council; (f) the Allied Health Professions Council of South Africa (AHPCSA); (g) the Office of Health Standards Compliance (OHSC); (h) the National Health Research Ethics Council; and (i) the Health Ombudsman.

The NHA is the first post-apartheid statute to regulate comprehensively the provision of healthcare services. One of the objects of the act is to "regulate national health and to provide uniformity in respect of health services across the nation by among other things, protecting, respecting, promoting and fulfilling the rights of the people of South Africa to the progressive realisation of the constitutional right of access to healthcare services. It thus establishes the national health system comprising the public and private healthcare services providers.

Nevertheless, the CMS continues on a case by case to consider exemption applications by medical schemes. In the event that the Minister decides to implement an LCBO framework, the current Annexure A to the MSA regulations would need to be amended to indicate that LCBOs are not required to fund these prescribed minimum benefits. This is a tedious and onerous process to undergo. We say this for the following reasons:

- An amendment to Section 29(1)(n) in respect of LCBOs would be required and it is necessary. This is so because in the view of Council, the current wording of Section 29(1)(o) could not be considered to be wide enough to allow for more than one set of prescribed minimum benefits.
- Furthermore, there will need to be detailed amendments to chapter 3 of the regulations under the MSA. The definition of "Low-Cost Benefit Option" must included in regulation 1 under the definitions and regulation 4(2) will require amendments. Section 33 of the MSA allows a medical scheme to offer more than one benefit option to its members.
- Section 33(2) of the MSA stipulates that the RMS shall not approve any benefit option unless the Council is satisfied that such benefit option includes "the prescribed benefits." Several of the specific

aspects that inform the benefit design of a LCBO, such as fees, levies, broker arrangements, minimum reserves are matters for regulation by the Health Minister in terms of section 67 of the MSA.

- Section 29A (4) does not permit waiting periods in respect of transfers between benefit options in a scheme. The Health Minister is not empowered to override this provision by regulation.

6.2 Landscape

National Health Act 2003 (NHA)
The Long-term Insurance Act, 52 of 1998 (LTIA)
The Short-term Insurance Act, 53 of 1998 (STIA)
The Medical Schemes Act, 131 of 1998 (MSA)
The Insurance Laws Amendment Act, 27 of 2008 (ILAA)
The Financial Sector Regulation Act, 9 of 2017 (FSRA)
The Insurance Act, 18 of 2017 (IA)
Section 29(1) of the MSA provides that "no medical scheme shall carry on any business, unless provision is made in its rules for… (o) the scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed". Section 33 of the MSA allows a medical scheme to offer more than one benefit option to its members.

Section 33(2) of the MSA stipulates that the Registrar shall not approve any benefit option unless the Council is satisfied that such benefit option includes "the prescribed benefits". Section 67(1)(g) of the MSA empowers the Health Minister, after consultation with the Council, to make regulations relating to "the prescribed scope and level of minimum benefits to which members and their registered dependants shall be entitled to under the rules of a medical scheme". Regulation 8(1), made by the Minister of Health pursuant to Section 67(1)(g) of the MSA, provides that "any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions".

Section 33(2) of the MSA was intended to mean that all benefit options offered by a medical scheme would be subject to the same prescribed benefits. However, it is in our view clear that the intention of Section 33(2) of the MSA is to establish a minimum benefit. Accordingly, whatever the PMBs may be from time to time, they must apply to all benefit options, including a proposed LCBO. Logically, if a set of benefits is prescribed by regulation to cater for LCBO's it will by definition become the new prescribed minimum benefits.

However, in our view, there is nothing in the wording of Section 29(1)(o) or 33(2) or 67(1)(g) of the MSA that prevents the health minister from prescribing different "prescribed benefits" for different benefit options, which suggests that the Minister of Health appears to be empowered to set different (higher) prescribed benefits for non-LCBO benefit options. Of course, the interpretation proffered above is not clear-cut, but in our view, it is reasonable when reference is made to section 7(a) and (b) of the MSA, and to the stated objects and sections 57 and 58 of FSRA.

Several of the specific aspects that inform the benefit design of an LCBO, such as fees, levies, broker arrangements and minimum reserves are matters for regulation by the Minister of Health in terms of Section 67 of the MSA, and accordingly, based on similar reasoning, they may be amended in the Minister's reasonable discretion by regulation. Chapters 7, 8, 9 and Annexure A of the Regulations would be affected.

Section 29A (4) does not permit waiting periods in respect of transfers between benefit options in a scheme. The Minister of Health is not empowered to override this provision by regulation. Arguably the CMS may use Section 8(h) to exempt those medical schemes that introduce LCBOs if it is satisfied that

they amount to exceptional cases, which may be the case. However, the safest option would be to amend the MSA through amendment legislation (by Parliament) if this is considered a necessary adaptation.

The final demarcation regulations governing medical gap cover, hospital cash plans and primary healthcare policies were published in January 2017. The regulations came into effect in April 2017, to draw a clear line between the products offered by health insurance companies and medical schemes.

The Regulations were published under the Long-term and Short-term Insurance Acts, which govern the insurance industry, following a lengthy consultation process between various stakeholders. Medical schemes are governed by the MSA. Since the practices of medical schemes and insurance firms are regulated by different statutory bodies, the risk of regulatory arbitrage exists. To date, this arbitrage has favoured the provision of health insurance products, since these products suffer from fewer restrictions and obligations than medical schemes, whilst simultaneously being allowed to operate for profit. The Council will need to consider the unique circumstances of current exemption holders and their beneficiaries if LBCOs are to be introduced through Section 8(h). This will be cumbersome to regulate through an exemption. In terms of Section 8(h) of the MSA, exemptions may only be granted in exceptional circumstances. Having the whole industry operating on the basis of exemptions militates against the granting of such exemption.

In accordance with Section 7 of the MSA, it outlines the responsibilities of the Council, which encompass safeguarding the interests of medical scheme beneficiaries and ensuring that its regulatory actions align harmoniously with the national health policy. The constitutional rights of beneficiaries, which comprise the right of access to healthcare services, to administrative justice and to freedom of association:

"The fact that the Council is required by law to control and co-ordinate the functioning of medical schemes does not give it license to act contrary to the Act or administrative law, or the Constitution."

Legally, Section 20 to 32 would probably not be applicable to this product and could potentially be deemed to be an insurance product. Exempt insurers may conduct the business of a medical scheme, but by virtue of their exemption they are not medical schemes in terms of the MSA.

Therefore, the functions of the CMS set out in Section 7(a) and (b) – to protect members' interests, and to co-ordinate medical schemes' functioning with national health policy – as well as all the oversight functions in subsequent chapters of the MSA do not find any application to Exempt Issuers or their Excluded Products. It is unlikely that the legislature's intention was to empower the CMS to effectively determine its own jurisdiction (or lack thereof) as opposed to modifying the application of the MSA in specific ways in respect of regulated entities within its jurisdiction.

Notably, Section 29 (1) of FSRA does not apply in respect of Exempted insurers (or their Excluded Products), because they are not medical schemes as defined in the MSA, even though they may conduct BOAMS. According to the FSRA, therefore, it is our view that between them, the PA and FSCA they have exclusive jurisdiction over registered insurers, regardless of whether such insurers issue Demarcation Products or Excluded Products, and regardless of whether they are Exempted Issuers or not.

Therefore, in our view, the PA and the FSCA have direct, and probably exclusive, responsibility to consider and address possible risks resulting from a discontinuation of Excluded Products in the absence of an MSA-compliant with LCBO that could substitute fully for Excluded Products. Accordingly, any arrangement that is designed to replace Excluded Products (or to regulate them in a manner that is materially and unreasonably more onerous and/or costly) will need to avoid a regressive effect on access to healthcare services, PHC services. If that cannot be achieved, then any regressive effect will need to be justified against the standards set out in the Constitution for the lawful limitation or reduction of fundamental rights, and in that analysis, one of the factors that must be considered is whether less disruptive means could be applied to achieve the same purpose.

The LCBO is not adequate to cover PMB's, and the proposal to have the LBCO risk pool separated from the general risk pool must be analysed against Regulation 4 (4). Furthermore, members in the LCBO will be faced with waiting periods when they want to move to normal options as the Minister of Health will be prevented from amending the provisions relating to waiting periods.

Legally, it is undesirable for an LCBO be introduced through an exemption. This will entail an analysis of "exceptional circumstances" on the basis of case law. This will be highly subjective and will create regulatory inefficiencies and CMS does not have the capacity to monitor such a wide range of dynamics.

Given CMS' legal duty in terms of Section 7 (b) to control and coordinate the functioning of the medical schemes in a manner that is complementary with the national policy and the argument is that, given how bare the LBCO is, this does not address the burden of disease and does not complement public health care pressures.

Given the fact that the state already provides health services that are more comprehensive than the proposed LCBO, - LCBO are not ideal to complement public-health interventions that contribute to the realisation of the universal right to health. As a precaution, unless there are measures in place to mitigate the consequences contemplated above, the CMS could not responsibly withdraw the Exemption Framework pending the implementation of a replacement solution.

Where the proposal to defer demarcation products back to FSCA is accepted by the Minister, the legislative framework exists and requires relatively little amendment. Furthermore, the FSCA is more than capable to regulate these products as has been demonstrated over the past decade.

Health Insurance products currently co-exist with medical schemes products to strengthen the National Health Policy in that policyholders reduce the burden on the public health system. 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.

There are years of experience in supervision of TCF related provisions within the FSCA. The insurers have the necessary capability and resources including experience to comply with the requirements in the framework that we make applicable to the LCBO products. However, the Minister will need to consult FSCA since this may necessitate income-based eligibility which will be challenging to define and administer and there would be no access to medical scheme tax credits.

6.3 Insurance Laws Framework

The power of the Minister of Finance to make demarcation regulations was deleted from the LTIA and the STIA from 1 July 2018 in terms of the IA. However, the IA contains an equivalent delegation of power in section 70(1)&(2). Parliament has empowered the Minister Finance, since December 2016 to date, to override the application of the MSA (and the jurisdiction of the CMS) in respect of certain policies that factually meet the BOAMS definition.

Section 70 of the IA empowers the Minister of Finance to determine an insurance product to be an insurance policy subject to the Insurance Act despite meeting the BOAMS definition under the MSA. Health service benefits "as defined" in the MSA are "financial products" (section 2(1)(f)), as are long-term and short-term insurance products. The activities of a medical scheme meet the definition of a "financial service". Legal Assumptions on process to return demarcation products to FSCA. It appears that the least disruptive, and most expeditious of the four available structures would be for the Finance Minister to amend the Demarcation Regulations to include PHCPs and HIP as Demarcation Products.

The apparent benefits of such an approach include: Relative speed by virtue of the notice periods of 30 days' notice to the public and tabling before Parliament for one month before promulgation;

- Parliamentary scrutiny in terms of section 70(4)(b);
- Material alignment with the social solidarity principles applicable to medical schemes, as well as the marketing, underwriting, and related restrictions that applied to the original Demarcation Regulations;
- The PA and FSCA have experience of supervising and regulating the Demarcation Products already;
- Applicability of related regulatory instruments such as the Financial Advisory and Intermediary Services Act (including its Codes of Conduct) and the Policyholder Protection Rules (PPR);
- The available framework for enacting specific principle-based provisions over and above the general ones in the PPR to provide for suitable specific matters, as was done with funeral insurance via Rule 2A of the PPRs.

6.4 Legal Risks for allowing LCBO

Major Risk: these include:
Solvency - Detailed calculations to substantiate such a reduction on the minimum accumulated funds as per Regulation 29.

Risk Pool - 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.

Product Design - Underwriting criteria differ between regulations. PMBs where 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 has not taken 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.

Will Medical Insurances exit from Insurer Binder Agreements or not? Underwriting benefits allowed Medical Insurances to attach a rand value to each benefit offered by the product, reducing the impact on the risk pool.

Regulatory and Legislative Amendments - Amendments to existing Acts, requires the input of a vast number of stakeholders and can be cumbersome and complex. Deliberation of the amendments to the Acts started in 2012 and are still under deliberation.

