CIRCULAR

Reference:	Evaluation of contribution increase assumptions for 2015
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CIRCULAR 23 OF 2015: EVALUATION OF COST INCREASE ASSUMPTIONS BY MEDICAL SCHEMES FOR 2015 FINANCIAL YEAR

Purpose

This Circular provides an evaluation of industry assumptions submitted by medical schemes for the 2015 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 how the CMS conducts its work 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"

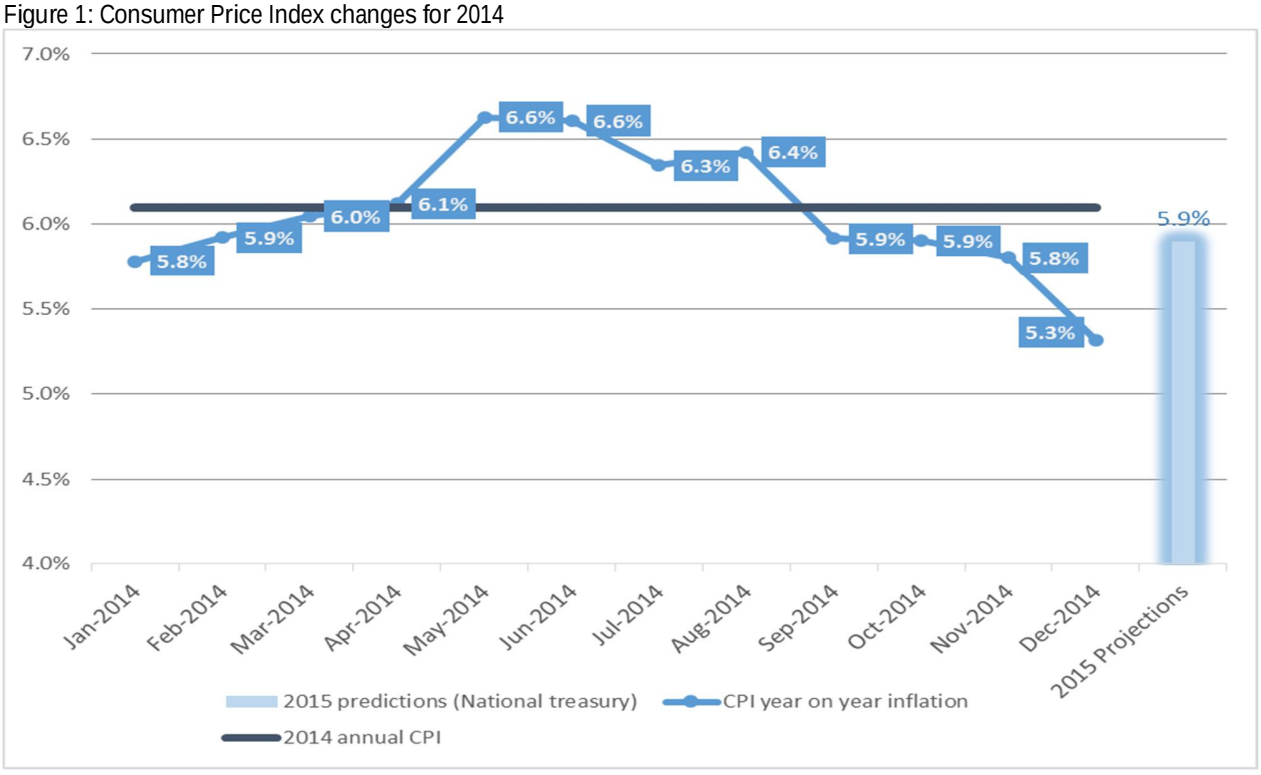
Overview

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

Economic indicators trends

The CMS published Circular 34 of 2014 in July 2014 advising medical schemes that cost increase assumption for 2015 should be limited to 6% for each individual cost item. The assumption was mainly based on headline inflation as measured by the Consumer Price Index (CPI). At the time of publishing the circular, the latest available headline inflation was 6.6% as at June 2014 (with the bi-annual average headline inflation of about 6.1%). The headline inflation for December 2014 was 5.3% resulting in the annual average headline inflation for 2014 being at 6.1% (Figure 1). The 2015 annual average headline inflation is projected at 5.9% by the National Treasury (2014 Medium Term Budget Policy Statement).

Figure 1: Consumer Price Index changes for 2014



Tough economic conditions since 2008 to 2009 due to the global financial crisis continue to affect most economies including South Africa. South Africa's economic performance has been deteriorating over the past several years. Slow economic growth therefore continues to be a worrying factor in 2014 and beyond (Budget review 2014). Whilst economic growth was reported to be at levels below 2% with Q3:2014 recording a growth rate of 1.4%, and projected GDP growth has been revised down from 2.5 to 2 per cent in 2015 (Economic Outlook, 2015).

