CIRCULAR

Reference:	Evaluation of contribution increase assumptions for 2013
Contact person:	Mondi Govuzela
Tel:	012 431 0408
Fax:	012 431 0642
E-mail:	m.govuzela@medicalschemes.com
Date:	12 March 2014

CIRCULAR 14 OF 2014: EVALUATION OF COST INCREASE ASSUMPTIONS BY MEDICAL SCHEMES FOR 2014 FINANCIAL YEAR

Purpose

This Circular provides an evaluation of industry assumptions submitted by medical schemes for the 2014 financial year as provided in the benefit review submissions. The purpose of providing this information is to increase transparency of the schemes pricing decisions and increase the quality of provider negotiations.

Since 2010 the Council for Medical Schemes (CMS) embarked on a process of stringent review of medical schemes contribution and cost increases in order to limit the transfer of inappropriate cost increases to beneficiaries.

Legislative requirement

The Medical Schemes Act outlines legislative requirements informing CMS working with regards to benefit content configuration as well as pricing of options:

Regulation 8 (1) of the Medical Schemes Act regulations requires that "any benefit option that is offered by a medical scheme must pay in full, without co-payments or use of deductibles , the diagnosis , treatment and care costs of the prescribed minimum benefit conditions

Section 24 (2) (e) sates that " … medical scheme does not or will not unfairly discriminate directly or indirectly against any person on one or more arbitrary grounds including race, age, gender, marital status, ethnic or social origin ,sexual orientation, pregnancy, disability and the state of health "

Section 29 (l) makes it mandatory for the scheme to communicate with their members on any change in contributions, membership fees, or subscription, benefits or any other condition affecting their membership.

Section 29 (2) and Section 35 of the Act which seeks to encourage financial soundness of Medical Schemes

Section 31 seeks to ensure that the scheme rules registration promotes equity in rule amendments, discourage prejudice towards the member through unlawful exclusion/limitation of benefits also promote public accountability and transparency.

Section 33 (2) outlines that "approval of benefit options will be subject to provision of prescribed benefits, self-supporting in-terms of membership and financial performance, financially sound, the option should not jeopardize the financial soundness of any existing options within the medical scheme"

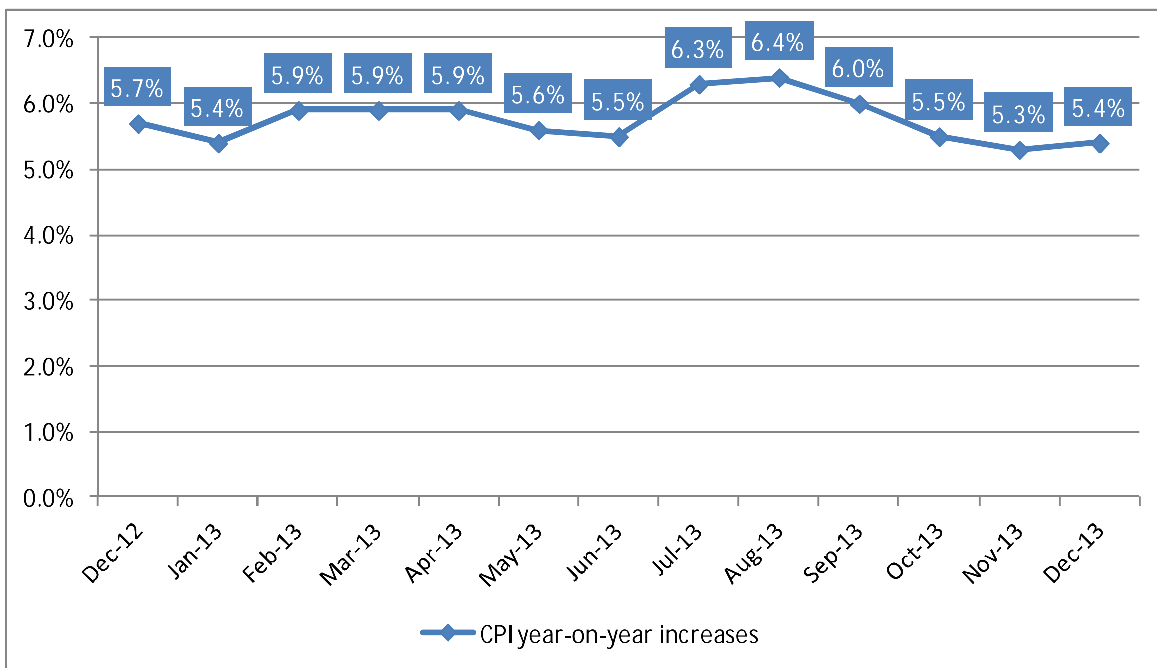
Overview

The analysis provided in this Circular unpack contribution increase assumptions into standard cost items and utilisation stratified by schemes size, scheme type, facility type, professional services, medicine costs, non-healthcare costs, ex gratia payments and all other relevant cost variables.

