CIRCULAR

Reference:	Low Cost Benefit Package Design
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Circular 37 of 2015 : Request For Proposal - Benefit design and pricing of a Low Cost Benefit Option (LCBO)

1. Introduction

The Council for Medical Schemes (CMS) introduced the concept of Low Cost Benefit Options (LCBO) in Circular 9 of 2015 with the principles of the framework that Council has adopted. The CMS also hosted an Indaba on 15 June 2015 in Cape Town, presenting the view of Council with the opportunity given to stakeholders to engage on this proposed framework. The CMS is currently in the process of developing guidelines for the industry that will outline the requirements of schemes intending to introduce these options once they have been finalised. The CMS envisages the LCBO framework to include a minimum set of predetermined benefits that must be part of every submission for the approval of a LCBO.

The purpose of this Circular is to provide the CMS with proposals on the benefit design and pricing that would form part of the minimum set of benefits that the CMS intends incorporating into the framework. This will inform the development of guidelines for schemes in preparing their submissions to the CMS for the request for exemptions and registration of these options. This request is an opportunity to engage with the industry stakeholders that the CMS requires to successfully implement the LCBO framework.

This Circular aims to set out the request for submissions regarding the proposed benefits and pricing of LCBO and further engagement on the supporting mechanisms to ensure that the benefits of this framework achieves the CMS' objective of stimulating the industry and promoting access to quality and cost effective healthcare.

2. Submissions of proposals for LCBOs

All interested stakeholders are invited to submit proposals for LCBOs that will assist the CMS in preparing the guidelines to be approved, within the framework already adopted by the Council. This section outlines the requirements for submissions by interested parties and is aimed to guide stakeholders as to the expectations of CMS regarding submissions for LCBOs. All stakeholders are alerted to the fact that this framework does not reflect nor

replace the health value framework as envisaged by CMS. The latter will be developed on the back of evidence-based principles that an acceptable and ethical level of health protection is secured by the LCBO.

The information requested below is not exhaustive of the information that may be included in the submission and may include information that stakeholders are in possession of, which will provide valuable insight into the development of the guidelines.

2.1 Proposed LCBO product design

It is envisaged that as part of the framework that the Council has adopted, the LCBOs must provide a standardised predetermined set of minimum benefits aimed at providing quality, evidence-based, cost-effective and affordable healthcare to the target market. The proposals submitted to the CMS will assist in setting out a set of benefits that will form part of the minimum requirements for a scheme seeking to apply for a LCBO. Hence, in order for a scheme to successfully obtain an exemption in order to register a LCBO, they will need to provide the minimum set of benefits in the option as set out in the final guidelines to be approved by Council. It is also important to note that benefit proposals in future may include enhanced benefits than the minimum required and this will be acceptable and reviewed on a case-by-case basis.

While tentative market projections estimate that the cost of providing a low cost benefit option may vary between R200 – R400 per member per month, in order to ascertain the probable average cost of providing these benefits, the CMS is now requesting interested parties to submit a report on the *estimated pricing of LCBOs based on the proposed benefit package below.*

The CMS envisages the LCBO to comprise categories of benefits and level of benefit as shown in the table below. The submission must be based on the two Options outlined in the table but it is important to note that the total package that is offered must include the benefits in the Options provided. However, packages may exceed the benefits in the two Options based on the intended target market and value proposition of the intended benefits. Option limits are arbitrary thresholds for the costing exercise and do not reflect the CMS expectation of the final health value proposition.

Scope of minimum benefits that can be included in the LCBO package:

LCBO product design* – Possible benefit offering			
		Option A	**Option B**
Consultations	General Practitioner Visits***	3 visits pbpy# and 12 visits pfpy**	Unlimited number of visits pfpy**
	Specialist visits with referral	None	1 pbpy#
	Nurses		
	Oral care practitioners		
Medication	Acute	Basic	Basic/Advanced
	Chronic	Basic	Basic/Advanced
Auxiliary services	Dentistry	None/Basic	Basic/Advanced
	Optometry	None/Basic	Basic/Advanced
	Pathology	Basic	Basic/Advanced
	Radiology	Basic	Basic/Advanced
Emergency services	Transportation (Public /Private)	None/Basic	Basic/Advanced
	Casualty	None/Basic	Basic/Advanced
Level of Hospitalisation Public/ Private		None/Basic	Basic/Advanced

**Product innovation/enhancement in benefit design is allowed subject to minimum requirements*

#pbpy: per beneficiary per year

***pfpy: per family per year*

****the number of visits need to cater for additional visits that a person suffering from a chronic illness may require*

The submission on the benefit design must be based on the proposed LCBO benefit design in the table above and must be in the form of a report outlining proposed benefits and pricing of a LCBO. In order to ensure consistency in the submissions on the LCBOs, the reports must include, but are not limited to the following detailed information:

2.1.1.1 Statistics on the intended target market including demographic and financial information;
2.1.1.2 Summary and source of data used;
2.1.1.3 Assumptions used in preparing the submission including the impact of anti-selection;
2.1.1.4 The benefits to be provided in the Options (A & B) proposed and the additional benefits that exceed the minimum in the table above, including information on the mechanism of contracting and managing the preferred provider arrangement(s);
2.1.1.5 The level of contributions charged for the Options;
2.1.1.6 The level of non-healthcare expenditure in the contributions and the manner in which these costs will be minimised to maximise the benefit to the LCBO beneficiary;
2.1.1.7 Financial projections of the options over the next three years; and
2.1.1.8 Detailed annexures of the acute and chronic formularies, list of procedures/tests covered by the auxiliary services.
2.1.1.9 Annexures outlining quality of care monitoring
2.1.1.10 Detailed annexures outlining continuity of care
2.1.1.11 Evidence-based limitations and exclusions;
2.1.1.12 Consideration to prioritising essential health services vs. non-essential health services
2.1.1.13 Considerations of equity

For the purpose of this benefit design submission, interested parties are encouraged to assume minimal regulatory barriers and enablers in their benefit design in order to maximise value for the consumers.