The unemployment rate in quarter 3 of 2014 was 25.4% (Quarterly Labour Force Survey, Q3: 2014). Whilst the labour force participation rate and the absorption rate remained slightly unchanged during 2014. According to the Quarterly Employment Survey (QES) in quarter 3 of 2014, formal sector employment increased by 1.0% on year-on-year comparisons but declined by -1.5% on quarter-on-quarter comparisons. The average earnings paid to employees increased by 6.6% year-on-year (Quarterly Employment Survey, Q3:2014). These factors highlights the pressure on the economy to translate economic growth into job creation.

The current fiscal pressure might have a negative impact on the medical schemes in general. The slow economic growth and low employment levels may constrain growth in medical schemes' membership. Medical schemes' contributions in excess of CPI and income growth will most likely create affordability challenges for medical scheme 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 2015 benefit year. The analysis undertook a quantitative review of 2013-2014 Annual Statutory Return 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 2014, 85 medical schemes submitted cost assumptions data with the submission of benefit changes and contribution increases for 2015. The data from the submissions were consolidated, verified and analysed. Data from 76 medical schemes, representing about 98% of all beneficiaries in the industry, was found to be of adequate quality for inclusion in the analysis, as shown in Table 1 below. The medical schemes submissions that were found to be of adequate quality were made up of 23 open and 53 restricted medical schemes with 4 864 931 (56%) and 3 818 224 (44%) beneficiaries, respectively. About 20% of the medical schemes that submitted data of adequate quality had risk pools of at least 65 000 (Table 1 below).

Table 1: Medical Schemes size categories

Type of scheme	Size of scheme*	Number of schemes	Beneficiaries	Percentage of beneficiaries
Open	Small	6	68 438	1.41%
	Medium	6	207 695	4.27%
	Large	8	111 3971	22.90%
	Very Large	3	3 474 827	71.43%
Total open		23	4 864 931	100.00%
Restricted	Small	26	217 841	5.71%
	Medium	18	550 988	14.43%
	Large	7	722 302	18.92%
	Very large	2	2 327 093	60.95%
Total restricted		53	3 818 224	100.00%
All schemes	Small	32	286 279	3.30%
	Medium	24	758 683	8.74%
	Large	15	1 836 273	21.15%
	Very large	5	5 801 920	66.82%
Total all schemes		76	8 683 155	100.00%

*Small: < 15 000 beneficiaries; Medium: ≥ 15 000 but ≤ 65 000 beneficiaries; Large: > 65 000 but ≤ 220 000 beneficiaries; Very large > 220 000 beneficiaries

Scheme tariff increase assumptions for 2015

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, the CMS advised in Circular 34 of 2014 that cost increase assumptions for the 2015 benefit year should be limited to 6.0% for each individual cost driver in line with the prevailing consumer price index.

Table 2: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2015 financial year

Cost item	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	6.38%	6.20%	7.50%	7.88%	6.18%	6.63%
Theatre fees	6.26%	6.20%	7.50%	7.88%	5.96%	6.63%
Consumables	6.51%	6.00%	6.80%	7.75%	6.61%	6.38%
Medicines	5.97%	6.00%	6.50%	7.50%	5.69%	6.32%
Equipment	6.09%	6.00%	7.00%	7.60%	5.94%	6.29%
Procedure	6.09%	6.00%	6.80%	7.75%	5.93%	6.29%
Managed Care	5.87%	6.00%	6.50%	7.50%	5.56%	6.25%
Other	6.06%	6.00%	6.80%	7.60%	5.83%	6.35%
Public hospitals						
Ward fees	6.29%	6.20%	7.13%	7.60%	6.17%	6.45%
Theatre fees	6.17%	6.20%	7.10%	7.60%	5.95%	6.45%
Consumables	6.42%	6.00%	6.80%	7.52%	6.60%	6.19%
Medicines	5.96%	6.00%	6.50%	7.50%	5.81%	6.15%
Equipment	6.01%	6.00%	6.80%	7.50%	5.93%	6.11%
Procedure	6.01%	6.00%	6.80%	7.50%	5.92%	6.12%
Other	6.01%	6.00%	6.70%	7.50%	5.91%	6.13%
Professional services						
General practitioners	6.17%	6.00%	6.20%	6.50%	6.25%	6.07%
Specialists	6.34%	6.00%	6.20%	6.70%	6.56%	6.08%
Dentists	6.15%	6.00%	6.20%	6.50%	6.23%	6.05%
Allied	6.63%	6.00%	6.20%	6.50%	7.09%	6.05%
Other professional	6.16%	6.00%	6.20%	6.50%	6.25%	6.05%
Medicines out-of-hospital	6.16%	6.00%	6.20%	6.96%	6.17%	6.14%
Ex gratia payments	5.31%	0.00%	6.00%	6.25%	5.04%	5.65%
Out-of-hospital managed care	6.41%	6.00%	6.20%	6.65%	6.22%	6.64%
Non-healthcare expenditure	5.87%	5.97%	6.00%	6.50%	5.42%	6.43%
Overall weighted tariff assumption increase	6.25%	6.03%	6.62%	7.05%	6.23%	6.28%