Inflationary trends

As published in Circular 33 of 2013, the year-on- year 2012-2013 CPI increase was 5.6% in May 2013, with the office of the Registrar advising that cost increase assumption for 2014 be limited to 6.0%. The headline inflation rate was 5.3% in November 2013 and 5.4% in December 2013 resulting in an average annual inflation rate of 5.7% for 2013. On the other hand, the National Treasury's average year-on-year CPI increase projection for 2013 and 2014 is between 5.1% and 5.5% (2013 Budget Review Report). Furthermore National Treasury expects the economy to grow by 2.7% in 2013, to 3.8% in 2015. The graph (Figure 1) below provides historical Consumer Price Index (CPI or inflation) figures as published by Statistics South Africa for the year ending December 2013.

Figure 1: Consumer Price Index Changes for 2013



The Statistics South Africa's 3rd Quarterly Labour Force Survey and Quarterly Employment Statistics recently published employment statistics. According to Statistics South Africa, the unemployment rate decreased by 0.9 of a percentage point from 25.6% in Quarter 2: 2013 to 24.7% in Quarter 3: 2013, while the absorption rate and labour force participation rate increased by 0.8 and 0.4 of a percentage point respectively (Quarterly Labour Force Survey, Quarter 3, 2013). Compared to a year ago, in Quarter 3: 2013 employment increased by 2.8%, and unemployment decreased by 1.2%. Within this increase, the formal sector and private households contributed positively to the increase in employment (Quarterly Labour Force Survey, Quarter 3, 2013). Whilst this increase might lead to an increase in members within some medical schemes, National Treasury continues to be worried about "sluggish job creation" which in their view is likely to inhibit real disposable income growth, while elevated household debt levels could restrain consumer spending (2013 Budget Review Report).

Therefore, the current fiscal pressure and including the increase in the cost of living might have a negative impact on medical schemes in general, while contribution increases in excess of CPI tends to be higher than income growth, creating affordability challenges for most members. In addition, an affordability barrier due to excessive premium increase prevents low-income members to participate meaningfully in the medical scheme market and this limits opportunity for meaningful risk pooling and cross subsidisation within the industry.

Industry cost assumption data

This section provides an outline of the methodology followed in the analysis of cost assumptions data submitted by medical schemes for 2014 benefit year. The analysis undertook a quantitative review of 2012-2013 Annual Statutory data, medical schemes cost assumptions data, review of actuarial reports and an analysis of medical schemes risk measurement data triangulated with contextual analysis of the medical schemes market.

In December 2013, 81 medical schemes submitted cost assumptions data with the submission of benefit changes and contribution increases for 2014. The data from the submissions were consolidated, verified and analysed. Data from 76 medical schemes, representing 8 273 390 beneficiaries (or 95.3% of all beneficiaries in the industry), was found to be of adequate quality for inclusion in the analysis, as shown in

Chairperson: Prof. Y Veriava Chief Executive & Registrar: Dr M Gantsho
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Tel: 012 431 0500 Fax: 012 430 7644 Customer Care: 0861 123 267
Information@medicalschemes.com www.medicalschemes.com

Table 1 below. The submissions were made up of 20 open and 56 restricted medical schemes with 4 461 067 (53.9%) and 3 820 687 (46.1%) beneficiaries, respectively. Schemes were further divided into four different size groups. Ninety-three percent of all schemes that submitted data covered had risk pools of at least 30 000 beneficiaries.

Table 1: Medical Schemes size categories

Type of scheme	Size of scheme*	Number of schemes	Beneficiaries	Percentage of beneficiaries
Open	Small	1	3 577	0.1%
	Medium	7	120 869	2.7%
	Large	12	4 336 621	97.2%
Total open		20	4 461 067	100.00%
Restricted	Small	7	20 699	0.5%
	Medium	33	452 797	11.9%
	Large	16	3 338 827	87.6%
Total restricted		56	3 812 323	100.00%
All schemes	Small	8	24 276	0.3%
	Medium	40	573 666	6.9%
	Large	28	7 675 448	92.8%
Total all schemes		76	8 273 390	100.0%

*Small: < 6 000 beneficiaries; Medium: ≥ 6 000 but < 30 000 beneficiaries; Large: ≥ 30 000 beneficiaries

Scheme tariff increase assumptions for 2014

The average assumed increases for different tariff items i.e. excluding the effect of utilisation, demographic changes and reserve building are summarised in Table 2 and Figure 2. Having considered the year-on year CPI inflation rate and other key economic indicators, CMS advised in Circular 33 of 2013 that cost increase assumptions for the 2014 benefit year should be limited to 6.0% for each individual cost driver in line with the prevailing consumer price index.

The reported weighted average assumed tariff increase for different cost drivers ranging between 5.5% and 7.1%. The inter-quartile range was overall 1.6% or less for all cost drivers. This indicates low variability in the cost increase assumptions reported by medical schemes.

The median assumed increase assumption for cost items in private and public hospitals was between 6.8% and 7.5%. The median assumed tariff increase assumption for out-of-hospital cost drivers was lower, ranging from 6.0% to 6.4%.