It is envisaged that subject to the merit of each business case, Council will consider granting medical schemes an exemption from complying with certain sections of the Act in terms of Section 8 of the Act.

2.2 Risk-pooling and open enrolment

It is envisaged that LCBOs will not be structured in a manner that undermine the current risk pools established in medical schemes. In order to ensure that the current risk pools are not undermined we need to understand the risk-factors to the current risk pool. The mechanism(s) to ensure that the risk-factors pose a significant risk to the current risk pools need to be reviewed and motivated in the submissions by stakeholders to the extent that an exceptional case may be made for the application of the mechanism.

The risk-factors to the current risk pools that need to be motivated by stakeholders in their submissions include, but are not limited to the risk of:

2.2.1.1 buy-downs by existing members of medical schemes; and
2.2.1.2 anti-selection by individuals.

It is imperative that evidence in support of these risks-factors are based on fact and have been evaluated in the submission to demonstrate that they may be harmful to the current environment.

The mechanism(s) that may be deemed necessary for the management of the risk-factors to ensure that the implementation of LCBOs do not undermine the current risk pools have to be provided in the submission. The mechanism(s) must include evidence to demonstrate that the application of the mechanism(s) directly impacts/reduces the ability of the risk-factors to undermine the market.

The restrictions that the submissions may consider that are not permissible in the current regulatory environment will need to be motivated to the extent that they demonstrate an exceptional case based on factual evidence without which the LCBO cannot be implemented without a risk to the current environment.

The possible restrictions that need to be motivated to reduce the effect of the risk-factors are:

2.2.1.3 eligibility of membership of these options based on the current membership of medical schemes;

2.2.1.4 the enrolment of individual versus group membership; and

2.2.1.5 using income to determine eligibility of membership.

These restrictions are inconsistent with the principle of open enrolment and the case for the exemption from this principle needs to be demonstrated in the submission.

2.3 Benefit delivery

The submission must include details the mechanism used to ensure that these benefits are provided to the target market. In order to attract as many uncovered lives to this product as possible it is envisaged that as part of the application to offer a LCBO, a medical scheme must ensure proximity and accessibility in respect of a network of providers, particularly in areas close to the target market and rural areas.

The submission must include the details of the proposed network of providers and the method of contracting with these providers. It is envisaged that the schemes will be able to contract with providers on a capitated basis and using managed care interventions to ensure that potential LCBO members have the most cost effective mechanism for accessing healthcare benefits. The submission would have to consider the possibility of members accessing benefits outside their area of residence at a network/capitated provider.

Medical schemes that intend to offer LCBOs are therefore encouraged to explore and extend network/capitation arrangements with efficient service providers in rural and township areas if not already in place. The details of the network arrangements and the capitation model needs to be included in the submission, including the mechanisms that will be implemented to ensure that healthcare outcomes can be monitored and assessed.

2.4 Fees payable to brokers

With effect from 01 March 2015, the Minister of Health has approved a maximum of R75.00 plus Value Added Tax (VAT) as an amount that is payable by medical schemes to brokers In terms of section 65 of the MSA read with Regulation 28(2) (a). Assuming the estimated monthly contribution of between R200-R400 per member for a LCBO, it is clear that the current remuneration model was not intended for the LCBO framework. As part of the submission, CMS is requesting interested parties to submit proposals on a remuneration model for brokers offering LCBOs. The model should take into account affordability constraints, the need to maximise value for members but at the same time compensating brokers for their services.

2.5 Solvency Protection

As indicated in Circular 9 of 2015, the statutory solvency requirement in terms of the Act is a principle that the LCBO framework intends maintaining as the requirement is geared at maintaining the overall financial stability of a medical scheme. The possibility of schemes not being able to maintain the current level of solvency and a further reduction in the solvency level due to the introduction of a LCBO needs to be evaluated by stakeholders in their submissions. The Council does not envisage granting medical schemes exemptions from complying with the statutory solvency requirements.

3. Criteria for evaluation

The purpose of the submissions will guide the CMS in the development of the guidelines for the consideration of Council and industry. The review of the submissions on the LCBOs will be based on:

3.1.1 Demonstrable value proposition of the proposal;

3.1.2 Proposed service and accessibility with proximity being guaranteed within previously disadvantaged communities (capitation arrangements);

3.1.3 Cost effective benefits that meets the need of the target market;

3.1.4 Ease of implementation and proper oversight;

3.1.5 Management of potential risks; and

3.1.6 Marketing plan/strategy.

It is anticipated that a follow-up and interactive communication will be made once all submissions have been collated and evaluated. This interactive communication includes a possible workshop with medical schemes, should schemes require further face to face engagement and an Indaba to share proposed guidelines with the industry.

Interested stakeholders are invited to submit their proposed LCBO package and pricing by **Monday 15 June 2015. Please respond to** LCB@medicalschemes.com

Your cooperation is always appreciated.

Daniel Lehutjo
Acting Chief Executive and Registrar
Council for Medical Schemes