The reported overall weighted tariff assumption increase for 2015 was 6.25%. The overall weighted tariff assumption increase were slightly similar between open schemes (6.23%) and restricted schemes (6.28%). The reported weighted average assumed tariff increase for different cost drivers ranged between 5.31% and 6.63%. The range was about 1.32% for all cost drivers. This indicates low variability in the cost increase assumptions reported by medical schemes.

The weighted average assumed tariff increase assumption for private hospitals ranged between 5.87% and 6.51%. The median assumed increase assumption for cost items in private hospitals was between 6.50% and 7.50%. The median assumed increase assumption for cost items in public hospitals was almost similar to that of private hospitals and was between 6.50% and 7.13%. The weighted average assumed tariff increase for public hospitals was between 5.96% and 6.42%.

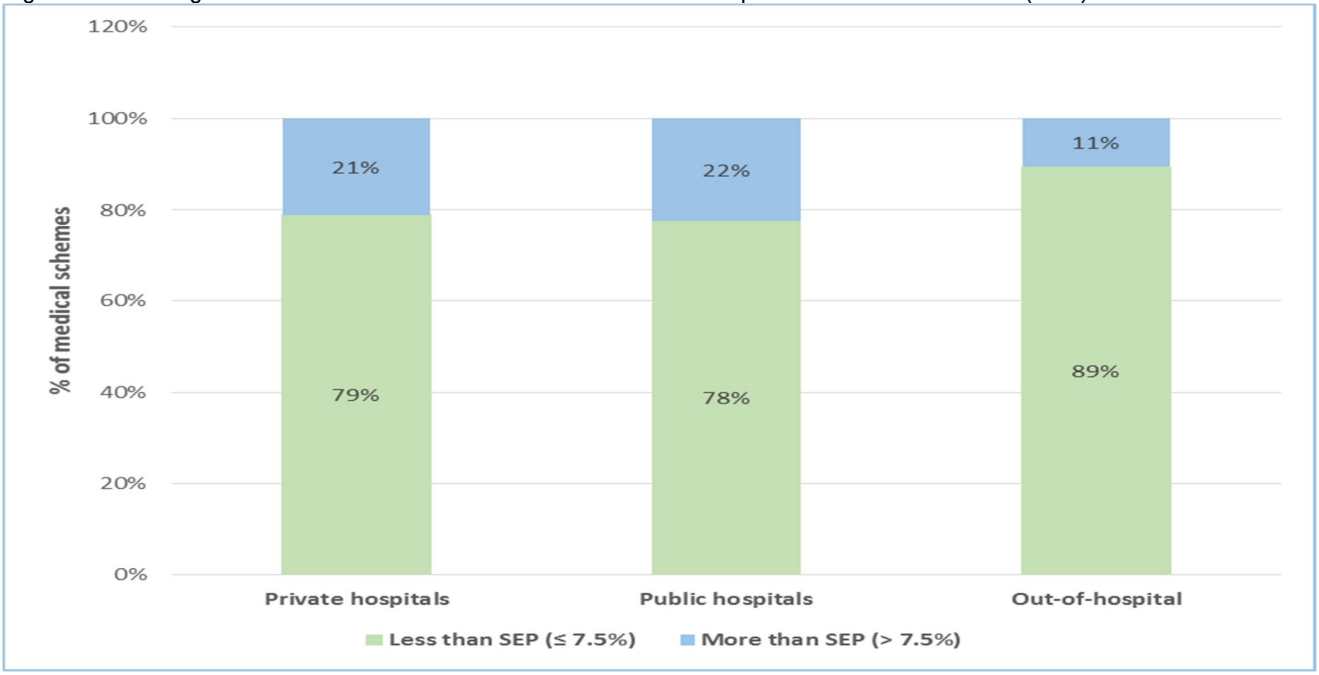
Private hospitals weighted tariff increase assumptions analysis by medical scheme size shows that for small medical schemes tariff increases ranged between 6.12% and 6.82% with an average of about 6.50%. Whilst medium medical schemes submitted tariff increase assumptions between 6.35% and 6.76% with the average of about 6.58% and large medical schemes had the highest tariff increase assumptions ranging between 6.02% and 7.56% with an average of about 6.89%. Very large medical schemes had the lowest tariff increases compared to all medical schemes implying that very large schemes continue to have competitive advantage on tariff negotiations even in absence of price regulation and the presence of other challenges within the demand and supply side of the market.