Prescribed Minimum Benefits - 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 has not taken 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.

Complaints process - Complaints pre-migration carries the risk of being bound by the Insurance Regulations and impact the risk pool that would have been held by the Insurer.

Existing Binder Agreements - Binder Agreements are based on underwriting criteria that is vastly different to MSA. There will be complexities related to LCBOs wanting to remain within Binder Agreements for the surety of the risk pool and discussions with Insurers would be required.

Table 14: Comparison between medical schemes and medical insurance legal framework

Medical Schemes	Medical 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).	Covers specified illness, accident, and day-to-day events, and are not required to cover PMBs.
Any emergency medical condition.	Emergency medical events up to a specific amount.
27 chronic conditions.	Not all chronic conditions included.
271 medical conditions.	Benefits for specific medical events.
Medical aids cover a combination of benefits paid from a risk pool at a percentage and have savings plans.	A rand value is attached to each benefit offered by the product.
Members are often not aware of the amount available as this is given as a percentage.	Members are informed of the total amount allocated per event.

CHAPTER 7 KEY FINDINGS AND OPTION ANALYSIS

Summary

7.1 Findings

In the proposed Guidance Framework on the LCBO by the industry (Annexure 2), there is a need to address the historical desire of medical schemes to offer options tailored for low-income earners. This requires careful consideration similar to the fate of primary health insurance products operating under the regulatory exemption of the CMS through Section 8(h) of the MSA. To comprehensively address this, the framework aims to answer the following questions:

- Should medical schemes be allowed to offer options targeted at low-income earners? If so, under what conditions and implications?
- Should medical schemes be prohibited from providing options for low-income earners, and if so, the justification and implications of this decision?
- Should primary health insurance products under the CMS regulatory purview continue beyond the current exemption period, and if so, under what conditions and implications?
- Should primary health insurance products under the CMS regulatory purview be discontinued beyond the current exemption period, and what are the implications?

These questions should be analysed together to form a comprehensive view of recommendations for medical scheme options and primary health insurance products. The CMS will ensure that recommendations consider the need for options for low-income earners and the fate of exempted primary health insurance products when presented to the Minister of Health.

The previous proposal by medical schemes for low-income options was rejected due to inadequately addressing the country's burden of disease and lacking financial risk protection for prospective members. The current proposal needs to address these shortcomings to avoid a similar outcome. The impact of the proposed LCBO needs to be evaluated for key stakeholders:

- Current and prospective medical scheme members.
- Medical schemes, administrators, brokers, and managed care organisations.
- The CMS and its legislative mandate.
- Service providers, including professionals, hospitals, and pharmaceuticals.
- The primary health insurance market and
- The conduct of medical schemes and their associations leading up to the LCBO recommendations.

Additionally, the analysis should consider the broader context of health reform initiatives, including the implementation of the National Health Insurance. Regarding the question of allowing medical schemes to offer options for low-income earners, several issues need to be addressed. The LCBO is not officially recognised under the Medical Schemes Act, and its need must be established before guidance on its implementation is provided. The proponents of the LCBO argue that it will address the lack of growth in medical scheme beneficiaries due to unaffordable current options, partly caused by mandatory PMBs that are costly to provide.

The proposed LCBO aims to offer cheaper options by excluding certain PMBs and providing reduced benefits. Proponents claim it will attract up to 20 million new beneficiaries, and its introduction is linked to possible tax credits and subsidies from the National Treasury. However, concerns arise over compromised healthcare quality, increased out-of-pocket expenses, and the profit motives behind its introduction. The assumption that migrating more individuals to medical schemes will improve overall health outcomes is challenged, as health investment should focus on sustainable, quality care.

Moreover, not all individuals without medical scheme coverage lack healthcare access, as some are covered by public health funding. The fate of exempted primary health insurance products under CMS regulation needs to be evaluated based on competition concerns, regulatory environment adequacy, and the conduct of the entities. Implications on current policyholders, asset preservation, and other stakeholders must be considered.

7.2 Option Analysis and Potential Risks

The table presented below illustrates four potential options for consideration. Each option is accompanied by a description of its limitations, potential risks, and possible benefits:

Table 15: Perspectives of Stakeholder Groups and classification**

Policy Option	Allow LCBO for Medical Schemes (Yes/No)	Allow Currently Exempted Products to continue (Yes/No)
Option A	No	No
Option B	Yes	No
Option C	No	Yes
Option D	Yes	Yes

CHAPTER 8: RECOMMENDATIONS

Summary

After careful consideration of the proposed package resulting from the industry consultation process, the identification of limitations, and analysis of the existing legal framework, as well as policy and technical analysis, the CMS has formulated the following two recommendations. These recommendations aim to address the requirement for medical schemes to provide a LCBO and determine the future of currently exempted products:

8.1 Recommendation 1

No Introduction of LCBO and Winding Out Exempted Products. The CMS advises against the introduction of the LCBO and advocates for the gradual phase-out of currently exempted products. This recommendation is put forth based on the subsequent findings and observations:

Insufficient Benefits in the Proposed Industry Package
One of the primary reasons for the CMS's recommendation is that the proposed industry package lacks comprehensive benefits in comparison to the CMS package. The insufficiency of benefits in the industry package may hinder effective management and coverage of the burden of disease among beneficiaries.

Uncertain Reduction in the Burden on Public Health Services
The introduction of the proposed option does not guarantee a significant reduction in the burden on state/public health services. This raises concerns about whether the new option would alleviate pressure on the public healthcare system, which remains a crucial objective.

Undermining of Guaranteed PMB Dispensation
The CMS is concerned that introducing the proposed option may undermine the guaranteed PMB dispensation. PMBs are fundamental to ensuring that all scheme members receive essential medical services, and any potential erosion of this guarantee is a significant cause for apprehension.

Potential Increase in Out-of-Pocket (OOP) Expenses
There is a legitimate worry that the introduction of the new option could lead to an increase in OOP expenses for healthcare, thereby exacerbating the financial challenges already faced by individuals seeking medical care.

Widening of Healthcare Access Inequities
The CMS is concerned that the proposed introduction could further widen the existing inequities in healthcare access, especially among the missing middle. Such inequities are contrary to the goal of achieving a more equitable healthcare system.

Preservation of NHI Implementation
Another critical factor in the CMS's recommendation is the need to preserve and protect the implementation of the NHI. The proposed LCBO may introduce complexities that could hinder or disrupt the progress toward achieving a comprehensive and universal healthcare system.

Complex Legal Requirements and Legislative Changes
The introduction of the proposed option entails complex legal requirements that would necessitate legislative changes which will engender fragmentation as opposed to universal coverage. This presents a substantial administrative and legal challenge that needs to be carefully considered.

Preservation of Competitive Environment
Persisting with the existing exempted products raises legal concerns and is perceived as a strategy to uphold competitiveness within the medical schemes sector. This approach aims to foster a competitive landscape, potentially offering consumers a broader spectrum of choices and potentially more favourable pricing.

8.1.1 Proposed phasing out of the currently exempted products proposed indicative timelines.

This section elucidates the various phases involved in the gradual elimination of currently exempted products from the regulatory framework. The proposed actions are underpinned by a critical consideration of the declaration order, which may potentially lean toward the termination of these products. However, it is imperative to maintain a balance that ensures the provision of suitable alternatives for all parties that could be affected, including those individuals currently benefiting from these covered plans. This approach underscores the need for careful deliberation and a comprehensive strategy to navigate the transition effectively and fairly within the healthcare insurance landscape. Table 15 to 17 illustrate the potential actions and associated timelines for phasing out currently exempted products. Nevertheless, it's important to note that this discontinuation process will necessitate additional discussions and collaboration with key stakeholders, including the National Treasury, FSCA, PA, as well as other relevant parties like policyholders, insurance brokers, and insurance companies. These consultations and engagements are crucial to ensure a smooth and fair transition for all parties involved.

Table 16: Roadmap on Demarcation products- April 2024 to 31 March 2025

Action	Description
Outlaw ALL Demarcation Products	Prohibit the sale and operation of any Demarcation Products that are not part of the current Exemption Dispensation, effective immediately.
Impose heavy fines	Impose substantial fines ranging from R10 million to R20 million on entities operating outside the current exemption framework.
Publication through Gazette	Publish these regulatory changes through an official Gazette in the year 2024.
Separate and remove non-medical cover from products	Exclude non-medical coverage such as Funeral, Dreaded Disease, and Disability Cover from Demarcation Products.
Review marketing of these products	Assess and revise the marketing practices associated with these products to ensure compliance with regulations.
Commitment to discontinue Standalone Day to Day, etc.	Commit to phasing out standalone Day-to-Day and Hospital Plans by the end of March 2025.
Non-compliance consequences	Emphasize that failure to comply with these requirements will disqualify the product from consideration in the end-March 2025 exemption process.

Table 17: Roadmap on Standalone Day to Day and Hospital Plans- April 2024 to 31 March 2025

Action	Description
Scrap and outlaw Standalone Day to Day and Hospital Plans	Prohibit standalone Day-to-Day and Hospital Plans, effective by the end of March 2025.
Mandatory Comprehensive Cover	I Require all entities to provide Comprehensive Cover with Minimum Mandatory Benefits by the end of March 2025.
Standardize Basic Comprehensive Cover	Ensure that the Basic Comprehensive Cover is standardized across all products by the end of March 2025.
New marketing approach	Implement a new marketing approach for these products to align with regulatory changes.
Registration and accreditation of intermediaries	Mandate registration and accreditation of all Brokers, Administrators, and Managed Care entities dealing with Demarcation Products by the end of March 2025
Compliance with Annual Statutory Returns	Enforce compulsory compliance with Annual Statutory Returns by the end of March 2025.
Introduce Social Solidarity elements	Introduce elements of Social Solidarity, including Open enrolment and Community rating, to membership applications.

Table 18 Roadmap on Migration to existing Scheme Option- April 2024 to 31 March 2025

Action	Description
Migration to existing Scheme Option	Facilitate the migration of members directly from Comprehensive Cover to an existing Scheme Option by April 2025.
Migration to a Medical Scheme	Enable members to migrate directly from Comprehensive Cover to a Medical Scheme by April 2025.
Migration via interim LCBO Framework	Employ an interim LCBO Framework-directed process in 2025 for migration from Comprehensive Cover.
Implementation of key compliance matrices	Incrementally implement key compliance matrices, including Solvency, claims ratio, Broker fees, and National Health Expenditure (NHE), during this period as outlined in the guidelines.
Accreditation of intermediaries	Continue accreditation efforts for Administrators, Managed Care entities, and Brokers.
Annual Statutory Returns	Maintain the requirement for Annual Statutory Returns to ensure ongoing regulatory compliance.
Introduce Social Solidarity elements	Introduce elements of Social Solidarity, including Open enrolment and Community rating, to membership applications.

8.2 Recommendation 2

LCBO Introduction and Retention of Exempted Products the CMS proposes introducing the LCBO while retaining the exempted products, provided that the following conditions are met; this recommendation is contingent on meeting specific conditions to ensure its successful implementation. The industry is contemplating and made proposals on the introduction of the LCBO within the medical schemes industry. This initiative is aimed at providing affordable healthcare coverage to a broader segment of the population while simultaneously retaining certain products that have historically been exempted from regulation. However, the success of this proposal hinges upon the fulfilment of several essential conditions.

Comprehensive Epidemiological and Demographic Study

One critical condition is the necessity to conduct a comprehensive epidemiological and demographic study of the targeted market. This study is essential for understanding the unique healthcare needs and challenges faced by different demographic groups within the population. It will provide insights into prevalent diseases, risk factors, and the demand for healthcare services. By obtaining a thorough understanding of the market, policymakers can tailor the LCBO to address the specific health concerns of the population effectively.

Finalisation of PMBs and Alignment with LCBO

Another crucial aspect of this proposal is the finalisation of the review of PMBs. The LCBO should be designed based on the recommended final product from this review. PMBs serve as a critical component of healthcare regulation, ensuring that essential medical services are provided to all scheme members. The alignment of LCBO with PMBs is crucial to guarantee that the LCBOs still offers comprehensive coverage for essential healthcare needs.