The average assumed tariff increase for medicines was around 7.0%, over 1 percentage point higher than the gazetted medicines Single Exit Price (SEP) increase for 2014 (5.82%). The assumed increase assumptions for this cost driver ranged from 0% to 9.0%. The 2014 SEP increase was not available at the time when these assumptions were made by medical schemes. Fifty percent of all schemes that submitted cost increase assumption data took a view that the tariff increase on medicines will not be greater that 6.0%. This is in line with the view of CMS that tariff increase assumptions on medicines must not exceed 6.0%.

Assumed tariff increases for professional services ranged from 3.0% to 8.2%. More that 75% of schemes assumed that the tariff increase for providers in this category will be 6.5% or less.

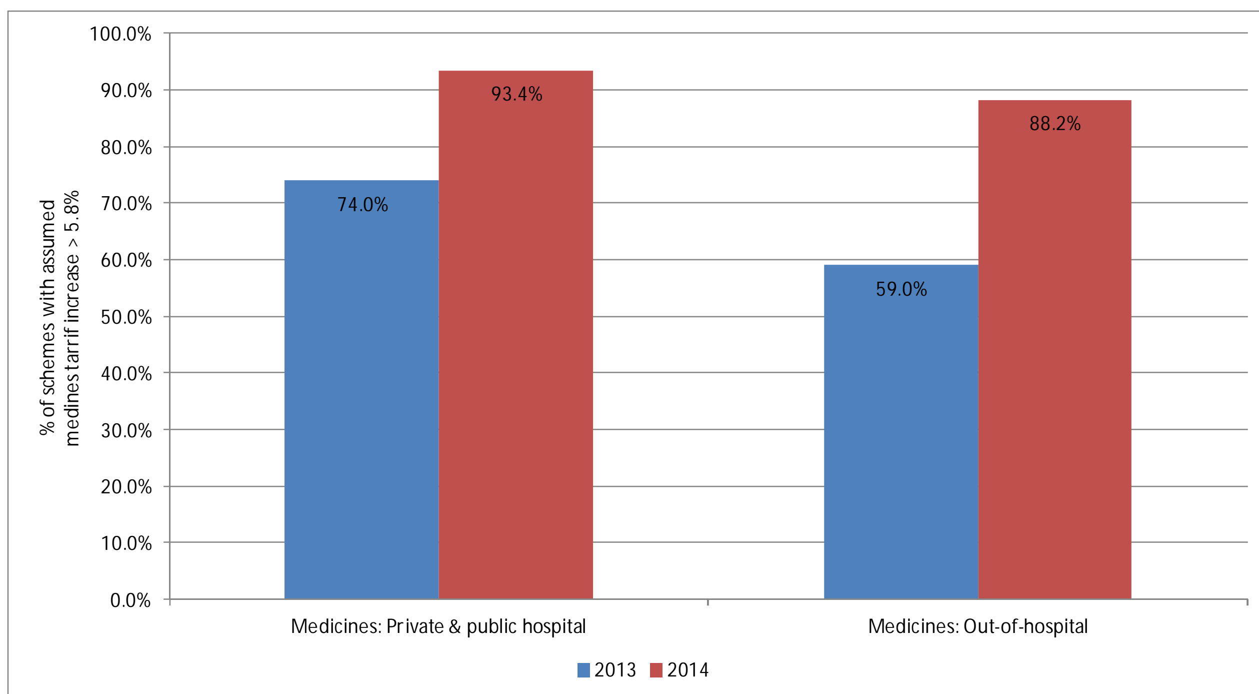
The average increase in Non-Healthcare Expenditure ranged from -2.8% to 11.5%, with 75% of schemes proposing an increase greater than 6.0%.

Table 2: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2014 financial year

Cost item	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Private hospitals						
Ward fees	7.1%	7.0%	7.5%	7.7%	4.2%	9.3%
Theatre fees	6.8%	6.8%	7.5%	7.7%	0.0%	9.3%
Consumables	7.0%	6.8%	7.5%	7.6%	5.0%	9.0%
Medicines	7.1%	6.0%	7.0%	7.6%	0.0%	9.0%
Equipment	6.8%	6.5%	7.5%	7.6%	0.0%	9.0%
Procedure	6.8%	6.5%	7.5%	7.6%	0.0%	9.3%
Managed Care	6.2%	6.0%	6.9%	7.5%	-2.8%	10.0%
Other	6.8%	7.0%	7.5%	7.7%	0.0%	9.0%
Public hospitals						
Ward fees	6.8%	6.5%	7.3%	7.5%	0.0%	9.3%
Theatre fees	6.7%	6.5%	7.5%	7.6%	0.0%	9.3%
Consumables	6.7%	6.5%	7.4%	7.6%	0.0%	9.3%
Medicines	7.0%	6.4%	7.3%	7.5%	0.0%	9.3%
Equipment	6.6%	6.0%	6.8%	7.5%	0.0%	9.3%
Procedure	6.6%	6.0%	7.0%	7.5%	0.0%	10.0%
Other	6.6%	6.0%	6.9%	7.5%	0.0%	9.3%
Professional services						
General practitioners	6.6%	6.0%	6.0%	6.5%	5.0%	8.0%
Specialists	6.3%	6.0%	6.0%	6.5%	4.9%	8.2%
Dentists	6.1%	6.0%	6.0%	6.5%	3.0%	8.0%
Allied	6.5%	6.0%	6.0%	6.5%	5.0%	8.0%
Other professional	6.1%	6.0%	6.0%	6.5%	5.0%	8.0%
Medicines out-of-hospital	7.0%	6.0%	6.4%	7.4%	3.5%	8.5%
Ex gratia payments	5.5%	5.8%	6.0%	6.0%	0.0%	8.5%
Out-of-hospital managed care	6.0%	6.0%	6.0%	6.5%	-2.8%	11.0%
Non-healthcare expenditure	6.4%	6.0%	6.0%	6.0%	-2.8%	11.2%