The weighted average assumed tariff increase for professional services ranged between 6.15% and 6.63%. The median assumed increase assumption for professional services cost items was 6.20%.

The average assumed tariff increase for medicines dispensed out-of-hospital was around 6.16% about 1.3 percentage point lower than the gazetted medicines Single Exit Price (SEP) increase for 2015 (7.5%). The 2015 SEP increase was not available at the time when these assumptions were made by medical schemes. Fifty percent of all medical schemes that submitted cost increase assumption data took a view that the tariff increase on out-of-hospital medicines will not be greater than 6.2%. This correlates with the view of CMS that tariff increase assumptions on medicines must not exceed 6.0%.

The percentage of medical schemes whose medicines assumed tariff increase were less than the SEP increase was about 79% for medicines dispensed in a hospital setting, and 89% for out-of-hospital medicines (Figure 2).

Figure 2: Percentage of schemes assumed medicines tariff increase compared to 2015 SEP increase (7.5%)



Some of the important aspects of the CMS includes monitoring costs incurred in running the medical schemes, which includes non-healthcare costs. The CMS is therefore responsible for ensuring that schemes attain a reasonably minimal level of non-healthcare costs in order to cater for the necessary costs of healthcare.

The weighted average assumed tariff increase in non-healthcare expenditure was about 5.87% with the median of 6.0%. About 25% of the schemes assumed an increase of above 6.50%. The impact of non-healthcare expenditure on the tariff increase was slightly different between open and restricted medical schemes. As shown in Table 3, the average assumed tariff increases were 5.42% and 6.43% for open and restricted medical schemes, respectively.

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

Type	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile
Open	23	5.42%	5.97%	6.00%	6.00%
Restricted	53	6.43%	5.80%	6.00%	6.50%
All schemes	76	5.87%	5.97%	6.00%	6.50%

The size of the scheme was found to be unrelated to the level at which non-healthcare expenditure has been assumed to increase. The assumed tariff increase in non-healthcare expenditure in the small sized medical schemes (6.05%) was higher than in the medium (3.78%) and large (5.98%) medical schemes (Table 4). Assumed tariff increases in non-healthcare expenditure for restricted medical schemes were higher for almost all medical scheme sizes as compared to open medical schemes.

Small sized medical schemes was the only category where the assumed tariff increase for non-healthcare expenditure in open (6.38%) medical schemes was higher than that of restricted (5.96%) medical schemes (Table 4). It is worth noting that more than 70% of small medical schemes are restricted medical schemes. The high level comparisons of non-healthcare assumed tariff increase need to be interpreted with caution since the scheme's risk profile, governance and other operating factors need to be considered.

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

Scheme size	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
						Open	Restricted
Small	32	6.05%	6.00%	6.00%	6.50%	6.38%	5.96%
Medium	24	3.78%	5.00%	6.00%	6.20%	0.51%	4.88%
Large	15	5.98%	6.00%	6.30%	6.60%	4.85%	7.73%
Very large	5	6.12%	5.97%	6.00%	6.00%	5.87%	6.49%
All schemes	76	5.87%	5.97%	6.00%	6.50%	5.42%	6.43%

*Small: < 15 000 beneficiaries; Medium: ≥ 15 000 but ≤ 65 000 beneficiaries; Large: > 65 000 but ≤ 220 000 beneficiaries; Very large > 220 000 beneficiaries

Scheme utilisation demographic increase assumptions for 2015

The weighted average assumed impact of utilisation and demographic changes on contribution increases across all medical schemes was 2.94%. The assumed impact of utilisation and demographic changes on contribution increases assumptions did not differ significantly between open medical schemes (3.12%) and restricted medical schemes (2.72%). About 22 medical schemes made assumptions of more than 3% in the impact of utilisation and demographic changes (Table 5).

Table 5: Summary of the utilisation & demographic assumptions incorporated into overall contribution increase for the 2015 financial year