Basic Comprehensive Option and Alignment with NHI

The ultimate objective for both the LCBO and primary insurance products should be to align with the Basic Comprehensive Option across all medical schemes, as outlined in the NHI framework. This alignment aims to standardize healthcare coverage, ensuring that individuals receive a basic level of care regardless of their chosen scheme. This not only promotes equity in healthcare access but also simplifies the administration and regulation of medical schemes.

Addressing Legislative Challenges and Risks

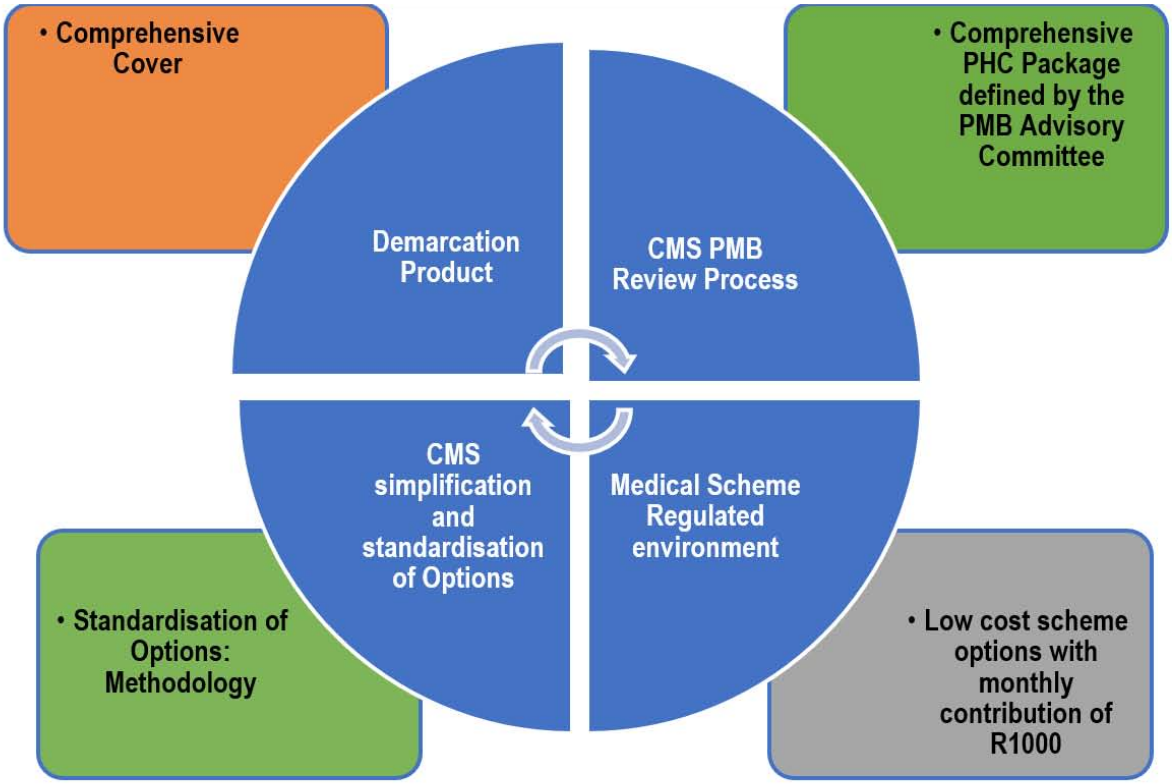
Lastly, it is imperative to address all legislative challenges and risks associated with implementing the LCBO and retaining currently exempted products. This includes navigating legal complexities, ensuring compliance with existing healthcare laws, and managing any competitive dynamics within the medical schemes industry. Comprehensive legal and regulatory frameworks are essential to mitigate potential risks and challenges that may arise during the implementation of this proposal. The introduction of the LCBO while retaining exempted products within the medical schemes industry is a multifaceted endeavour that requires a thorough understanding of the market, alignment with existing regulations, and the consideration of various potential impacts. This recommendation not only seeks to provide affordable healthcare options but also addresses broader issues related to healthcare access, equity, public health, and the evolving landscape of the medical schemes industry. Effective implementation of these recommendations will significantly impact the healthcare landscape and the lives of the population they serve.

8.2.1 Alignment with the Comprehensive Base Benefit Package across schemes by the conclusion of 2027.

The figure presented below illustrates key elements that collectively contribute to the regulatory framework and the accessibility of healthcare insurance products within the South African healthcare system. These elements include the Comprehensive Cover and the Comprehensive PHC Package, both of which play pivotal roles in ensuring robust healthcare benefits for individuals and families. Comprehensive Coverage encompasses a broad spectrum of medical services and treatments, affording policyholders comprehensive coverage for their healthcare needs.

Meanwhile, the Comprehensive PHC Package is defined and curated by the PMB Advisory Committee. It constitutes an inclusive package of primary healthcare services and benefits that must be made available to all members of medical schemes. The efforts led by the CMS to simplify and standardise healthcare plan options are instrumental in fostering consumer understanding and facilitating informed choices. This

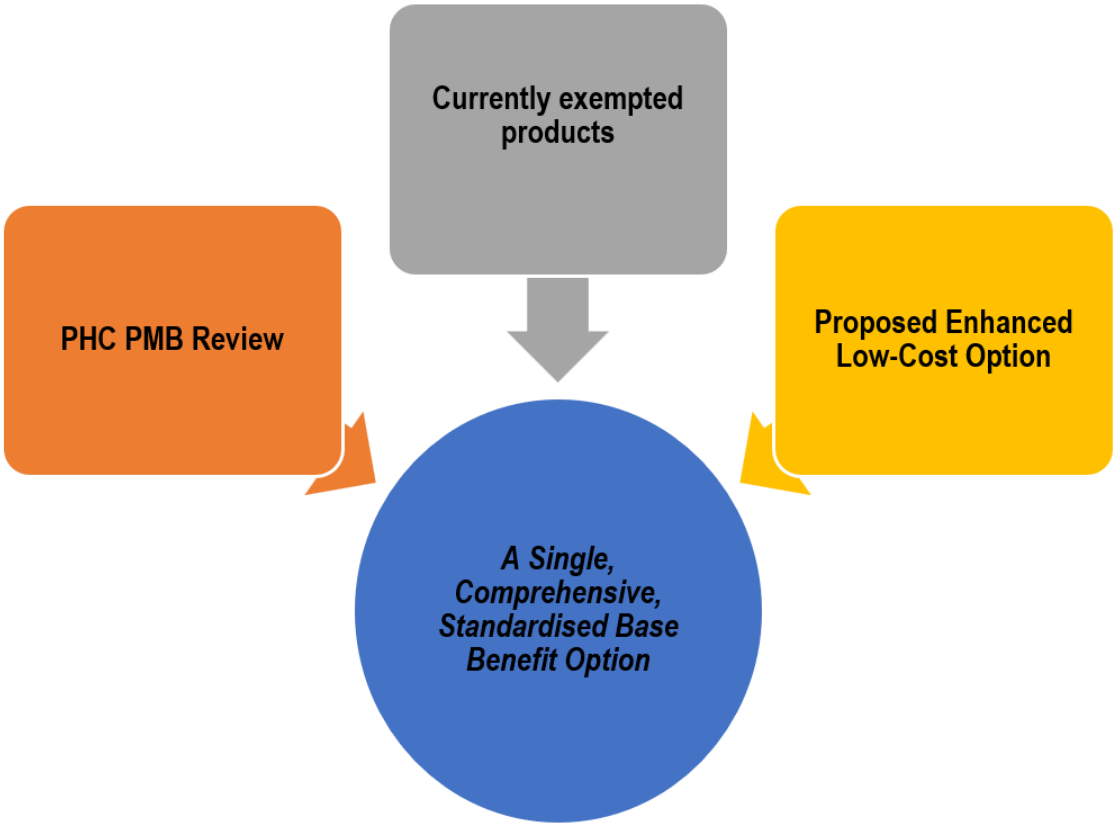
Figure 14 Synthesis of the LCBO



The significance of these elements lies in their contribution to achieving convergence toward a common base benefit package, as envisioned by the HMI. The proposed base benefit package is intended to be regulated under the Medical Schemes Act. The long-term vision, extending to the year 2025, entails the alignment and harmonisation of these diverse elements, resulting in a comprehensive base benefits package that spans across different medical schemes. This timeline to 2025 serves a dual purpose: ensuring the sustainability of the healthcare system and addressing affordability constraints while preserving the richness of healthcare benefits and alleviating the financial burden on the state.

Furthermore, it is imperative that the proposed base benefit package undergoes periodic reviews to ensure alignment with the primary healthcare benefit offerings outlined in the NHI package. This alignment is essential to conform to the principles set forth in Section 33 of the NHI Bill. The finalisation and definition of key elements within the package will be crucial steps in this ongoing process of healthcare regulation and reform.

Figure 15: Convergence into A Single, Comprehensive, Standardised Base Benefit Option



The recommendations present different approaches to addressing the need for a LCBOs and the fate of currently exempted products. The decision should consider the potential impact on disease burden, healthcare access, equity, public health, NHI implementation, legal complexities, and competitive dynamics within the medical schemes industry. The CMS recommends against the introduction of the LCBO and instead advocates for a phased-out approach to currently exempted products. This recommendation is driven by concerns about the adequacy of benefits, potential adverse impacts on public health services, legal complexities, and the overarching goal of achieving equitable and comprehensive healthcare through the NHI.

8.3 Other considerations and legal risks

8.3.1 Reversal of demarcation regulations

As mentioned earlier, the reversal of demarcation regulations necessitates a comprehensive approach. The most seamless and expeditious method among the four available options appears to be amending the Demarcation Regulations by the finance minister to include Primary Health Care Products (and Health Insurance Policies as Demarcation Products. This approach offers several advantages, such as swift implementation due to a 30-day notice to the public and a one-month period for parliamentary review

before promulgation. It aligns with the principles of social solidarity applicable to medical schemes, as well as the marketing, underwriting, and related restrictions stipulated in the original Demarcation Regulations. Moreover, the PA and FSCA already possess experience in supervising and regulating Demarcation Products. This approach also allows for the application of related regulatory instruments, including the Financial Advisory and Intermediary Services Act, along with its Codes of Conduct, and the Policyholder Protection Rules (PPR). Additionally, it provides a framework for enacting specific principle-based provisions that address unique concerns, similar to what was accomplished with funeral insurance through Rule 2A of the PPRs.

The available framework for enacting specific principle-based provisions over and above the general ones in the PPR to provide for suitable specific matters, as was done with funeral insurance via Rule 2A of the PPRs.

8.3.2 Declaratory Order of vouchers

The current unfinalised Medical Schemes Amendment Bill has provisions that will declare the carrying on of the business of a medical scheme by a person not registered as a medical scheme to be a specific offence. This relates to various health plans and cash plans that purport to be selling health products like medical schemes do whereas they are not registered with the Council for Medical Schemes but opted to register with the FSB now called FSCA. The FSCA has amended its rules to exclude such entities from registering with them.

Furthermore, CMS has taken appropriate steps to approach a competent court to determine the legality of these products.

8.3.3 Zimbabweans Exempted Permit (ZEP)

The recent court judgment concerning the Zimbabweans Exempted Permit (ZEP) has yielded invaluable insights regarding the impact of consultations on parties similar to the currently exempted stakeholders. In its verdict, the Gauteng High Court in Pretoria declared the Department of Home Affairs' 2022 decision to terminate the special exemption for Zimbabwean citizens as 'unlawful' and 'unconstitutional' due to the absence of a 'fair process' of consultation. In response to this, the CMS recommends that the Minister initiate consultations with a broader spectrum of key stakeholders, including the National Treasury and other relevant parties. Figure 9 and Table 10 delineate the pivotal stakeholders who should be included in this consultative process.