The percentage of schemes whose medicines tariff increase were greater than the SEP increased from 74.0% to 93.4% for medicines dispensed in a hospital setting, and 59.0% to 88.2% for out-of-hospital medicines between 2013 and 2014, respectively, as shown in Figure 2.

Figure 2: Percentage of schemes assumed medicines tariff increase greater than SEP (5.8%)



The impact of non-healthcare expenditure on the tariff increase was not different between open and restricted medical schemes. As shown in Table 3, the average increases were 6.4% and 6.3% for Open and Restricted medical schemes, respectively. Overall, the assumed budgeting for non-healthcare expenditure contributed 6.4% towards the tariff increase in 2014.

Table 3: Non-healthcare expenditure by scheme size (%)

Type	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Open	20	6.4%	6.0%	6.0%	6.0%	-2.8%	11.1%
Restricted	56	6.3%	6.0%	6.0%	6.2%	-1.2%	11.2%
All schemes	76	6.4%	6.0%	6.0%	6.0%	-2.8%	11.2%

Chairperson: Prof. Y Veriava Chief Executive & Registrar: Dr M Gantsho
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Tel: 012 431 0500 Fax: 012 430 7644 Customer Care: 0861 123 267
Information@medicalschemes.com www.medicalschemes.com

The size of the scheme was found to be unrelated to the level at which non-health expenditure has been assumed to increase. The assumed increase in non-health expenditure in the small sized medical schemes (5.9%) was lower than in the medium (6.2%) and large (6.4%) medical schemes (Table 4). The observed differences were not statistically significant.

Table 4: Non-healthcare expenditure by scheme size (%)

Scheme size	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Small	8	5.9%	6.0%	6.0%	6.0%	5.0%	6.0%
Medium	40	6.2%	6.0%	6.0%	6.0%	-1.2%	11.2%
Large	28	6.4%	6.0%	6.0%	7.4%	-2.8%	11.1%
All schemes	76	6.4%	6.0%	6.0%	7.4%	-2.8%	11.2%

Scheme utilisation demographic increase assumptions for 2014

The weighted average assumed impact of utilisation and demographic changes on contribution increases across all schemes was 2.3%. Twenty medical schemes made an unrealistic assumption of 3% or more in the assumed impact of utilisation and demographic changes.

Table 5: Summary of the utilisation & demographic assumptions incorporated into overall contribution increase for the 2013 financial year

Variable	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Private hospitals						
Ward fees	2.9%	1.4%	2.0%	3.0%	0.0%	5.5%
Theatre fees	2.8%	1.2%	2.0%	2.8%	0.0%	5.5%
Consumables	2.9%	1.4%	2.0%	3.0%	0.0%	5.5%
Medicines	2.8%	1.2%	2.0%	2.9%	-0.6%	5.5%
Equipment	2.8%	1.0%	1.9%	2.7%	0.0%	5.5%
Procedure	2.8%	1.0%	1.9%	2.7%	0.0%	5.5%
Managed Care	2.1%	0.0%	1.0%	2.0%	0.0%	5.5%
Other	2.8%	1.0%	1.9%	2.7%	0.0%	5.5%
Public hospitals						
Ward fees	2.5%	1.0%	1.8%	2.7%	0.0%	5.5%
Theatre fees	2.5%	1.0%	1.6%	2.7%	0.0%	5.5%
Consumables	2.5%	1.0%	1.8%	2.7%	0.0%	5.5%
Medicines	2.5%	1.0%	1.8%	2.7%	0.0%	5.5%
Equipment	2.4%	0.1%	1.5%	2.5%	0.0%	5.5%
Procedure	2.4%	0.1%	1.5%	2.5%	0.0%	5.5%
Other	2.4%	0.0%	1.5%	2.5%	0.0%	5.5%
Professional services						
General practitioners	2.6%	1.0%	1.5%	2.8%	-1.0%	8.2%
Specialists	2.7%	1.2%	2.0%	2.9%	0.0%	8.2%
Dentists	2.6%	0.8%	1.5%	2.7%	0.0%	8.2%
Allied	2.6%	0.8%	1.5%	2.8%	0.0%	8.2%
Other professional	2.5%	0.5%	1.5%	2.8%	0.0%	8.2%
Medicines out-of-hospital	3.3%	1.0%	2.0%	2.8%	-0.6%	7.5%
Ex gratia payments	2.4%	0.0%	0.0%	1.8%	0.0%	5.5%
Out-of-hospital managed care	1.7%	0.0%	0.0%	0.8%	0.0%	4.7%
Non-healthcare expenditure	-0.3%	0.0%	0.0%	0.0%	-1.3%	3.5%
Overall weighted utilisation increase	2.3%	1.1%	1.5%	2.4%	0.0%	5.0%