Variable	Weighted average**	25th percentile	50th percentile	75th Percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	3.25%	1.00%	2.00%	3.00%	3.53%	2.90%
Theatre fees	3.15%	1.00%	2.00%	3.00%	3.35%	2.90%
Consumables	3.25%	1.00%	2.00%	3.00%	3.53%	2.90%
Medicines	3.25%	1.00%	2.00%	3.00%	3.53%	2.90%
Equipment	3.14%	0.60%	2.00%	2.96%	3.34%	2.89%
Procedure	3.14%	0.60%	2.00%	2.96%	3.34%	2.89%
Managed Care	2.86%	0.00%	1.50%	2.69%	3.18%	2.46%
Other	3.14%	0.60%	2.00%	2.96%	3.34%	2.89%
Public hospitals						
Ward fees	3.17%	0.62%	2.00%	3.00%	3.50%	2.76%
Theatre fees	3.07%	0.60%	2.00%	3.00%	3.32%	2.76%
Consumables	3.17%	0.62%	2.00%	3.00%	3.50%	2.76%
Medicines	3.17%	0.62%	2.00%	3.00%	3.49%	2.76%
Equipment	3.06%	0.00%	1.95%	2.96%	3.31%	2.75%
Procedure	3.06%	0.00%	1.95%	2.96%	3.31%	2.75%
Other	3.03%	0.00%	1.63%	2.96%	3.31%	2.67%
Professional services						
General practitioners	3.33%	0.50%	1.79%	2.96%	3.85%	2.69%
Specialists	3.24%	0.74%	1.96%	3.00%	3.59%	2.81%
Dentists	3.26%	0.00%	1.50%	2.96%	3.77%	2.61%
Allied	3.18%	0.00%	1.63%	2.90%	3.65%	2.60%
Other professional	3.44%	0.00%	1.50%	3.00%	3.60%	3.24%
Medicines out-of-hospital	3.82%	0.60%	1.50%	2.96%	4.70%	2.72%
Ex gratia payments	2.78%	0.00%	0.00%	1.63%	3.14%	2.34%
Out-of-hospital managed care	2.45%	0.00%	0.00%	1.00%	2.78%	2.05%
Non-healthcare expenditure	0.87%	0.00%	0.00%	0.00%	0.06%	1.88%
Overall weighted utilisation increase	2.94%	0.75%	1.79%	3.05%	3.12%	2.72%

** Note the rounding off effect when calculating the total contribution assumption increase. All values are rounded to two decimals.

Medical scheme total[1] increase assumptions for 2015

The weighted average total assumed increase for 2015 across all medical schemes was 9.20%, which is similar to the 2014 total cost assumption increase. The average total assumed increase for 75% of schemes was 9.51% or less. The summary statistics for the overall cost assumption changes are shown in Table 6.

[1] Due to rounding and weighting, tariff assumption increase and utilization tariff increase may not add up to the total cost assumption increase at level beyond one decimal.

Table 6: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2015 financial year

Variable	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	9.68%	8.43%	9.29%	10.50%	9.84%	9.48%
Theatre fees	9.46%	8.30%	9.28%	10.50%	9.44%	9.48%
Consumables	9.90%	8.30%	9.00%	10.50%	10.29%	9.42%
Medicines	9.35%	7.50%	9.00%	10.00%	9.34%	9.36%
Equipment	9.37%	8.00%	9.00%	10.30%	9.41%	9.31%
Procedure	9.36%	8.00%	9.10%	10.31%	9.41%	9.31%
Managed Care	8.80%	6.60%	8.74%	9.50%	8.87%	8.71%
Other	9.28%	7.86%	9.10%	10.27%	9.31%	9.24%
Public hospitals						
Ward fees	9.45%	7.86%	9.10%	10.50%	9.79%	9.02%
Theatre fees	9.23%	7.63%	9.00%	10.30%	9.39%	9.02%
Consumables	9.67%	7.50%	9.00%	10.50%	10.25%	8.96%
Medicines	9.20%	7.20%	8.86%	9.91%	9.43%	8.91%
Equipment	9.14%	7.20%	9.00%	10.17%	9.37%	8.86%
Procedure	9.14%	7.20%	9.00%	10.03%	9.36%	8.87%
Other	9.10%	7.00%	9.00%	10.00%	9.35%	8.80%
Professional services						
General practitioners	9.61%	7.00%	8.23%	9.53%	10.28%	8.77%
Specialists	9.68%	7.34%	8.50%	9.50%	10.31%	8.89%
Dentists	9.51%	6.77%	8.15%	9.14%	10.18%	8.67%
Allied health professionals	9.93%	6.60%	8.15%	9.10%	10.95%	8.65%
Other Professional	9.69%	6.79%	8.06%	9.34%	10.02%	9.29%
Medicines out-of-hospital	10.11%	7.00%	8.50%	9.60%	11.10%	8.87%
Ex gratia payments	8.19%	0.00%	6.20%	8.15%	8.35%	7.99%
Out-of-hospital managed care	8.95%	6.00%	6.60%	8.50%	9.16%	8.69%
Non-healthcare expenditure	6.74%	6.00%	6.00%	6.50%	5.47%	8.32%
Reserve loading	-0.05%	0.00%	0.00%	0.00%	0.06%	-0.18%
Total assumption increase	920%	6.89%	8.46%	9.51%	9.18%	9.11%

The 9.64% total contribution increase assumption by large medical schemes was the highest when medical schemes are stratified by size. Very large medical schemes assumed a slightly lower increase of 9.25%. The lowest assumed total contribution increase was assumed by medium medical schemes (7.70%) which is similar to the 2014 cost assumption increase. The overall assumed contribution increase in open medical schemes and restricted medical schemes was 9.18% and 9.11% respectively (Table 7). The high level comparisons of cost increase assumptions by medical scheme size and type need to be interpreted with caution since the scheme's risk profile, governance and other operating factors need to be considered.