8.3.4 Ministerial Advisory Team

The proposition by the CMS entails a comprehensive approach to decision-making within the healthcare sector. It suggests that the minister should deliberate upon the formation of a multifaceted team, consisting of experts with diverse backgrounds and areas of expertise. This team's primary mandate would be to provide impartial and well-informed advice to the minister, offering valuable insights into a range of critical aspects and recommendations made in the current report.

One of the key responsibilities of this expert panel would be to explore and evaluate alternative options that are available within the healthcare framework. Their in-depth analysis would consider various strategies, solutions, and approaches, providing the minister with a comprehensive overview of the choices at hand. This approach aims to ensure that the decision-making process is based on a thorough examination of all potential paths, ultimately leading to the selection of the most suitable and effective course of action. Furthermore, this multidisciplinary team would assess the holistic impact of these

options on the healthcare system as a whole. Their collective expertise would enable them to weigh the potential consequences and benefits associated with each alternative. By doing so, they can assist the Minister in making well-informed decisions that align with the broader goals and objectives of the healthcare system, thus promoting its overall efficiency and effectiveness.

CHAPTER 9. CONCLUSION

The CMS is dedicated to delivering thoroughly researched and evidence-based guidelines and recommendations to the Minister, aiming to facilitate informed decision-making. The primary objective is to ensure that the LCBO and the future of exempted products are addressed in a manner that aligns harmoniously with the broader goals of the healthcare system, including the successful implementation of the NHI. Even after the submission of the final recommendations, which are scheduled to be presented to the Minister, the CMS will continue to offer ongoing support to the Minister.

This commitment demonstrates the CMS's dedication to assisting the Minister throughout the decision-making process, ensuring that all necessary information and resources are available to make well-informed choices. By maintaining this collaborative approach, the CMS strives to achieve optimal outcomes that benefit the healthcare system and the population it serves. This report (including any enclosures and attachments) has been prepared for the exclusive use and benefit of the addressee(s) and solely for the purpose for which it is provided. Unless we provide express prior written consent, no part of this report should be reproduced, distributed or communicated to any third party. We do not accept any liability if this report is used for an alternative purpose from which it is intended, nor to any third party in respect of this report.

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ANNEXURE 1: SCENARIO ANALYSIS

Table 19: Scenario analysis

Policy Option No.	Type of an LCBO Product	Applicable to administrative implementation	Legislative requirement changes & compliance	Related risks /Comments
Option 1	Current Medical Scheme regime	Currently exempted products & new applications This option is already in place for medical schemes	• Comply with provisions of the MSA. • Exempted products to register as a new medical scheme within 2 years. • No new requirements for medical schemes	• Affordability • Constraints • Package will not be affordable to low-income earners. • Product might not be sustainable. • Eligibility criteria and • Buy-downs. • Guarantees financial protection
Option 2	Minimum package - Full exemption from PMBs (If PMBs are excluded) Current Exempted products and other existing products regime	Currently exempted products, other existing non-exempted products, new applications & medical schemes	• Exemption from PMBs • Adherence to LCBO guidelines • Adherence to an exemption framework that will set out all conditions. • Will need Council approval. • Exempted products and new applications will need to register as a new medical scheme within 2 years.	• Affordability • constraints minimal as the proposed LCBO product is much richer than what was proposed by the advisory committee and what is currently offered by the exempted products • Product might not be sustainable • Eligibility criteria and Buy-downs

			• Medical schemes can be allowed subject to meeting an exemption framework.	• No Financial protection for members / No guaranteed benefits such as PMBs • No enabling environment • Will need
Option 3	Minimum package + Partial exemption from PMBs (e.g., Minimum of 3 of the PMBs & CDLs)	Currently exempted products, other existing non-exempted products, new applications & medical schemes (including Bargaining Schemes)	• Exemption from full suite of PMBs • Adherence to LCBO guidelines in terms of the minimum package • Adherence to an exemption framework that will set out all conditions. • Will need Council approval. • Exempted products and new applications will need to register as a new medical scheme within 2 years. • Medical schemes can be allowed subject to meeting an exemption framework.	• Affordability • constraints are considerable as the proposed LCBO product is much richer than what was proposed by the advisory committee and what is currently offered by the exempted products. • Product might not be sustainable. • Eligibility criteria and Buy-downs. • No or limited financial protection for members / No guaranteed benefits such as PMBs as only a select list of PMBs is covered
Option 4	Minimum package + Partial exemption from PMBs (Minimum	Currently exempted products, other existing non-exempted products, new	• Exemption from full suite of PMBs	• Affordability • constraints amplified as the proposed LCBO product is much richer

	of 5 PMBs)	applications & medical schemes	• Adherence to LCBO guidelines in terms of the minimum package • Adherence to an exemption framework that will set out all conditions. • Will need Council approval. • Exempted products and new applications will need to register as a new medical scheme within 2 years. • Medical schemes can be allowed subject to meeting an exemption framework.	than what was proposed by the advisory committee and what is currently offered by the exempted products. • Product might not be sustainable. • Eligibility criteria and Buy-downs. • No or limited financial protection for members / No guaranteed benefits such as PMBs as only a select list of PMBs is covered
Option 5	New type of an LCBO product or Medical Scheme No exemption process but will require accreditation of entities (new entities) and registration of LCBO	Currently exempted products, other existing non-exempted products, new applications & medical schemes	• This process will require either a regulation amendment, legislative amendment, or both. • Medical schemes can be allowed subject to register an option subject to meeting the exemption framework requirements / under strict conditions.	• Affordability • constraints unknown • Amendments may take longer to be approved • Eligibility criteria will need to be clearly defined
Option 6	Minimum package + New suite of PMBs	Currently exempted products, other existing non-exempted	• Exemption from full suite of PMBs	• Affordability • constraints unknown as the proposed LCBO

		products, new applications & medical schemes	• A new set of PMBs will need to be drafted for consideration by the Minister- long drawn-out process. • Adherence to LCBO guidelines in terms of the minimum package at the time of application • Adherence to an exemption framework that will set out all conditions. • Will need Council approval. • Exempted products and new applications will need to register as a new medical scheme within 2 years. • Medical schemes can be allowed subject to register an option subject to meeting the exemption framework requirements / under strict conditions.	product is much richer than what was proposed by the advisory committee and what is currently offered by the exempted products. • Product might not be sustainable. • Eligibility criteria and Buy-downs. • Some or limited financial protection for members / No guaranteed benefits such as PMBs as only a select list of PMBs is covered. • Uncertainly on the types of PMBs that will be covered (new suite of PMBs) • May need legislative requirements.

Table 20: Financial Service Conduct Authority (FCSA): Insurance Act Dispensation (Option 7)

Type of an LCBO Product	Applicable to	Legislative requirement changes & compliance	Related risks
Product to exclude all medical scheme-relevant health services. (Strip out the business of a medical schemes component: This applies to existing exempted demarcation products)	Currently exempted products & other existing products	• Provisions of insurance products • Current products would need to consider selling the book to the existing medical scheme. • Exempted products and other existing products to convert to a full insurance product (FCSA product) or deregister within 2 years.	• Unbundling might take longer; therefore, consider an incremental phase-in. • Eligibility criteria and Buy-downs. • This option however does not solve affordability constraints for low-income earners as a result the need for this benefit will remain

ANNEXURE 2: PROPOSED LCBO BENEFIT FRAMEWORK & BUSINESS PLAN

Benefit Design

-

The proposed minimum benefit package for LBCOs is envisaged to adhere to the following:

- Exemption from the 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. After a thorough risk assessment, the scheme may add a limited chronic cover at its discretion. 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 and
- Exclusion of hospitalisation. Any option covering hospital services would need to comply with PMBs to prevent arbitrage against the provisions of the MSA.

The benefit design could include the features set out below to optimise healthcare delivery while providing members with improved choice and access. Funders and currently exempted products will therefore be at liberty to provide more comprehensive benefits should they choose to, subject to the private hospital exclusion noted above. The LCBO must be delivered via a network arrangement for cost-effectiveness. Medical schemes and organisations currently offering exempted products must submit their contractual agreements with the providers to the Registrar. The State cannot be the default network provider for the provision of the LCBO package. Table 13 outlines the proposed minimum benefit package as outlined by the Advisory Committee. Items that are added are proposed enhancements by the regulator.

Table 21: LCBO mandatory minimum package and conditions

Benefit package		
Advisory committee recommendation	CMS recommendation	Comments
Nurse-based care	5 consultations pbpa from a DSP/network provider.	Support & propose the primary healthcare approach framework with gatekeeping by a GP or nurse based on Norms and standards, see attached document. Annexure A of Primary Healthcare package (PX111).
GP-based care	5 consultations pbpa from a DSP/network provider.	Support & propose the primary healthcare approach framework with gatekeeping by GP or nurse-based on NORMS standards of South African standards see attached document. Annexure A of Primary Healthcare package (PX111).
Basic pathology	Basic pathology required to deliver acute care and defined chronic benefits. Subject to referral from DSP/network provider.	Package needs to be specific on which tests are covered for each condition (clinically appropriate tests for diagnosis, treatment and care).
Basic radiology	Basic radiology required to deliver acute care and defined chronic benefits. Subject to referral from DSP/network provider.	Package needs to be specific on which tests are covered for each condition (clinically appropriate tests for diagnosis, treatment, and care).
Dentistry	Maximum of 2 consultations pbpa. Oral hygienist and dental therapists to provide comprehensive oral assessment. Includes scaling, polishing, filling (motivation - Xray).	Added (reviewed and recommended for inclusion by CMS)

Optometry	Basic eye examination, basic frame & lens cover. Consultation every 2 years per beneficiary.	Added
Emergency transportation	To public hospital.	Emergency road transport benefit is only a transport benefit to assist members in emergency situations. Purpose is to provide a reliable service at the appropriate level for transportation to a public facility. Supported for improved access to medical care. Define what the emergency definition is and need for transportation. BLS, ILS, ALS, to be covered.
Preventative health screenings	Must be included as part of nurse-based consultations: -Chronic disease management -Vaccinations -Other health screenings	Supported and it must be compulsory. Specified tests as part of wellness and negotiate a global fee. Age and gender appropriate screening services must be included. E.g.: Children: Hearing + sight screenings Adults: Chronic disease screenings Elderly: Hearing, sight + chronic disease screenings.
Chronic medication	Prescribed medication for limited chronic conditions at DSP/network pharmacy based on limited protocols and formularies. Must include medication cover for the following CDLs as a minimum:	Supported based on NORMS, standards and EML.

	-HIV/TB management -Hypertension -Diabètes -Respiratory conditions (Asthma, COPD).	
Acute medication	Limited to prescribed medication during an acute care visit.	Supported. Should be limited to the approval formulary
Sexual health	Cover for Contraceptives, Rape, PEP, TB, STI. HIV management - Diagnosis and acute management.	Added
Antenatal care	2 consultations with Nurse or GP. 1st consult – Hb, HIV, Syphilis, RH. 2nd consultation - 20/52 ultrasound scan. Refer to State for continuation of care and preparation for delivery. Nurse, GP - p29 Guidelines for maternity care in South Africa 4th Edition 2016	Added
Mental Health services	Screening by Nurse or GP. Refer to State facility for continuation of care.	Added

LCBO mandatory drug list and tests

A defined list of mandatory LCBO essential drugs, pathology tests, radiology tests, dental procedures and a limited chronic condition list must be included as part of the benefit offering as outlined in the Annexures.

Provider remuneration and contracting

Healthcare providers shall be remunerated at 100% of the negotiated tariff or agreed tariff for services rendered. In addition, schemes are required to provide the following on application for a LCBO:

- The contracts and/or agreements with providers/MCOs,
- The formulary of medicines provided.
- The list of radiology and pathology tests provided and
- The list of network providers at nurse, GP, pharmacy, and clinic level.

Out-of-pocket payment and penalties to members

No medical scheme shall impose any co-payment deductible for any LCBO claims. Claims must be paid at 100% of the negotiated tariff.