Scheme total increase assumptions for 2014

The weighted average total assumed increase for 2014 across all medical schemes was 9.2%, slightly lower than the 2013 increase of 9.6%. The average total assumed increase for 75% of schemes was 9.6% or less. The summary statistics for increases by type of scheme are shown in Table 6.

Table 6: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2013 financial year

Variable	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Private hospitals						
Ward fees	10.1%	8.5%	9.5%	10.4%	6.0%	14.0%
Theatre fees	9.7%	8.5%	9.3%	10.3%	0.0%	14.0%
Consumables	10.0%	8.5%	9.5%	10.4%	6.0%	13.3%
Medicines	10.0%	8.0%	9.0%	10.0%	0.0%	13.3%
Equipment	9.7%	8.0%	9.1%	10.2%	0.0%	13.3%
Procedure	9.6%	7.7%	9.0%	10.3%	0.0%	13.3%
Managed Care	8.4%	6.8%	8.0%	9.7%	-2.8%	11.5%
Other	9.6%	7.9%	9.0%	10.2%	0.0%	13.3%
Public hospitals						
Ward fees	9.4%	7.6%	9.1%	10.2%	0.0%	14.0%
Theatre fees	9.2%	7.5%	9.1%	10.2%	0.0%	14.0%
Consumables	9.3%	7.5%	9.1%	10.2%	0.0%	13.3%
Medicines	9.6%	7.5%	8.7%	10.0%	0.0%	13.3%
Equipment	9.2%	7.1%	9.0%	10.2%	0.0%	13.3%
Procedure	9.2%	7.0%	8.7%	10.2%	0.0%	13.3%
Other	9.1%	7.0%	8.6%	10.0%	0.0%	13.3%
Professional services						
General practitioners	9.3%	7.4%	8.0%	9.1%	5.6%	15.2%
Specialists	9.1%	7.5%	8.2%	9.5%	5.7%	15.2%
Dentists	8.8%	7.0%	7.7%	8.9%	4.0%	15.2%
Allied health professionals	9.2%	7.1%	7.7%	9.3%	5.7%	15.2%
Other Professional	8.7%	7.0%	7.6%	9.3%	5.7%	15.2%
Medicines out-of-hospital	10.4%	7.4%	8.5%	9.8%	4.5%	15.7%
Ex gratia payments	8.0%	5.9%	6.5%	8.0%	0.0%	11.8%
Out-of-hospital managed care	7.8%	6.0%	6.0%	7.5%	-2.8%	14.5%
Non-healthcare expenditure	6.1%	6.0%	6.0%	6.6%	-2.8%	14.5%
Reserve loading	0.0%	-0.1%	0.0%	0.0%	-5.7%	3.5%
Total assumption increase	9.2%	7.5%	8.5%	9.6%	-4.6%	12.9%

The 9.3% total contribution increase proposed by large medical schemes was the highest when schemes are stratified by size, and small medical schemes proposed a slightly lower increase of 8.8%. The lowest assumed total contribution increase was proposed by medium medical schemes, as displayed in Table 7.

Table 7: Weighted average total contribution increase proposed by size of medical scheme

Size of scheme	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Small	8	8.8%	6.0%	8.1%	9.9%	4.0%	10.1%
Medium	40	7.7%	7.4%	7.9%	9.0%	-4.6%	11.0%
Large	28	9.3%	8.5%	8.9%	9.9%	6.2%	12.9%
All schemes	76	9.2%	7.5%	8.5%	9.6%	-4.6%	12.9%

The type of scheme, restricted or open, did not seem to influence the proposed contribution increase. As depicted in Table 8, the average increase for restricted and open medical schemes was 9.2% and 9.3%, respectively.

Table 8: Weighted average total contribution increase proposed by type of medical scheme

Size of scheme	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Minimum	Maximum
Open	20	9.3%	7.7%	8.9%	9.8%	-4.6%	12.9%
Restricted	56	9.2%	7.5%	8.1%	9.5%	4%	12.2%
All schemes	76	9.2%	7.5%	8.5%	9.6%	-4.6%	12.9%

Figure 3 below depicted that only 8 medical schemes proposed a contribution increase of 6.0% or less. Most medical schemes (58) assumed an increase of between 6.0% and 10.0%. Ten medical schemes proposed a contribution increase greater than 10.0%. As noted in the previous year, size of medical schemes seems not to be related to cost increases, but it is worth noting that no large medical scheme proposed a contribution increase lower than 6%.