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

Size of Scheme*	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
						Open	Restricted
Small	32	8.30%	5.96%	8.46%	8.93%	8.87%	8.14%
Medium	24	7.70%	6.98%	7.95%	8.94%	9.88%	6.96%
Large	15	9.64%	8.17%	9.33%	10.65%	9.60%	9.69%
Very large	5	9.25%	8.20%	8.37%	9.92%	9.01%	9.60%
All schemes	76	9.20%	6.89%	8.46%	9.51%	9.18%	9.11%

*Small: < 15 000 beneficiaries; Medium: ≥ 15 000 but ≤ 65 000 beneficiaries; Large: > 65 000 but ≤ 220 000 beneficiaries; Very large > 220 000 beneficiaries

Figure 3 below depicts that only ten medical schemes reported a contribution increase assumption of 6.0% or less. Most medical schemes (52) assumed an increase of between 6.0% and 10.0%. Fourteen medical schemes assumed an assumption increase greater than 10.0%. As noted in the previous year, size of medical scheme seems not to be related to cost increase assumptions, but it is worth noting that only one very large medical scheme assumed a contribution increase assumption lower than 6%.

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

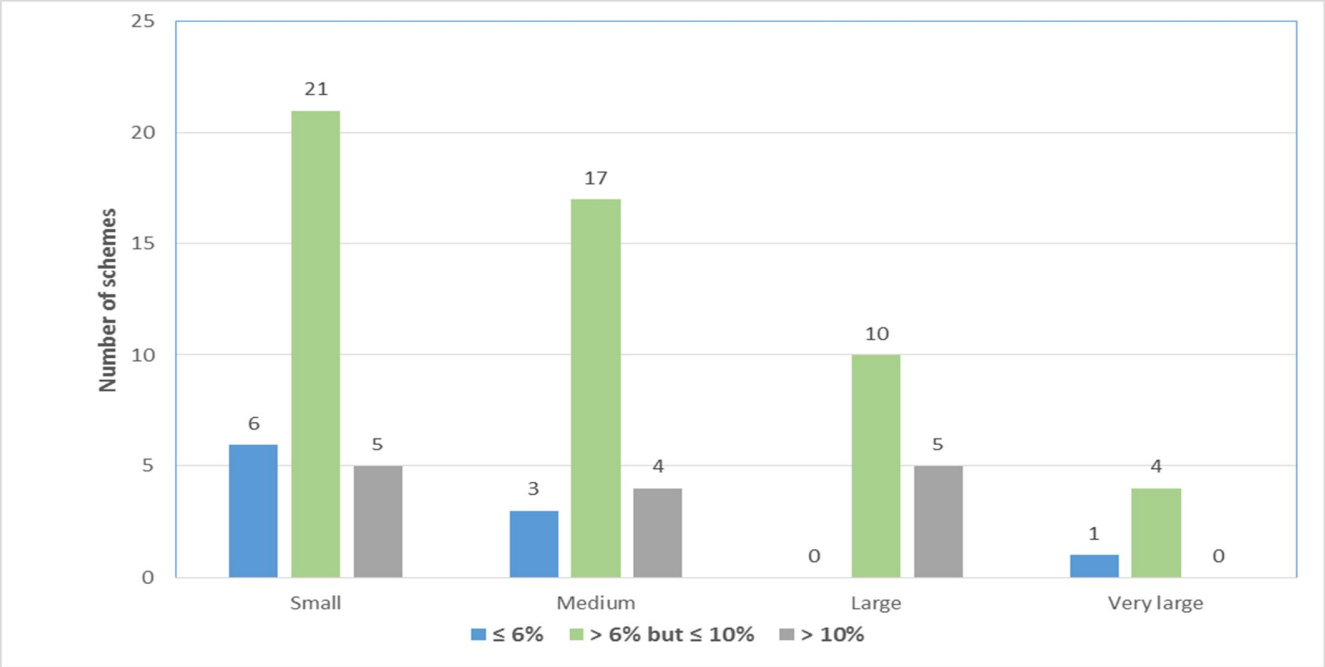


Figure 4 below displays a summary of the most important assumptions for cost items incorporated into the overall contribution assumption increase for the 2015 financial year. The assumed tariff increase assumption for most of the cost drivers are above 6.0%. The weighted average assumed effect of utilisation and demographic changes was between 2.0% and 3.8% for most cost drivers. The effect of utilisation on out-of-hospital managed care and non-healthcare costs was 2.45% and 0.87%, respectively.