Membership eligibility criterion

Table 22: Membership eligibility criterion

Advisory committee recommendation	CMS recommendation	Comments
Target market is individuals earning less than R18 000 per month based on statistical analysis on affordability of medical cover across income groups.	Agreed	
However, instead of imposing an eligibility criterion based on income, the benefit design and pricing structure of LCBOs will ensure that the product is only attractive to the intended target market.	Disagree.	Without an explicit income-based criteria, it would be difficult to protect the existing risk-pool from buy-ups and buy-downs (anti-selection) without strict underwriting.
Restricting membership to compulsory groups to mitigate against anti-selection.	Agree, but with the option for expansion to non-group cover if the scheme can demonstrate financial sustainability.	Restricting membership to compulsory groups perpetually can be discriminatory. However, it may be necessary to do so in the first 3 years of the launch of LCBOs.

- Compulsory group may refer to mandated group coverage through an employer.

Underwriting conditions (waiting period and late joiner penalties)

Table 23: Underwriting conditions

	Advisory committee recommendation	CMS recommendation	Comments
Waiting periods (WP)	LCBOs should maintain the above 3- and 12-month waiting periods that is currently applied by medical schemes. 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).	Agree. Underwriting should comply with the provisions of the MS Act.	No underwriting should be applied on policyholders that held cover under exempted insurers: • Where the waiting period has not been completed – then the remainder of the period can be carried over to the scheme. • Waiting period completed via the insurer – no waiting periods should be applied by medical schemes.
Late joiner penalties (LJPs)	Late Joiner Penalties should be applied to individuals based on age at entry. The penalties may be waived for groups joining at the discretion of the medical scheme. Late joiner periods are discretionary in terms of the MSA and regulations.	Agree; however, LJPs can impact affordability, which contradicts the aim of LCBOs.	The impact of LJPs on member contributions would need to be monitored.

Movements between benefit options – buy ups	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 because of a change in circumstances as contemplated in section 29A(6)(a) and (b). Buy ups should be considered as a pathway to more comprehensive cover but noting the risk of anti-selection if there is a two-way movement. It is suggested that underwriting applies on benefits not included in LCBO minimum benefits.	Disagree. Section 29(4) – A medical scheme may not impose a general waiting period or a condition-specific waiting period on a beneficiary who changes from one benefit option to another within the same medical scheme unless that beneficiary is subject to a waiting period on the current benefit option, in which case any remaining period may be applied.	In the current medical scheme environment space, no underwriting is applied when members move between options. This is allowed, hence the provisions for members to move. – window periods etc. • Schemes would be in possession of the risk profile of a member under the LCBO and therefore, there would be no basis for further underwriting. • Underwriting based on this statement suggests that the LCBO will be ring-fenced to certain groups of individuals which is not allowed in terms of Regulation 4(4) of the MSA

Movements between benefit options – buy downs	Buy downs should be discouraged but may be necessary where there is a loss of employment and so underwriting should apply (general waiting period) unless there is a change in employment as provided for in the Medical Schemes Act.	Disagree. Section 29(4) – A medical scheme may not impose a general waiting period or a condition-specific waiting period on a beneficiary who changes from one benefit option to another within the same medical scheme unless that beneficiary is subject to a waiting period on the current benefit option, in which case any remaining period may be applied.	Underwriting should not apply as the scheme would already know the risk profile of the member. The change in this regard would be triggered by affordability/change in income bands.

Provision for non-health expenditure (NHE)

Table 24: Provision for non-health expenditure

	Advisory committee recommendation	CMS recommendation	Comments
NHE	Per life per month Administration: R30 – R50 Managed care: R20 – R40 Marketing and distribution: R5 – R10	Per member per month. No specific Rand amounts however, NHE should be capped at 30% of contributions in line with the experiences of similar existing products in the medical schemes' environment (i.e., bargaining council schemes).	1. NHE charged at per life will be significantly high at a family/household level. Therefore, the proposal is to cap it per member per month. The policy per member family is administered as one policy and not separate policies per life / beneficiary. 2. The administration of these products should be simple given their nature (primary care) and should reach economies of scale quickly given the target market (high volumes).
Broker remuneration	Per life per month. R30 – R50 ongoing, and consideration could also be given to a sign-on fee to facilitate member education.	Per member per month. Commission should be paid in terms of Regulation 28(2)(a) and(b).	Entities providing broker services on LCBOs should be regulated in terms of the MSA. Member education should form part of the ongoing payment to a broker in terms of the service levels agreed to between the broker and the medical scheme based on the written agreement between them.

Statutory solvency requirement

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 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. Therefore, a solvency requirement of 15% (adjusted upwards from the 10% proposed by the Advisory Committee) in respect of LCBO contributions could be stipulated. The 15% solvency would cover for approximately 2 months of contributions. This option is however available outside the Medical Schemes Act where an exemption application to Regulation 29 will be sought (more applicable to exempted products for a limited period). The organisation offering exempted products will need to register a medical scheme if this dispensation is within the MSA. LCBOs offered by a registered medical scheme will still need to adhere to the requirements of the MSA.

Renewal of exemptions

Medical schemes intending to provide LCBOs will have to apply to Council to be exempted from complying with certain provisions of the Act. Accordingly, Council has to also approve certain principles that must be adhered to by any medical scheme seeking an exemption to register an LCBO.

Any exemption granted under section 8(h) for registration of an LCBO shall be valid for a period of up to 24 months. A medical scheme must apply for renewal of the exemption prior to its expiry. Council may revoke the exemption if the Registrar/Council has a reason to believe that any conditions imposed, or principles outlined in this document are not complied with.

Section 8(h) MSA (""Act""), as amended states:

""The Council shall, in the exercise of its powers, be entitled to –

Exempt, in exceptional cases and subject to such terms and conditions and for such period as the Council may determine, a medical scheme or other person upon written application from complying with any provision of this Act" ".

Exemptions granted in terms of Section 8(h)

Section 8(h) confers power on Council to exempt medical schemes from complying with any provision of the Act.

Any medical scheme intending to offer an LCBO may apply for an exemption to the Council in terms of section 8(h) of the Act from complying with the following sections of the MSA:

- Open enrolment (Section 29(3)(a) & Section 29(1)(n)),
- PMBs (Section 33(2)(a); Section 29(1)(o) & Section 29(1)(p)) or
- Broker remuneration (Section 65 & Regulation 28(2)).
- Any other prescript that is not consistent with the requirements of the MSA

Guard risk Case can be added as part of the introduction.

Following the Guardrisk ruling, health insurance policies proliferated and were aggressively marketed. The High Court of South Africa ruled that health insurance products were conducting the business of a medical scheme. However, in March 2008, the Supreme Court of Appeal overturned the decision of the High Court in March and stated that healthcare insurance policies would not undermine the MS Act. The ruling further noted a need for these policies, i.e., alleging the affordability of these products.

Definition of the business of a medical scheme

On 23 December 2016, the final Demarcation regulations were published, effective 1 April 2017. In light of the demarcation regulations, the definition of a medical scheme's business was also modified as of April 1, 2017. This was done to make it easier to distinguish between what constitutes an insurance business and the business of a medical scheme when the legal Framework is ambiguous or uncertain.

Benefit design

The benefit design must be premised on the minimum LCBO benefit package defined by CMS. No benefit option shall be granted exemption without the minimum benefits. However, for market competitiveness, medical schemes may top up the package subject to affordability constraints. The scheme should also include the rules of the LCBO.

Benefit designs incorporating hospitalisation will not be considered at this stage as the LCBO options are required to provide essential benefits at the primary healthcare level only. A review of the minimum LCBO benefit package will be considered as and when it is necessary.

Analysis of benefit structures of the existing options compared to the new LCBO.

The scheme should perform a detailed comparison between the benefit design of the existing options and the LCBO.

Membership/targeted market strategy

The scheme and exempted products will have to project the proposed membership of the LCBO. The scheme should also indicate the target market. The scheme should submit at least the following information:

A detailed marketing strategy

- Forecast in terms of membership growth, including reasonability testing,
- Demographic profile of the current and projected beneficiaries (i.e., average age, chronic profile and pensioner ratio (65+ years),
- Geographical area of the current and projected members and beneficiaries, if applicable,
- Current and projected average family size for the LCBO, compared to the existing options,
- If the contribution tables differentiate between income bands, the scheme should indicate the number of members per income band. If the schemes' contribution tables do not provide for income bands, an indication of the salary income bands of the proposed target market should be provided for.,
    - Illustrate the impact of the risk profile of the new members on the existing membership and the scheme's solvency level,
    - Probability of movement of members between options, and the impact thereof on the self-sustainability of all options (i.e., buy-ups and buy-downs) and

- Methods to ensure that experience reflects the expected movements assumed in the point above, as well as the mitigating factors identified by the scheme to address the adverse movement of members.

Customer needs analysis.

The scheme should provide any letter(s) of intent by prospective employers, if applicable, as well as the scheme's communication strategy (i.e., road shows, pamphlets, advertising, etc.)

Market comparison

The scheme should furthermore submit a detailed competitive comparison with the primary competitors likely to offer the LCBO.

Contributions

The scheme should provide detailed contribution tables per option (if they pursue an income-based market eligibility strategy) and the underlying assumptions used in pricing the contributions. The following table depicts the contribution structure for an income-based option:

Table 25: Contributions

Income	Member	Adult	Child
R0-R4 500			
R4 501-R9 000			
R9001-R13 600			
R13 5001-R18 000			

It is important to note the basis/underlying assumptions for arriving at the monthly contribution rate charged. The breakdown of the monthly contribution should be based on per member / per beneficiary per month. The following tables depict the minimum information to be disclosed:

Table 26: Information Requirement

	LCBO		
Description	pmpm	pbpm	% of GC
Portion – healthcare related			
Portion – NHE related			
Contribution to reserves/investment income			
Total proposed contribution per month			

pmpm= per member per month; pbpm= per beneficiary per month; GC = Gross Contribution

Affordability of contributions

Because an LCBO would be targeted at a specific income group, the scheme should further comment on the affordability of the LCBO in relation to the individual's income (e.g., 22.5% of an individual's income (monthly) will go towards medical aid contributions). The scheme must also give an indication of how many members might receive employer subsidies as well as the level of the employer subsidy. The impact of the employer subsidy on a member and affordability should be quantified.

Projected claims costs

The projected claims costs for the LCBO option should be listed in the business plan on a per member/beneficiary per month basis as well as a percentage of risk contribution income. Detailed calculations and assumptions on which the benefits are based should be provided.

Non-Healthcare expenditure

As indicated in the principles, to maximise value for beneficiaries, NHE for the LCBO must be kept to the minimum. The scheme should perform a detailed analysis of the NHE. The business plan must include the LCBO's non-healthcare expenditure, expressed as a percentage of risk contribution income and a per member per month / per beneficiary per month basis. For example:

Table 27: Non-Healthcare Expenditure

LCBO			
	pmpm	pbpm	% of GC
Administration expenditure			
Administration fees			
Other administration expenditure			
Managed care: managed services			
Broker fees			
Total			

pmpm = per member per month

pbpm =per beneficiary per month

GC =Gross Contribution

Reserve building

The submission should also include a sensitivity analysis illustrating the impact of reserve building on the scheme's reserves. The following are examples of such sensitivity analysis:

- The impact of different utilisation patterns on the projected reserve levels,
- The impact of different risk profiles of members on the projected reserve levels,
- The impact of different membership targets on the projected reserve levels and
- The impact of buy-downs (if any) on the projected reserves.

ANNEXURE 3: STAKEHOLDER MAPPING SUMMARY FINDINGS

6.1 All findings from the (quadrants and intersections of interest)

In these quadrants we want to pay attention to those stakeholders who have no legitimacy (meaning there is a low probability of reaching an agreement with them) as well as the intersections of non-legitimate stakeholders and legitimate stakeholder which will reveal possible areas where we can adjust to meet the needs of non-legitimate stakeholders and bring them closer to agreement. This had been summarized in Table 28 below. These intersections will be analysed in the next section.

Table 28 Strategy for understanding intersections of legitimate and non-legitimate stakeholders.

