CIRCULAR

Reference:	Evaluation of contribution increase assumptions for 2016
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Date:	7 April 2016

CIRCULAR 26 OF 2016: EVALUATION OF COST INCREASE ASSUMPTIONS BY MEDICAL SCHEMES FOR 2016 FINANCIAL YEAR

Purpose

This Circular provides an evaluation of industry cost increase assumptions submitted by medical schemes for the 2016 financial year as provided in the benefit review submissions. The purpose of providing this information is to increase transparency of the schemes' pricing decisions.

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, 131 of 1998 (the Act) outlines legislative requirements informing how the CMS conducts its business with regards to benefit content configuration, as well as pricing of options:

Regulation 8 (1) of the Act 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."

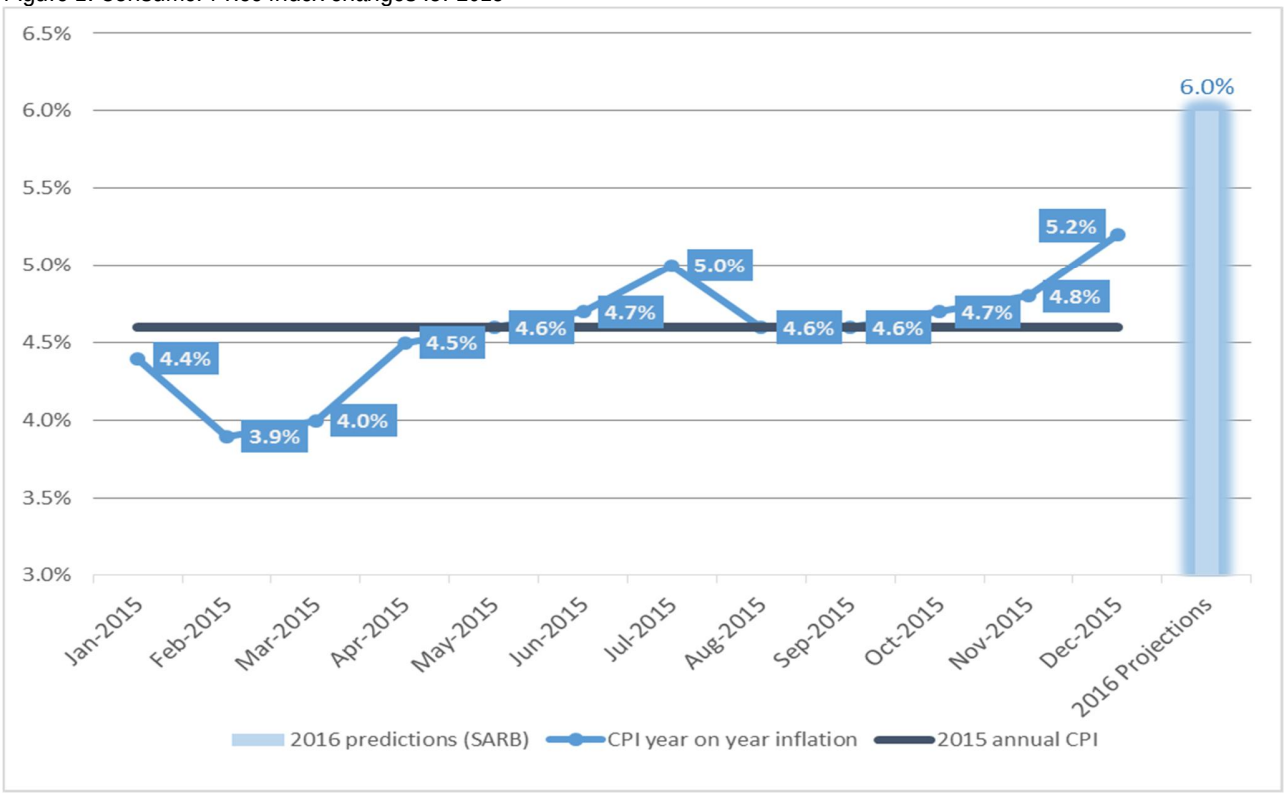
Overview

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.