Figure 3: Total contribution increase bands by size of medical scheme

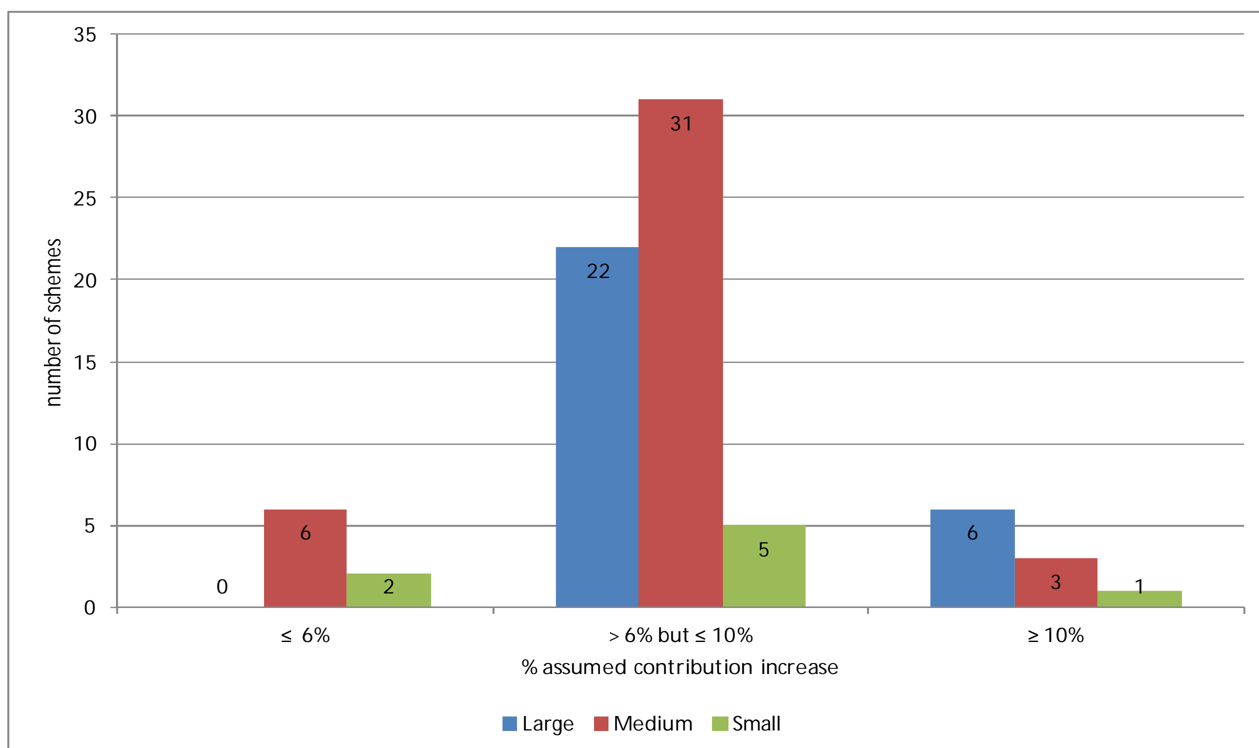
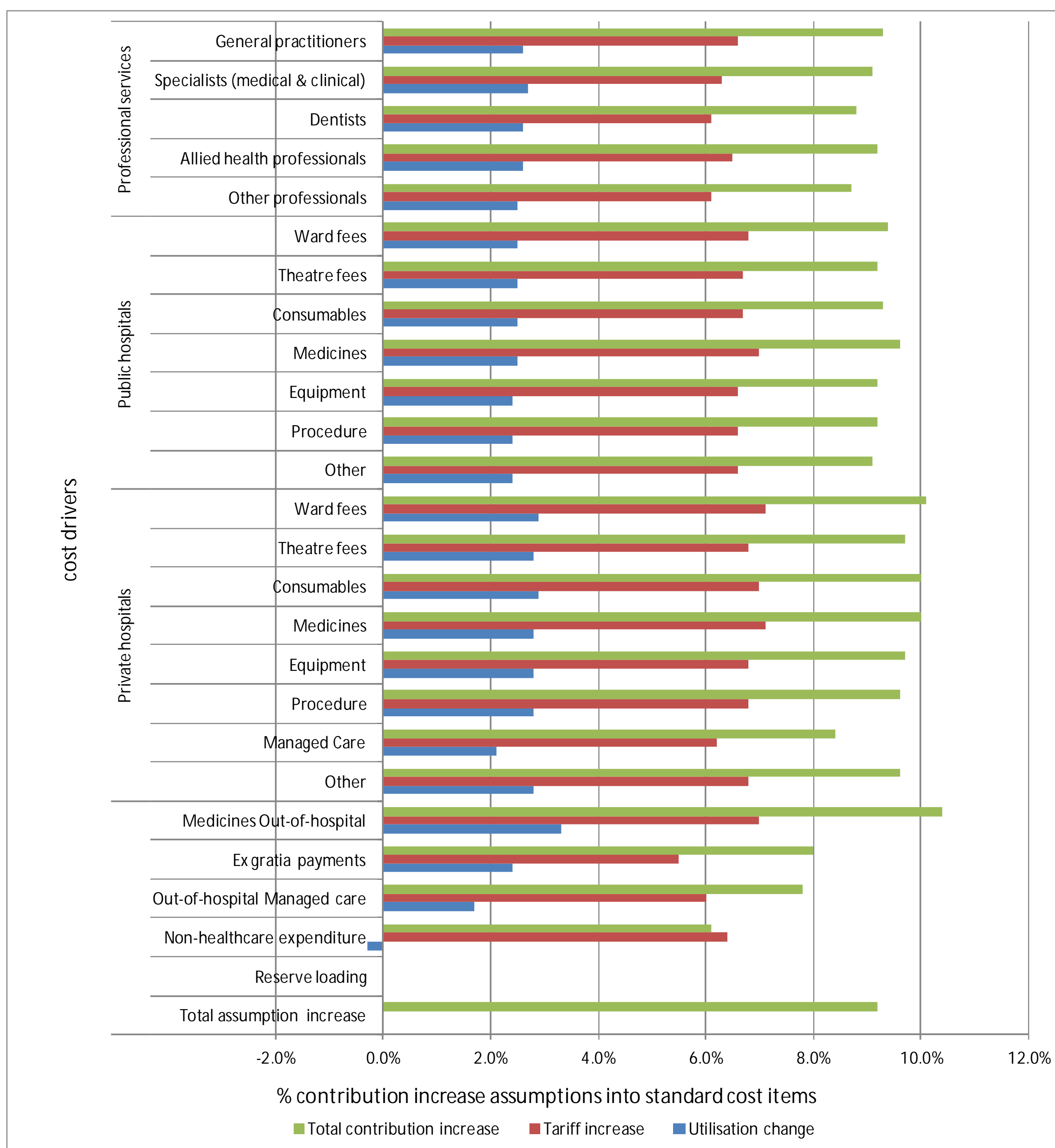