	Have Legitimacy	Have no legitimacy	Intersections of interest
Stakeholder profiles	Dominant	High-risk: High interest	High interest ∩ Dormant ∩ Demanding
	Discretionary	Dormant	
	Dependent	Demanding	Discretionary ∩ Dominant ∩ High interest Discretionary ∩ Dominant ∩ Dormant
Strategy	High probability of agreement/convergence	Low probability of agreement/convergence	Adjusting to meet those without legitimacy (increase probability of agreement/convergence)

Intersection between stakeholders who lack legitimacy (Dormant, High interest and demanding)

**High-risk: High interest; Demanding: Exacting; Discretionary: Optional; Dominant: Prevailing; Dormant: Inactive

The first intersection of interest we analysed looks at all the stakeholders who lack legitimacy (Dormant, High interest and demanding). This is the most straightforward intersection as it reveals the stakeholders who are least likely to agree with us (as they lack legitimacy) and would ultimately pose the biggest risk in terms of litigation against the CMS if the LCBO framework is not aligned with their interests. Understanding the points of intersection of these stakeholder reveals the key issues and recommendations that unify them and can see them form coalitions in their lobbying efforts.

Benefit and Pricing: Intersection of Dormant, High interest and Demanding

The keep policy issues that are shared amongst these stakeholders is solvency requirements, exclusions and controls as shown in Figure 16 below. Under solvency requirements, the most frequent (mode) recommendation is that solvency should be capped at ten percent for LCBOs due to keep contributions affordable. The CMS recommends a solvency of 15 percent, however ten per cent solvency is adequate in the beginning if schemes can demonstrate that this level of solvency is sufficient to cover operational and business risk.

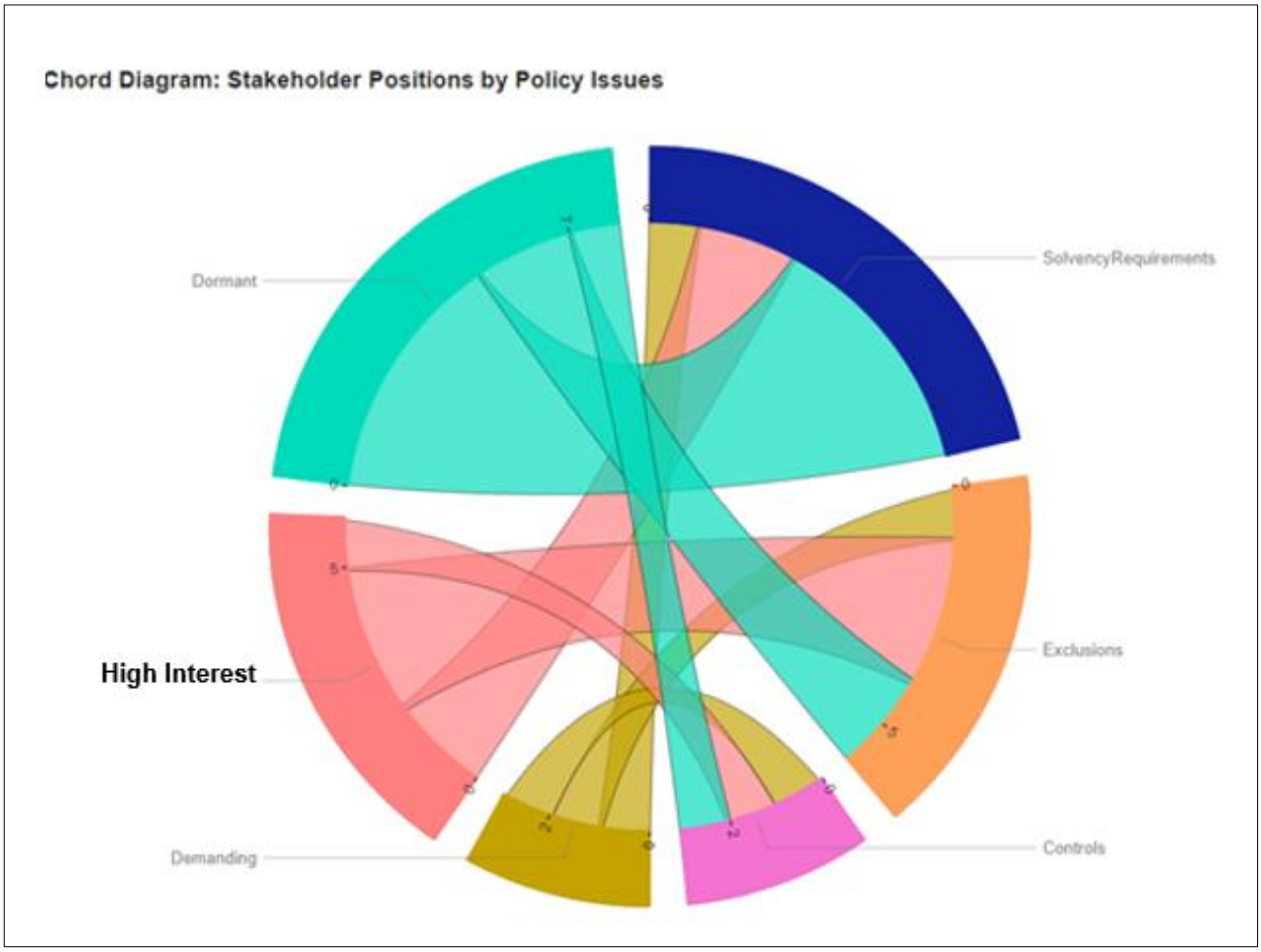

Figure 16 Chord diagram linking stakeholder positions to policy issues under Benefit and Pricing

Under Exclusions, stakeholders have recommended that several services should be excluded from the LCBO benefit package. These include hospitalisation, some maternity cover including delivery and postnatal care, emergency transportation and specialist care. The reasons for these exclusions are mostly centred around concerns of buy-downs if LCBOs offer comprehensive benefits that are attractive to current medical schemes members. The CMS recommends that early antenatal care should be the minimum provision under maternity cover. Furthermore, the CMS recommends that emergency

transportation should be included if there is specification for the services that will be provided. Moreover, any recommendation to include or exclude services needs should not go against the provision of the MSA and should consider potential buy-down effects if LCBOs are too comprehensive.

Lastly, stakeholders have recommended that strict controls need to be put in place to manage healthcare pathways. These include gatekeeping, nurse referrals to GPs, unlimited GP capitation arrangements, GP networks, public sector EML for chronic and acute medication, formulary based basic pathology and radiology and PPP arrangements with State hospitals. The CMS agrees with this recommendation as it in line with appropriate service delivery and care pathways.

Legal and Compliance: Intersection of Dormant, High interest and demanding.

The key shared issues under this workstream are transition period, LCBO in the MSA, Consumer protection and adverse selection as shown below in Figure 17. The recommendations relating to the transition period relate to the proposed length of time for LCBOs to be implemented, with time periods ranging from six months to two years. During this time, the proposal is that LCBOs would be phased in incrementally to those who are not covered. Another stakeholder recommendation is that of having LCBOs regulated under the MSA. Under the MSA, the possibility of tax credits would further enhance the affordability of LCBOs. Moreover, the stakeholder recommend that consumer protection should continue to be offered through the CMS complaints adjudication. On the issue of adverse selection, stakeholders proposed a myriad of recommendations; including imposing waiting periods of 3-and 12-months, waiving waiting periods for employer-based group membership, imposing waiting periods on similar benefits, imposing no waiting periods on member movements, and not allowing any member movement unless there are justifying circumstances.

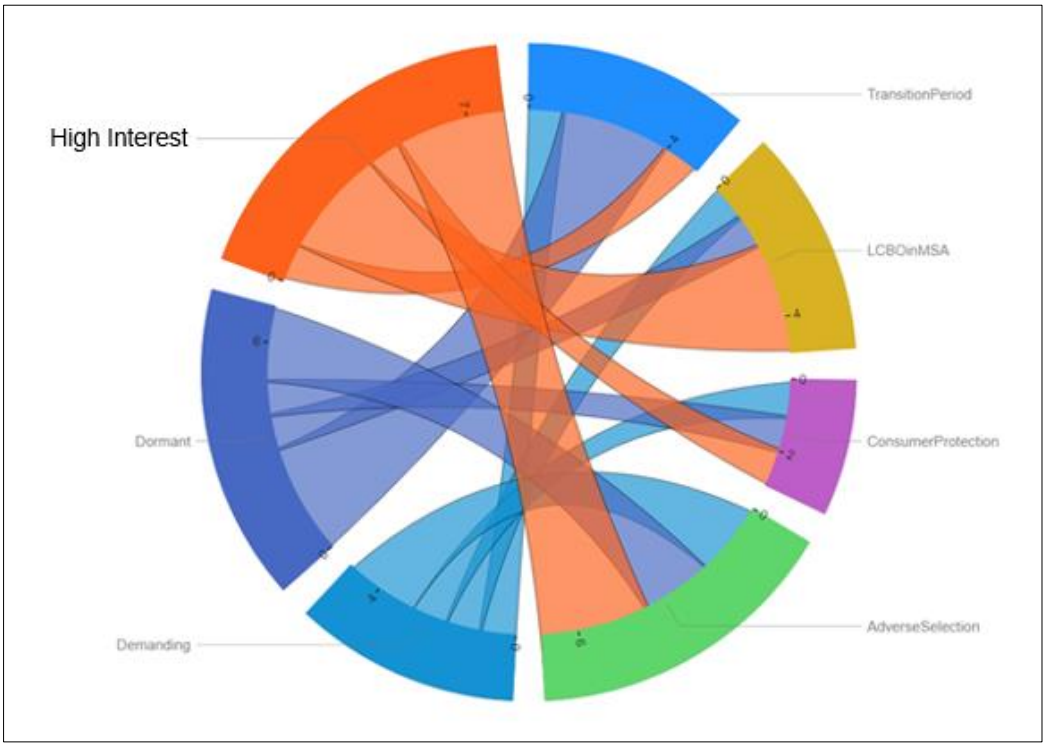

Figure 17 Chord diagram linking stakeholder positions to policy issues under Legal and Compliance

Market and affordability: Intersection of Dormant, High interest and Demanding.

The key shared issues under this workstream are eligibility criteria, group enrolment and tax credits. Under eligibility criteria, there is consensus on the recommendation that all uncovered employed individuals should qualify for LCBO cover, however there are stakeholder who prefer eligibility to be strictly income based while others argue that income cannot be the sole criteria and it doesn't reflect financial liability. Under group enrolment, stakeholders recommend mandatory employment-based group enrolment for the initial rollout of LCBOs. Lastly, the recommendation under tax credits is that tax credits would increase enrolment and make LCBOs affordable.