Trends in economic indicators

The CMS published Circular 48 of 2015 advising medical schemes that cost increase assumptions for 2016 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 4.7% as at June 2015 (with the bi-annual average headline inflation of about 4.34%). The headline inflation for December 2015 was 5.2%, resulting in the annual average headline inflation for 2015 being at 4.6% (Figure 1). The 2016 annual average headline inflation is projected at 6.0% by the South African Reserve Bank (SARB MPC statement, November 2015).

Figure 1: Consumer Price Index changes for 2015



Slow economic growth remains a concern in South Africa. South Africa's economy continued to grow slower than anticipated with economic growth forecasts continuing to be revised downwards (National Treasury: MTBPS, 2015). Economic growth has been at levels below 2% in 2015 with quarter 3 of 2015 recording an economic growth rate of 0.7%. The projected economic growth rate for 2016 has also been revised downwards to 1.5% (SARB MPC statement, November 2015).

The unemployment rate in quarter 3 of 2015 was 25.5% (Quarterly Labour Force Survey: Q3, 2015). The labour force participation rate and the absorption rate remained slightly unchanged during 2015. According to the Quarterly Employment Survey (QES) in quarter 3 of 2015, formal sector employment did not change on year-on-year comparisons but increased by 0.1% on quarter-on-quarter comparisons. The average earnings paid to employees increased by 6.2% year-on-year (Quarterly Employment Survey: Q3, 2015). These factors highlight the pressure on the economy to translate economic growth into job creation.

The current fiscal pressure, coupled with a weaker than anticipated global economic recovery, might have a negative impact on medical schemes in general. South Africa's consumers are expected to remain constrained against the backdrop of slow employment growth, declining disposable income growth, and rising inflation (SARB MPC statement, September 2015). 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 increases 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 the 2016 benefit year. In the analysis, the CMS undertook a quantitative review of the 2014-2015 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 2015, 83 medical schemes submitted cost assumptions data with the submission of benefit changes and contribution increases for 2016. The data from the submissions were consolidated, verified and analysed. Data from 72 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 49 restricted medical schemes with 4 899 975 (57%) and 3 699 869 (43%) beneficiaries, respectively (Table 1 below).

The data from medical schemes' submissions that were found to be of adequate quality were weighted by medical scheme size (number of beneficiaries) in order to calculate weighted averages reported in this document.

Table 1: Medical Schemes size categories

Type of scheme	Size of scheme*	Number of schemes	Beneficiaries	Percentage of beneficiaries
Open	Small	6	66 959	1.37%
	Medium	6	205 110	4.19%
	Large	7	886 942	18.10%
	Very Large	4	3 740 964	76.35%
Total open		23	4 899 975	100.00%
Restricted	Small	24	200 044	5.41%
	Medium	17	519 536	14.04%
	Large	6	647 488	17.50%
	Very large	2	2 332 801	63.05%
Total restricted		49	3 699 869	100.00%
All schemes	Small	30	267 003	3.10%
	Medium	23	724 646	8.43%
	Large	13	1 534 430	17.84%
	Very large	6	6 073 765	70.63%
Total all schemes		72	8 599 844	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 2016

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 48 of 2015 that cost increase assumptions for the 2016 benefit year should be limited to 6.0% for each individual cost driver.