Figure 4 below displays a summary of the most important assumptions for cost items incorporated into the overall contribution increase for the 2014 financial year. The proposed tariff increase for most of the cost drivers are above 6.0%. The weighted average assumed effect of utilisation and demographic changes was between 2.0% and 3.5% for most cost drivers. The effect of utilisation on out-of-hospital managed care and non-healthcare costs was 1.7% and -0.3%, respectively. The combination of tariff and utilisation pushes increases to levels higher for all cost drivers with the exception of out-of-hospital managed care.

Figure 4: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2014 financial year



Chairperson: Prof. Y Veriava Chief Executive & Registrar: Dr M Gantsho
Block A, Eco Glades 2 Office Park, 420 Witch-Hazel Avenue, Eco Park, Centurion, 0157
Tel: 012 431 0500 Fax: 012 430 7644 Customer Care: 0861 123 267
Information@medicalschemes.com www.medicalschemes.com

Table 9 below shows the difference between the total contribution increase assumptions made in 2013 and 2014 for the different cost drivers. The difference is negligible for most cost drivers. The effect of managed care, in- and out-of-hospital, seems to be more significant in 2014 than in 2013. The assumed increase for in- and out-of-hospital managed care as a cost driver is 3.5 and 2.6 percent points higher in 2014. The significant increase was observed in medicines, increasing by more than 1 percentage point in 2014, despite the fact that the SEP was not available at the time of making these assumptions.

Table 9: Difference between the total contribution increase assumptions made in 2013 and 2014 for the different cost drivers

Variable	Weighted average		Percentage points difference
	2013	2014	
Private hospitals			
Ward fees	10.1%	10.1%	0.00%
Theatre fees	9.9%	9.7%	-0.20%
Consumables	9.4%	10.0%	0.60%
Medicines	8.9%	10.0%	1.10%
Equipment	9.6%	9.7%	0.10%
Procedure	9.5%	9.6%	0.10%
Managed Care	4.9%	8.4%	3.50%
Other	9.5%	9.6%	0.10%
Public hospitals			
Ward fees	9.5%	9.4%	-0.10%
Theatre fees	9.3%	9.2%	-0.10%
Consumables	8.8%	9.3%	0.50%
Medicines	8.4%	9.6%	1.20%
Equipment	9.1%	9.2%	0.10%
Procedure	9.1%	9.2%	0.10%
Other	9.2%	9.1%	-0.10%
Professional services			
General practitioners	8.7%	9.3%	0.60%
Specialists	9.2%	9.1%	-0.10%
Dentists	8.7%	8.8%	0.10%
Allied health professionals	9.3%	9.2%	-0.10%
Other professional	8.7%	8.7%	0.00%
Medicines out-of-hospital	9.0%	10.4%	1.40%
Ex gratia payments	7.8%	8.0%	0.20%
Out-of-hospital managed care	5.2%	7.8%	2.60%
Non-healthcare expenditure	5.9%	6.1%	0.20%
Reserve loading	0.9%	0.0%	-0.90%
Total Assumption Increase	9.6%	9.2%	-0.40%