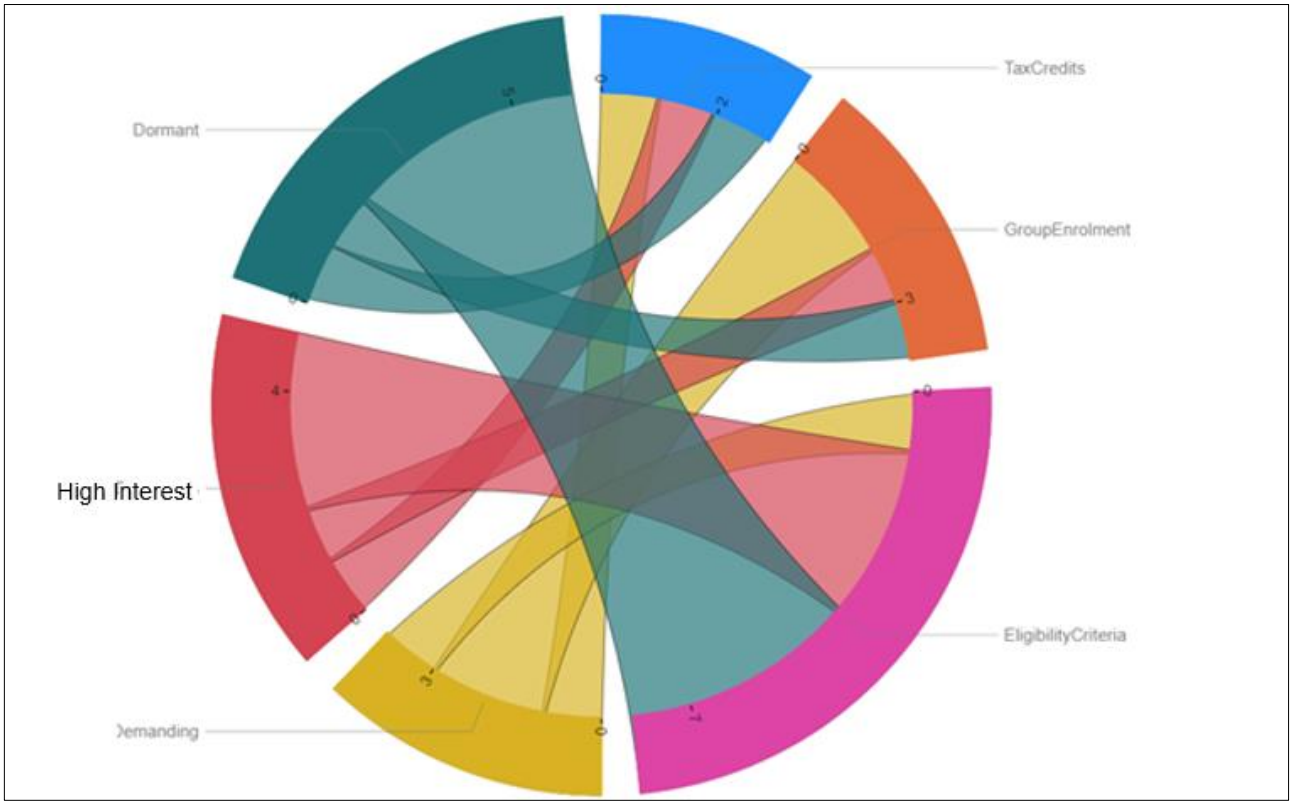

Figure 18 Chord diagram linking stakeholder positions to policy issues under Market and Affordability

Intersection between stakeholders who have legitimacy and those that do not have legitimacy.

The second and third intersections of interest are the intersection between stakeholders who have legitimacy *(discretionary, dominant, dependent)* and those that do not *(High interest, dormant and demanding)*. Analysing these intersections will reveal areas where there is commonality between stakeholders who are potentially not going to be happy with the final recommendations of the LCBO framework (those who lack legitimacy) and those who are likely to accept the final recommendations (those with legitimacy). In our quadrants of interest under the stakeholder mapping, discretionary and dominant stakeholders have legitimacy while High interest and dormant stakeholders have no legitimacy. Zooming into the quadrants of interests for these intersections reveals the following findings which will be discussed below.

Benefit and pricing intersections

Figures 19 and 20 denote the common issues as solvency requirements, risk equalisation, non-health expenditure, managed care, and controls. The issues of solvency requirements, controls and exclusions have already been dealt with in the previous section. The stakeholder recommendation on Managed Care is that this is needed in the LCBO environment to manage costs and improve value-based contracting. The CMS agrees with this recommendation provided that the CMS guidelines for managed care as well as the HMI recommendations are taken into consideration. The stakeholder recommendation on Non-Health Expenditure (NHE) is that CMS should monitor levels of NHE, there should be no Rand cap on NHE, and that NHE should be based on the level of benefits in the LCBO package. The CMS recommends that the NHE should follow the guidelines for administration fees as per CMS requirements. And lastly, stakeholder recommended that LCBO should be purely focused on primary healthcare (PHC), therefore excluding any form of hospitalisation. The CMS recommends that the PHC nature of LCBOs should be evaluated against the PHC PMB package to ensure that there is policy consistency and coordination. Also, LCBOs need to be differentiated from the current offering of medical schemes to reduce creating parallel markets and buy-downs from medical scheme options.

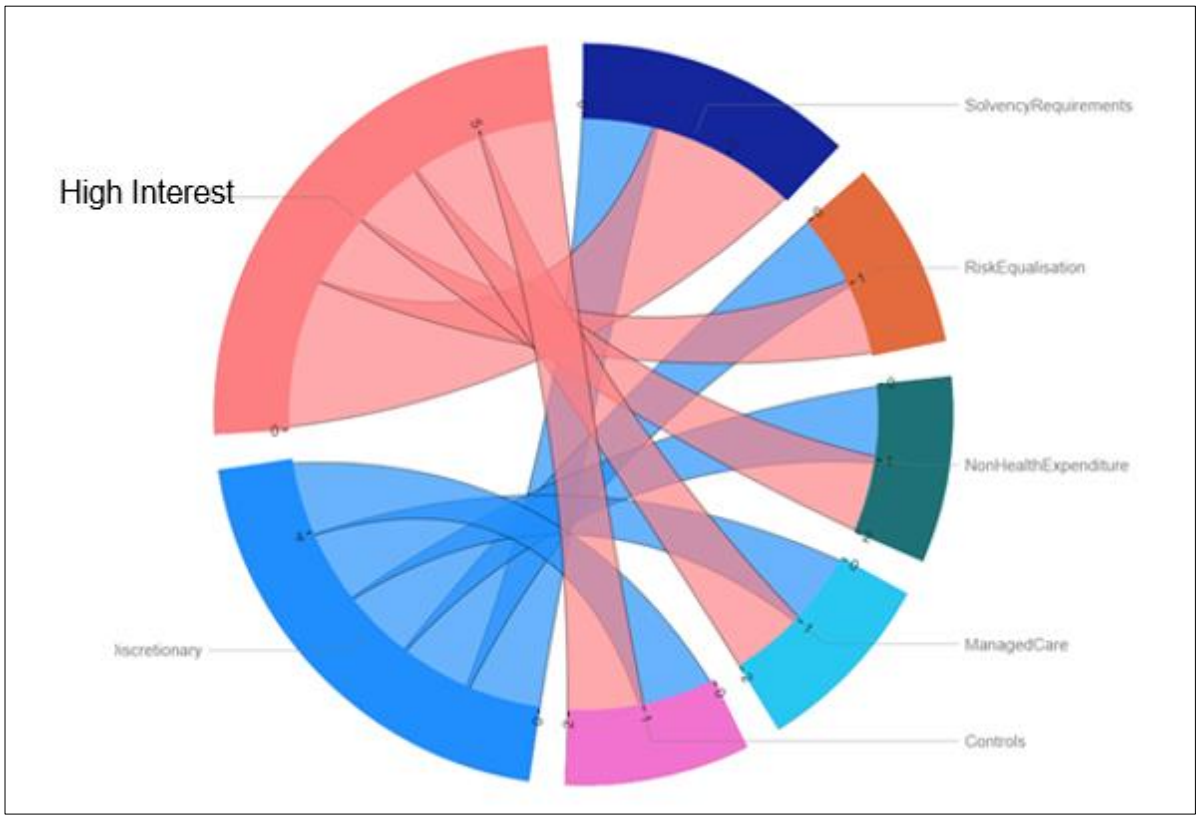

Figure 19 Chord diagram of discretionary and High interest

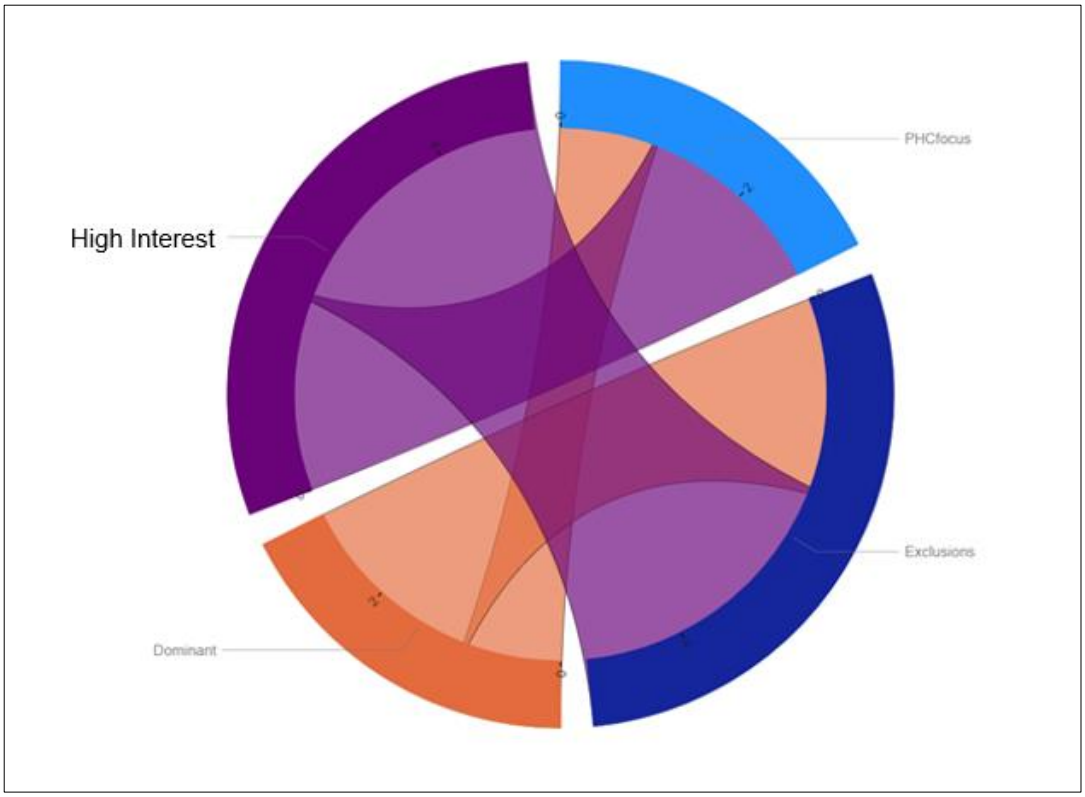

Figure 20 Chord diagram of dominant and High interest

Legal and compliance intersections

Separate intersections were evaluated for this analysis. Figure 21 denotes the common issues between High interest and discretionary stakeholders which are late joiner penalties and buydowns. Stakeholders recommend that late joiner penalties (LJP) should be imposed on members and that age entry exclusions and penalties to members who join beyond the age of 35 years old should be applied. The CMS recommends that LJPs should be implemented in line with the provisions of the MSA, and in manner that reduces the likelihood of buy-downs from medical schemes to LCBO products. The current provisions in the Demarcation products environment should also be considered. On the issue of buy-downs, stakeholders recommended that members should be prohibited from buying-down through schemes rules and regulations. The CMS recommends that any provisions limiting buy-downs should adhere to the MSA and that the current provisions in the Demarcation products environment should be considered.