Table 2: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2016 financial year

Cost item	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	5.95%	6.00%	7.31%	7.50%	5.67%	6.32%
Theatre fees	5.95%	6.00%	7.31%	7.50%	5.67%	6.32%
Consumables	5.47%	6.00%	6.50%	7.50%	5.03%	6.06%
Medicines	5.41%	6.00%	6.00%	7.00%	4.88%	6.11%
Equipment	5.73%	6.00%	6.50%	7.50%	5.50%	6.02%
Procedure	5.76%	6.00%	6.50%	7.50%	5.56%	6.03%
Managed Care	6.91%	6.00%	6.50%	7.50%	5.09%	9.29%
Other	5.76%	6.00%	6.50%	7.50%	5.52%	6.09%
Public hospitals						
Ward fees	5.87%	6.00%	7.00%	7.50%	5.63%	6.18%
Theatre fees	5.87%	6.00%	6.58%	7.50%	5.63%	6.18%
Consumables	5.42%	6.00%	6.00%	7.41%	5.05%	5.91%
Medicines	5.36%	6.00%	6.00%	6.60%	4.90%	5.96%
Equipment	5.68%	6.00%	6.00%	7.50%	5.53%	5.88%
Procedure	5.67%	6.00%	6.00%	7.41%	5.52%	5.87%
Other	5.70%	6.00%	6.10%	7.50%	5.54%	5.91%
Professional services						
General practitioners	5.53%	5.50%	6.00%	6.10%	5.33%	5.79%
Medical specialists	5.53%	5.72%	6.00%	6.13%	5.52%	5.55%
Dentists	5.34%	5.50%	6.00%	6.00%	5.20%	5.52%
Dental Specialists	5.37%	5.72%	6.00%	6.10%	5.24%	5.54%
Allied	5.41%	5.75%	6.00%	6.00%	5.32%	5.52%
Other professional	5.42%	6.00%	6.00%	6.00%	5.32%	5.54%
Medicines out-of-hospital	5.76%	5.50%	6.00%	6.50%	5.59%	5.98%
Ex gratia payments	4.94%	5.00%	6.00%	6.00%	4.47%	5.56%
Out-of-hospital managed care	7.55%	5.75%	6.00%	6.50%	5.77%	9.90%
Non-healthcare expenditure	8.62%	5.86%	6.00%	6.10%	6.05%	12.00%
Overall weighted tariff assumption increase	5.77%	6.00%	6.39%	6.79%	5.59%	6.02%

The overall weighted tariff assumption increase for 2016 was 5.77%. The overall weighted tariff assumption increase were slightly different between open schemes (5.59%) and restricted schemes (6.02%).

The weighted average assumed tariff increase assumption for private hospitals ranged between 5.41% and 6.91%, whilst the median assumed increase assumption for cost items in private hospitals was between 6.00% and 7.31%. The median assumed increase assumption for cost items in public hospitals was almost similar to that of private hospitals and was between 6.00% and 7.00%. The weighted average assumed tariff increase for public hospitals was between 5.36% and 5.87%.

Private hospitals' weighted tariff increase assumptions analysis by medical scheme size shows that for small medical schemes, assumed tariff increases ranged between 6.28% and 7.02%, with an average of about 6.60%. Medium medical schemes submitted tariff increase assumptions ranging between 4.13% and 6.86%, with an average of about 6.31%. Large medical schemes continued to have the highest tariff increase assumptions ranging between 5.85% and 7.37%, with an average of about 6.85%. Very large medical schemes had the lowest assumed tariff increases (ranging from 4.91% to 7.54%, with an average of about 5.47%) compared to all other medical schemes. This implies that very large schemes continue to have competitive advantage when negotiating private hospitals' tariff increases, even in the absence of price regulation and other demand and supply side challenges.

The weighted average assumed tariff increase for professional services ranged between 5.34% and 5.54%. The median assumed increase assumption for professional services cost items was 6.00%.

The average assumed tariff increase for medicines dispensed out-of-hospital was around 5.76%, about 0.9 percentage point above the gazetted medicines Single Exit Price (SEP) increase for 2016 (4.8%). The 2016 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 6.0%. This correlates with the view of CMS that tariff increase assumptions on medicines must not exceed 6.0%.

Only two medical schemes assumed tariff increase less than the SEP increase for medicines dispensed in a hospital setting, and only one medical scheme assumed tariff increase less than the SEP increase for medicines dispensed out-of-hospital.

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 8.62%, with the median of 6.00%. About 25% of the schemes assumed an increase of above 6.10%. 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 6.05% and 12.00% for open and restricted medical schemes, respectively. Higher than inflation non-healthcare expenditure assumed tariff increase of 12.00% for restricted medical schemes was as a result of one very large restricted scheme increasing its head office expenses and also considering implementing new contracts for 2016, as well as contracting new managed care service providers (Table 3).

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

Type	Scheme count	Weighted average	25th percentile	50th percentile	75th percentile
Open	23	6.05%	6.00%	6.00%	6.85%
Restricted	49	12.00%	5.50%	6.00%	6.10%
All schemes	72	8.62%	5.86%	6.00%	6.10%

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 medium sized medical schemes (6.44%) was higher than in large (6.10%) medical schemes (Table 4).