The following are CMS' concerns with regards to cost assumptions as submitted by the medical schemes:-

As was the case in 2013, cost increase assumptions for 2014 for private hospitals are still above CPI. Furthermore, we have noticed that the cost increase assumptions is on average 3.6 percentage points higher than the maximum cost increase assumption as per the Circular 33 guidance. The average utilisation assumption of around 3% further impacts on the affordability of medical scheme contributions as private hospital costs make up a significant portion of medical schemes' expenditure. The impact of utilisation on the total cost of providing cost effective medical scheme benefits cannot be ignored as it has a material impact on the key drivers of costs in the industry. Furthermore, limited competition within the hospital market continues whilst there are significant barriers of entry for new hospitals. Against this background, most medical schemes continue being price-takers during reimbursement and tariff increase negotiations and the fee-for-service reimbursement method is not necessarily aligned with equity principles since it has the potential of leading to over-servicing which can increase costs of private healthcare.

- Pharmaceutical costs within the hospitals also increased when compared to 2013 cost assumptions. Medicine pricing is assumed to increase by 6.0% on average which is slightly consistent with the approved SEP increase of 5.8% for 2014. The effect of utilisation caused an increase of 10.0% on the average cost of medicines in private hospitals. Whilst acknowledging the impact of the push factors (such as new drugs, currency depreciation and utilisation) and pull factors (such as managed care, generic market and voluntary SEP reduction), which influence medicine expenditure, medicine cost assumptions in total were expected to be closer to the SEP, especially if managed care interventions are effective in managing utilisation and promote the use of generic medicines whilst ensuring quality health outcomes. Private hospitals should also continue to manage medicine utilisation within their facilities including encouraging the use of generic substitution and better coordination of care.

- Expenditure on specialist continues to be one of the key cost drivers for healthcare costs. The weighted average cost increase assumption of 9.1% (tariff increase of 6.6%; utilisation component of 2.7%) for specialists is partly responsible for the larger than CPI increase in scheme contributions. Also, specialists continue to have a specific relationship with private hospitals in a fee-for-service market; where they remain a significant driver of healthcare expenditure within hospitals. Whilst acknowledging the challenges encountered by medical schemes in influencing the entire continuum of care, it is recommended that medical schemes should consider the use of alternative reimbursement mechanisms to counter the inherent incentive for over-servicing as indicated by the assumptions on utilisation in the pricing for 2014. Furthermore, medical schemes should strengthen care coordination within their preferred providers.

- It was interesting to observe that the in-hospital and out-of-hospital managed care average cost increase of 4.9% and 5.2% in 2013 increased to 8.4% and 10.4% in 2014, respectively. Whilst acknowledging that there are several factors influencing managed healthcare expenditure within the medical schemes industry, medical schemes are

encouraged to continue to undertake active steps to influence member health-seeking behaviour and the care-providing behaviour of doctors and other health professionals. Whilst managing access, utilisation, costs, and health quality outcomes.

- Non-health care costs continue to vary considerably within medical schemes industry with an average cost assumption increase of 6.1% compared to a median increase of 5.9% in 2013. This increase represents a 0.2 percentage points increase from the previous year's assumed cost increase. With regards to administration fees, it is recommended that medical schemes continue to undertake an efficiency analysis so as to identify any suboptimal administrative operations and processes. Improved administrative efficiency has a potential to free resources within the schemes which could be transferred to medical schemes members in terms of affordable contribution increases or other member benefits. Also, oversight by medical schemes is encouraged to ensure that the scheme funds are not spent on goods and services not involving medical services.

Conclusion

It is encouraging to see that the assumed tariff increase assumption for many schemes is now closer to the advised tariff increase assumption of 6% provided in Circular 33 of 2013. The reported weighted average assumed tariff increase for different cost drivers ranged between 5.5% and 7.1%. The impact of assumed utilisation changes, which ranged between from -0.3% to 3.3%, remain a concern. CMS has noted that utilisation estimates submitted as part of cost increase assumptions by some schemes do not correlate with worsening or improving demographic and disease profile of medical schemes for both open and restricted schemes. Combining these, the assumed tariff and utilisation change assumptions have pushed the industry average cost assumption increase to 9.2% for 2014. This is marginally lower than the 2013 figure of 9.6%.

Furthermore, as recommended earlier, medical schemes should attempt to address cost factors to the best of their ability, because failure to do this will lead to a continued affordability challenge in accessing healthcare, thereby threatening the long term sustainability of the industry since members are price sensitive. High input costs continue to be one of the barriers to entry for new members and will cause further challenges to growth in the industry.

MR DANIEL LEHUTJO
ACTING CHIEF EXECUTIVE AND REGISTRAR