Figure 4: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2015 financial year

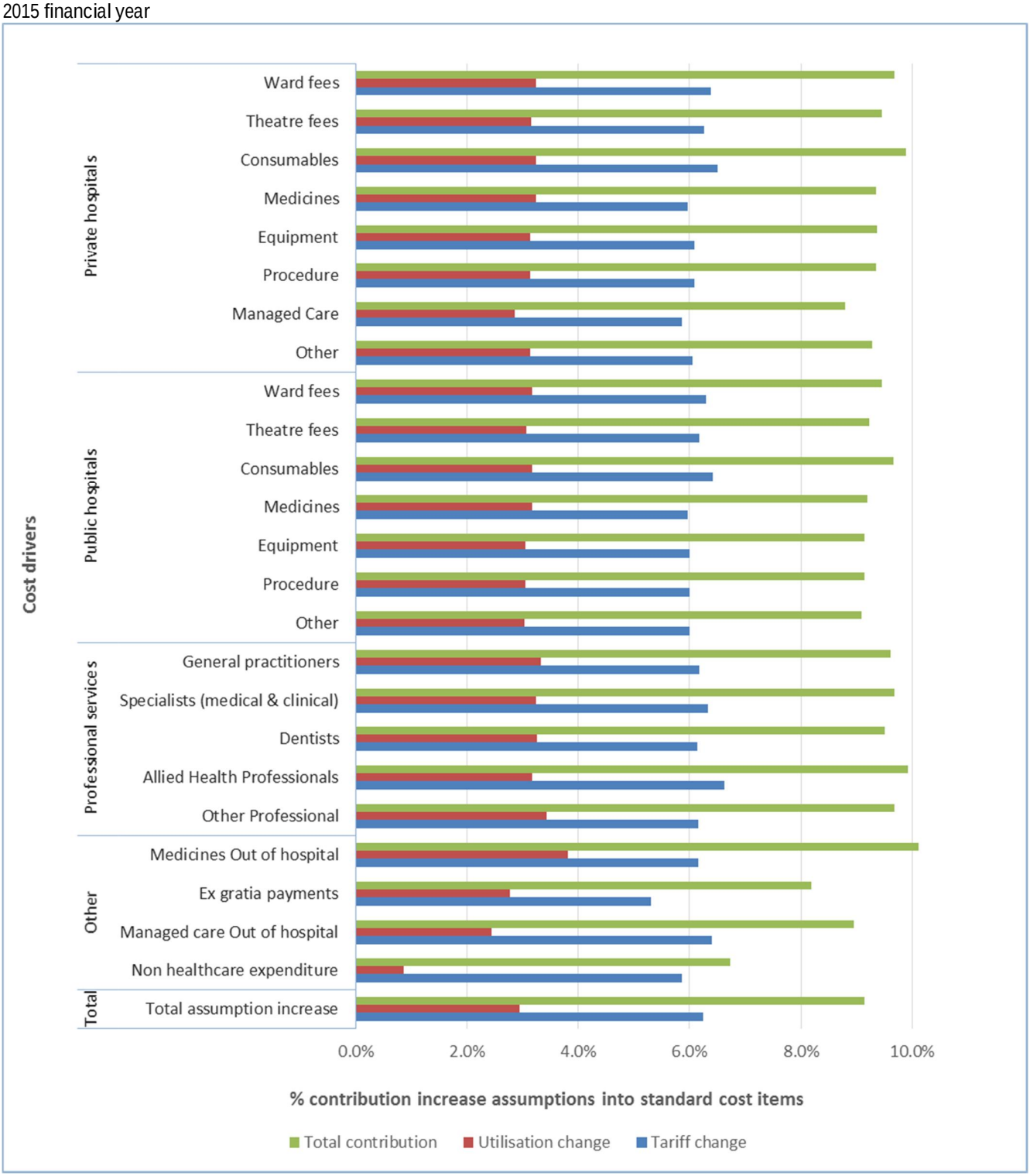


Table 8 below shows the difference between the total contribution increase assumptions made in 2014 and 2015 for the different cost drivers. The total contribution increase assumption made in 2015 was similar (9.20%) to the total contribution increase assumption made in 2014. The difference is negligible for most cost drivers.

The effect of managed care, in- and out-of-hospital, seems to be more significant in 2015 than in 2014. The assumed increase for in- and out-of-hospital managed care as a cost driver is 1.15 and 0.4 percent points higher in 2015.

Almost all cost assumption increases for private hospital cost items for 2015 were lower than 2014 assumptions. Managed care was the only cost item within private hospitals whose 2015 cost increase assumptions exceeds the 2014 cost increase assumptions.

All professional services cost items in 2015 reported slightly higher cost increase assumptions. A slight decrease was observed in medicines, with cost assumptions for 2015 decreasing by about 0.29 percentage points as compared to 2014 assumptions. This was despite the fact that the SEP was not available at the time of making these assumptions.