Small sized medical schemes' assumed tariff increase for non-healthcare expenditure in open (5.96%) medical schemes was higher than that of restricted (4.71%) medical schemes (Table 4). It is worth noting that more than 70% of small medical schemes are restricted medical schemes. Higher than inflation non-healthcare expenditure assumed tariff increase of 15.57% for very large restricted medical schemes was as a result of one very large restricted scheme increasing its head office expenses and also considering implementing new contracts for 2016, as well as contracting new managed care service providers (Table 4).

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	Weighted average Restricted
Small	30	5.02%	5.52%	6.00%	6.05%	5.96%	4.71%
Medium	23	6.44%	6.00%	6.00%	6.00%	7.02%	6.22%
Large	13	6.10%	6.00%	6.50%	7.50%	6.00%	6.23%
Very large	6	9.68%	5.40%	5.95%	8.49%	6.01%	15.57%
All schemes	72	8.62%	5.86%	6.00%	6.10%	6.05%	12.00%

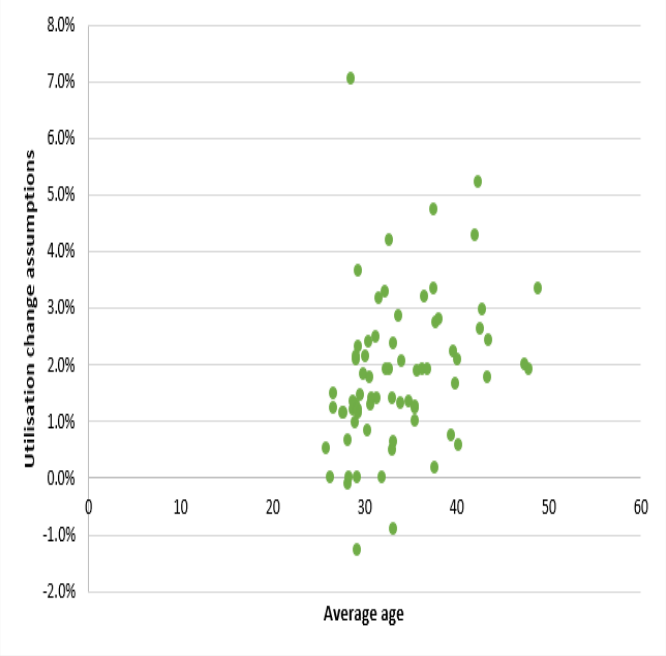
*Small: < 15 000 beneficiaries; Medium: ≥ 15 000 but ≤ 65 000 beneficiaries; Large: > 65 000 but ≤ 220 000 beneficiaries; Very large > 220 000 beneficiaries

Scheme utilisation demographic increase assumptions for 2015

The weighted average assumed impact of utilisation and demographic changes on contribution increases across all medical schemes was 3.05%. The assumed impact of utilisation and demographic changes on contribution increases assumptions did not differ significantly between open medical schemes (3.37%) and restricted medical schemes (2.62%). About 11 medical schemes made assumptions of more than 3% on the impact of utilisation and demographic changes (Table 5).

Figure 2 below indicates that utilisation estimates, submitted as part of cost increase assumptions by some medical schemes, do not strongly correlate with demographic and risk profiles of medical schemes. The correlation between utilisation demographic increase assumptions and average age was about 0.33, while correlation between utilisation demographic increase assumptions and schemes' community rate was about 0.36.