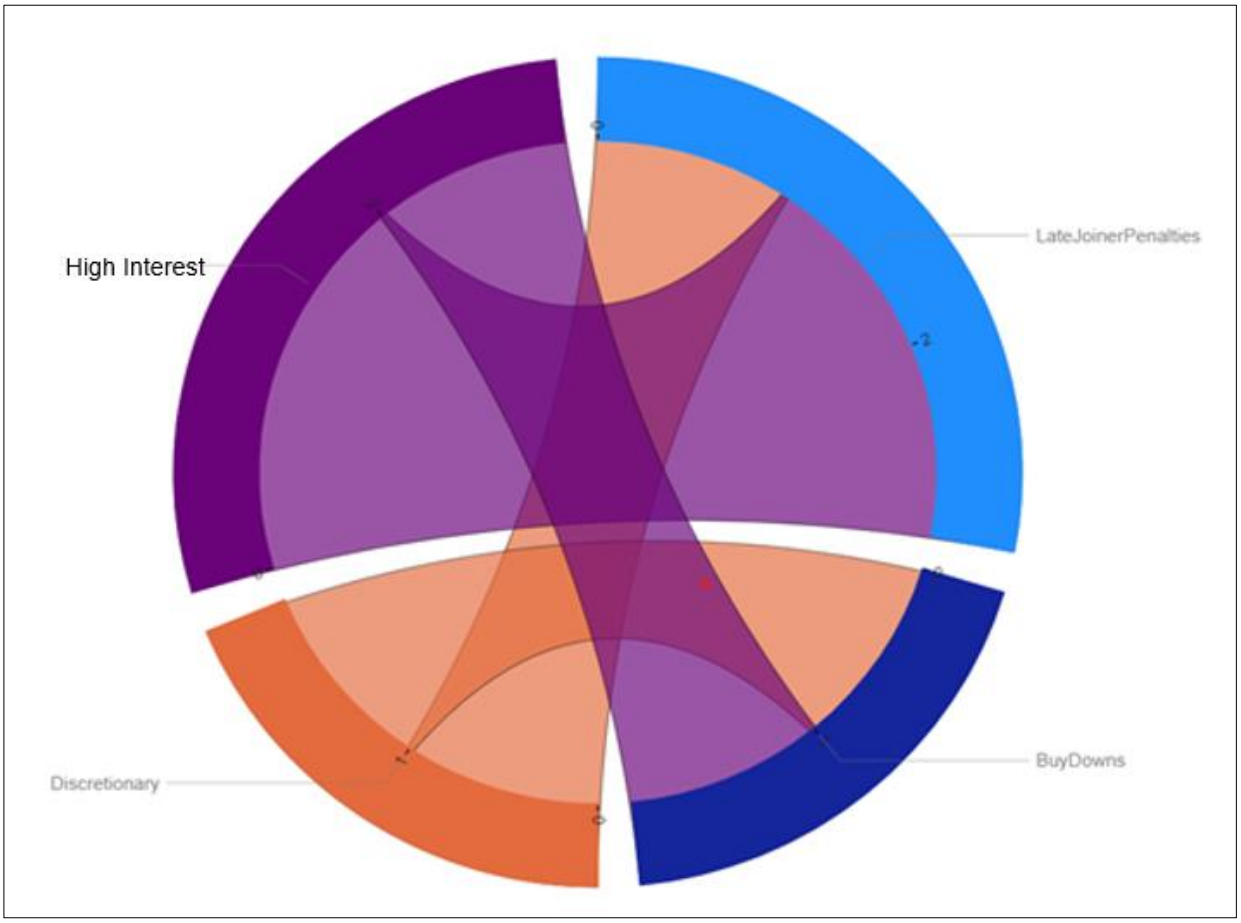

Figure 21 Chord diagram of High interest and discretionary stakeholders

Figure 22 denotes the common issue between High interest and dominant stakeholders, namely adverse selection. Stakeholders recommend that general and condition specific wating periods of 3 to 12 months should be imposed in order to reduce adverse selection. The CMS recommends that waiting periods should be implemented in line with the provisions of the MSA, and in manner that reduces the likelihood of buy-downs from medical schemes to LCBO products. The current provisions in the Demarcation products environment should also be considered.

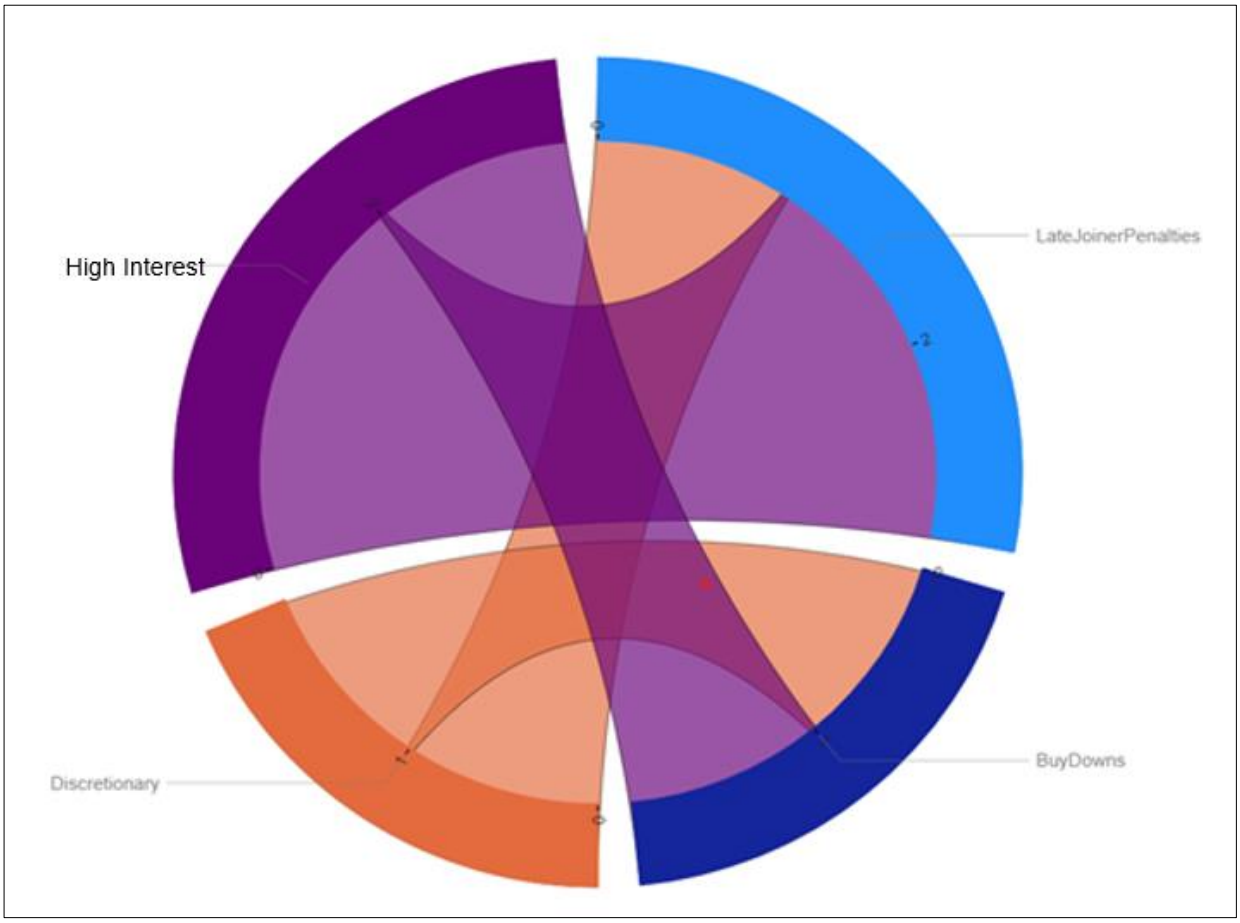

Figure 22 Chord diagram of High interest and Dominant stakeholders

Market and affordability intersections

Figure 23 illustrates the intersection between high interest, discretionary, and dominant stakeholders. The common issue shared by stakeholders is that of market eligibility which was covered in the previous section.

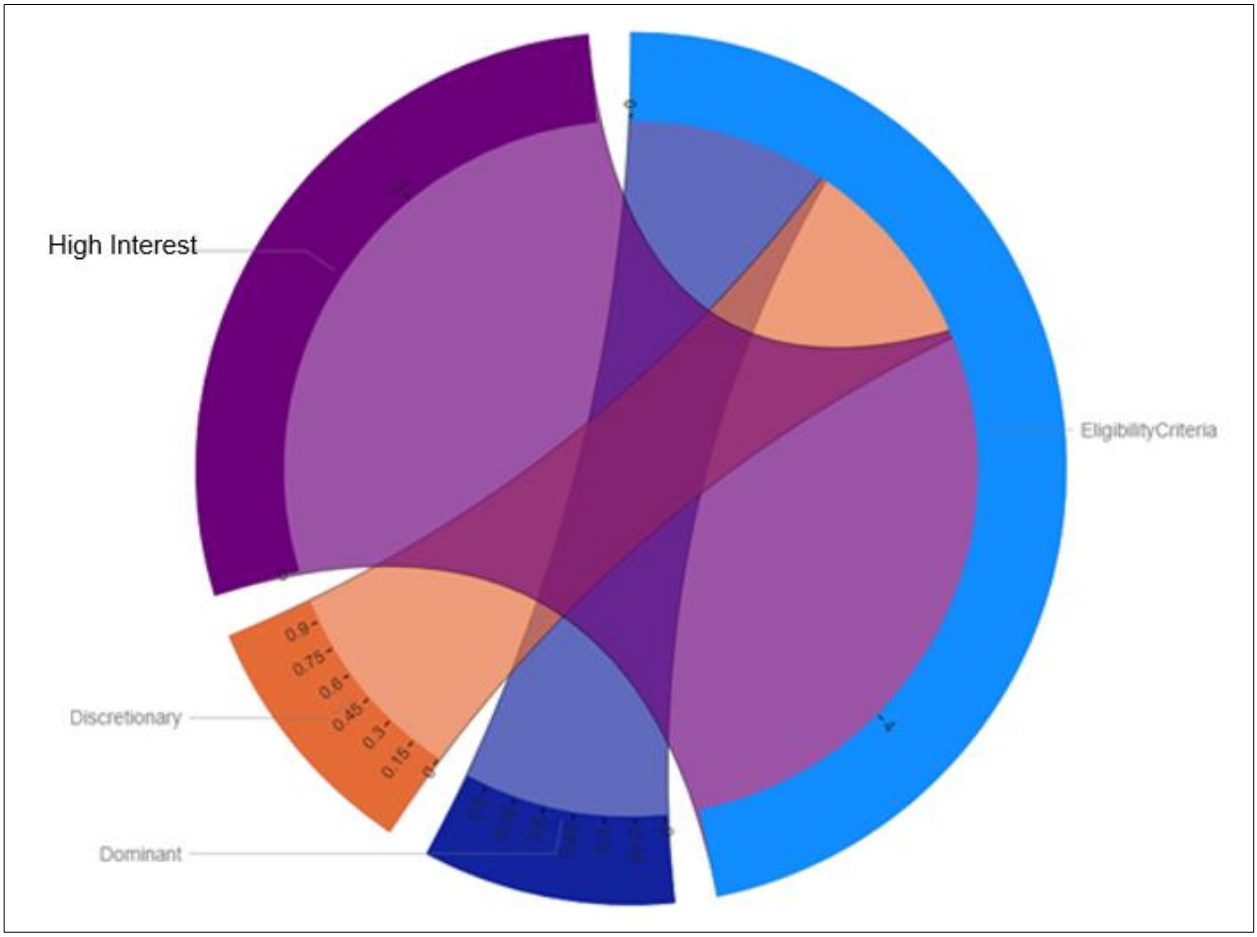

Figure 23 Chord diagram of High interest, Discretionary, and Dominant stakeholders

ANNEXURE 4: Circular 53 of 2022

Name of stakeholders that made submissions to Circular 53 of 2022 considered in the Public Comment and Stakeholder Analysis
Actuarial Society of South Africa (ASSA)
African Unity
Ahmed Moosa
AON
Alliance of South African Independent Practitioners Associations (ASAIPA)
Bestmed
Board Of Healthcare Funders (BHF)
Bonitas
Bowmans – Unions
Calvin Carl Viljoen Attorneys
Day1 Health
Discovery
Financial Intermediaries Association Southern Africa (FIA)
Free Market Foundation
Financial Services Conduct Authority (FSCA)
Government Employees Medical Schemes (GEMS)
Genric Insurance
GMC – Gynaecologists
Hospital Association of South Africa (HASA)
Health Funders Associatios (HFA)
Intercare
Independent Practitioner Association Foundation (IPAF)
Iso Leso
Kaelo
Kwazulu-Natal Doctors Healthcare Coalition (KZNDHC)
Leon Louw
Life Healthcare
Maretha Spies
Medi Call Healthcare
Mediclinic
Medscheme
Momentum Health Solutions
Profmed
Pharmaceutical Society of South Africa (PSSA)
South African Insurance Association (SAIA)
South African Medical Association (SAMA)
South African Medical Technology Industry Association (SAMED)
Sandra -- Radiographer's Society
South African Orthopaedic Association (SAOA)
South African Practitioners Forum (SAPPF)
Society Of Cardiovascular Intervention (SASCI)
Sasfin
South African Society of Physiotherapist (SASP)
Thebemed
Universal