Table 8: Difference between the total contribution increase assumptions made in 2014 and 2015 for the different cost drivers

Variable	Weighted average		Percentage points difference
	2014	2015	
Private hospitals			
Ward fees	10.10%	9.68%	-0.42
Theatre fees	9.70%	9.46%	-0.24
Consumables	10.00%	9.90%	-0.10
Medicines	10.00%	9.35%	-0.65
Equipment	9.70%	9.37%	-0.33
Procedure	9.60%	9.36%	-0.24
Managed Care	8.40%	8.80%	0.40
Other	9.60%	9.28%	-0.32
Public hospitals			
Ward fees	9.40%	9.45%	0.05
Theatre fees	9.20%	9.23%	0.03
Consumables	9.30%	9.67%	0.37
Medicines	9.60%	9.20%	-0.40
Equipment	9.20%	9.14%	-0.06
Procedure	9.20%	9.14%	-0.06
Other	9.10%	9.10%	0.00
Professional services			
General practitioners	9.30%	9.61%	0.31
Specialists	9.10%	9.68%	0.58
Dentists	8.80%	9.51%	0.71
Allied health professionals	9.20%	9.93%	0.73
Other professional	8.70%	9.69%	0.99
Medicines out-of-hospital	10.40%	10.11%	-0.29
Ex gratia payments	8.00%	8.19%	0.19
Out-of-hospital managed care	7.80%	8.95%	1.15
Non-healthcare expenditure	6.10%	6.74%	0.64
Reserve loading	0.00%	-0.05%	-0.05
Total Assumption Increase	9.20%	9.20%	0.00

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

The private hospitals total cost increase assumptions is on average about 3 percentage points higher than the maximum cost increase assumption as per the Circular 34 guidance. The private hospital's average utilisation assumption of around 3% remain a concern 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. Some medical schemes highlighted that amongst other factors, high tariff increases are also caused by private provider market structure factors such as the fee-for service (FFS) reimbursement environment, and issues related to provider-induced demand, member moral hazard and poor coordination of care between different levels of care. This trend therefore implies that whilst very large medical schemes might be benefiting from economies of scale and their dominance within the medical schemes market other medical schemes are still price takers who are largely reimburse private providers through a fee-for-service method. However as noted earlier, the high level comparisons of hospitals cost increase assumptions by medical scheme size and type need to be interpreted with caution since the scheme's risk profile, governance and other operating factors need to be considered.

Furthermore, within a FFS system environment there is no constructive link between cost-effectiveness, quality health outcomes, in tariff negotiation and determination. Private hospital groups have become more powerful as they have consolidated, leading to diminished bargaining power for some schemes. Medical schemes are therefore encouraged to continue to undertake active steps to influence member health-seeking behaviour, cost effective management of clinical conditions and to constantly review the role of managed care organisations in managing health care costs whilst demonstrating quality health outcomes

Pharmaceutical costs assumptions within the hospitals decreased when compared to 2014 cost assumptions. Medicine pricing is assumed to increase by about 6.0% on average which is lower than the approved SEP increase of 7.5% for 2015. The effect of utilisation caused an increase of about 9.35% 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, 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 specialists continues to be one of the key cost drivers for healthcare costs. The weighted average cost increase assumption of 9.6% (tariff increase of 6.34%; utilisation component of 3.24%) for specialists is partly responsible for the larger than CPI increase in medical scheme contributions. In addition, specialist driven care with a limited role for

GP's is not cost effective and contributes greatly to private healthcare costs. 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 continue applying managed care principles in channelling patients to the appropriate level of care including influencing cost effective delivery of healthcare. Furthermore, medical schemes should strengthen care coordination within their preferred providers.

The out-of-hospital managed care assumed average cost increase of 7.80% in 2014 increased to 8.95% in 2015. 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-healthcare costs continue to vary considerably within the medical schemes industry with an average cost assumption increase of 6.74% compared to the average cost assumption increase of 6.10% in 2014. This increase represents about 0.64 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 34 of 2014. The reported weighted average assumed tariff increase for different cost drivers ranged between 5.31% and 6.63% with the overall weighted average assumed tariff increase being 6.25%.

However cost increase assumption for hospitals and specialists remain on average 3% higher than the maximum guideline provided by CMS. Cognisant of the demand side factors, the oligopolistic nature of the private hospital market, the specialist and hospital relationship in a fee for service market and information asymmetry is amongst factors responsible for the higher than CPI cost increase assumption. While very few large medical schemes might be benefiting marginally from economies of scale, medical schemes remain largely price takers in this market.

The impact of assumed utilisation changes, which was 2.94% remain a concern. The CMS has noted that utilisation estimates submitted as part of cost increase assumptions by some medical 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 2015. This is similar to the 2014 figure of 9.2%.

Managed care cost increase assumptions continue to outpace inflation year-on-year. Medical schemes must continue to seek and demonstrate value for managed care expenditure in the form of quality healthcare outcomes and cost containment. 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.

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