Figure 2: Correlations between utilisation demographic increase assumptions and Average age (and Community rate)



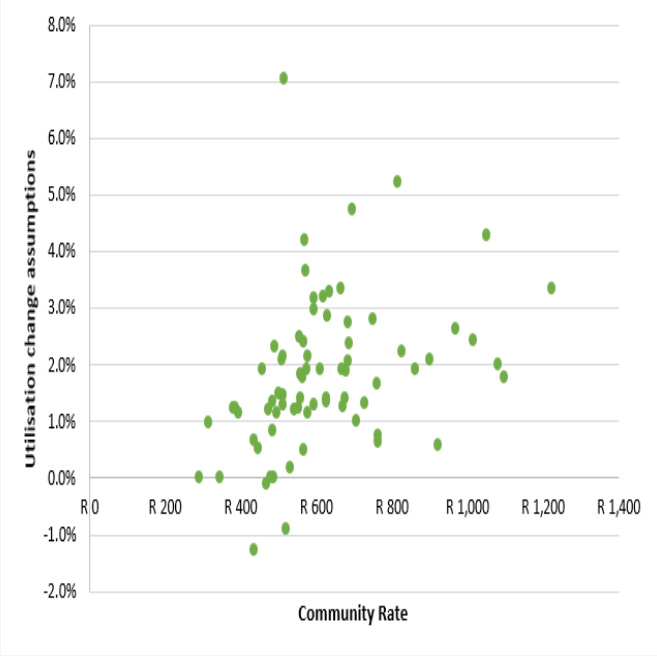


Figure 2 also indicates outliers in utilisation estimates, submitted as part of cost increase assumptions by some medical schemes. One small restricted medical scheme assumed utilisation increase above 7.00%. The medical scheme based the higher than 7% assumed utilisation increase on beneficiaries ageing and volatility in claims experienced by the scheme. About three restricted medical schemes assumed utilisation changes below 0%. These three medical schemes mainly based assumptions of negative utilisation impact on: expected decrease in average age; expected lower claims experience; and change in benefit options design (e.g. change in optical benefits from annual to once every two years).

Table 5: Summary of the utilisation & demographic assumptions incorporated into overall contribution increase for the 2016 financial year

Cost item	Weighted average	25th percentile	50th percentile	75th percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	3.43%	1.43%	2.00%	2.74%	3.86%	2.86%
Theatre fees	3.43%	1.43%	2.00%	2.74%	3.86%	2.86%
Consumables	3.43%	1.43%	2.00%	2.74%	3.86%	2.86%
Medicines	3.43%	1.32%	2.00%	2.67%	3.86%	2.86%
Equipment	3.42%	1.25%	2.00%	2.67%	3.86%	2.85%
Procedure	3.42%	1.25%	2.00%	2.67%	3.86%	2.85%
Managed Care	2.32%	0.00%	1.50%	2.19%	3.57%	0.68%
Other	3.42%	1.25%	2.00%	2.67%	3.86%	2.85%
Public hospitals						
Ward fees	3.32%	1.25%	2.00%	2.60%	3.78%	2.71%
Theatre fees	3.32%	1.25%	2.00%	2.60%	3.78%	2.71%
Consumables	3.32%	1.25%	2.00%	2.60%	3.78%	2.71%
Medicines	3.32%	1.00%	2.00%	2.60%	3.78%	2.71%
Equipment	3.31%	0.69%	1.90%	2.53%	3.78%	2.70%
Procedure	3.31%	0.69%	1.90%	2.53%	3.78%	2.70%
Other	3.27%	0.61%	1.63%	2.50%	3.78%	2.60%
Professional services						
General practitioners	3.49%	0.71%	1.85%	2.60%	4.12%	2.67%
Medical specialists	3.44%	1.22%	2.01%	2.74%	3.95%	2.77%
Dentists	3.31%	0.50%	1.50%	2.74%	3.88%	2.56%
Dental Specialists	3.40%	1.00%	1.85%	2.74%	3.94%	2.68%
Allied	3.32%	0.00%	1.50%	2.53%	3.93%	2.52%
Other professional	3.29%	0.00%	1.50%	2.60%	3.90%	2.50%
Medicines out-of-hospital	3.84%	1.13%	1.85%	2.63%	4.72%	2.69%
Ex gratia payments	2.98%	0.00%	0.00%	1.63%	3.50%	2.31%
Out-of-hospital managed care	0.54%	0.00%	0.00%	0.64%	0.78%	0.21%
Non-healthcare expenditure	0.09%	0.00%	0.00%	0.00%	0.11%	0.06%
Overall weighted utilisation assumption increase	3.05%	1.15%	1.66%	2.42%	3.37%	2.62%

Medical scheme total[1] increase assumptions for 2016

The weighted average total assumed increase for 2016 across all medical schemes was 8.82%, excluding the allowance for reserve loading by medical schemes. When allowing for reserve loading, the overall weighted average assumed increase for 2016 across all medical schemes was 8.67%, which is slightly lower than the 2015 total cost assumption increase. The average total assumed increase for 75% of schemes was 9.20% or less. The summary statistics for the overall cost assumption changes are displayed in Table 6.

[1] Due to rounding and weighting, tariff assumption increase and utilisation 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 2016 financial year

Cost item	Weighted average*	25th percentile	50th percentile	75th percentile	Weighted average	
					Open	Restricted
Private hospitals						
Ward fees	9.38%	9.13%	8.34%	10.00%	9.54%	9.18%
Theatre fees	9.38%	9.13%	8.34%	10.00%	9.54%	9.18%
Consumables	8.90%	8.94%	7.90%	9.78%	8.89%	8.91%
Medicines	8.84%	8.50%	7.50%	9.33%	8.74%	8.96%
Equipment	9.15%	9.00%	7.90%	9.78%	9.36%	8.87%
Procedure	9.19%	9.00%	8.00%	9.71%	9.43%	8.87%
Managed Care	9.23%	8.19%	6.59%	9.31%	8.66%	9.97%
Other	9.19%	9.00%	7.90%	9.84%	9.38%	8.93%
Public hospitals						
Ward fees	9.19%	9.00%	7.82%	9.96%	9.41%	8.89%
Theatre fees	9.19%	9.00%	7.82%	9.84%	9.41%	8.89%
Consumables	8.74%	8.73%	7.50%	9.50%	8.84%	8.62%
Medicines	8.68%	8.27%	7.43%	9.18%	8.69%	8.67%
Equipment	8.99%	8.53%	7.50%	9.54%	9.31%	8.58%
Procedure	8.98%	8.50%	7.50%	9.50%	9.30%	8.57%
Other	8.98%	8.50%	7.31%	9.50%	9.32%	8.52%
Professional services						
General practitioners	9.02%	7.90%	7.00%	8.94%	9.45%	8.46%
Medical specialists	8.97%	8.07%	7.43%	9.00%	9.47%	8.31%
Dentists	8.64%	7.75%	6.59%	8.73%	9.07%	8.08%
Dental Specialists	8.76%	7.90%	7.05%	8.75%	9.18%	8.22%
Allied	8.73%	7.63%	6.61%	8.60%	9.25%	8.04%
Other professional	8.71%	7.63%	6.59%	8.62%	9.22%	8.03%
Medicines out-of-hospital	9.60%	8.00%	7.25%	9.00%	10.31%	8.67%
Ex gratia payments	7.92%	6.00%	5.30%	8.00%	7.96%	7.86%
Out-of-hospital managed care	8.09%	6.10%	6.00%	7.50%	6.55%	10.12%
Non-healthcare expenditure	8.71%	6.00%	6.00%	6.85%	6.16%	12.06%
Reserve loading	-0.15%	0.00%	0.00%	0.00%	-0.35%	0.11%
Total assumption increase	8.67%	8.36%	7.08%	9.20%	8.61%	8.75%

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

The 8.83% 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 8.71%. The lowest assumed total contribution increase was assumed by small medical schemes (8.13%). The overall assumed contribution increase in open medical schemes and restricted medical schemes was 8.61% and 8.75%, 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	30	8.13%	6.86%	8.24%	9.11%	8.22%	8.10%
Medium	23	8.28%	7.20%	7.80%	8.90%	10.07%	7.60%
Large	13	8.83%	8.26%	8.90%	9.57%	8.76%	8.91%
Very large	6	8.71%	7.70%	8.72%	9.39%	8.51%	9.02%
All schemes	72	8.74%	7.08%	8.36%	9.20%	8.61%	8.75%

*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 nine medical schemes reported a contribution increase assumption of 6.0% or less. None of the open schemes reported a contribution increase assumption of 6.0% or less. Most medical schemes (54) assumed an increase of between 6.0% and 10.0%. Nine medical schemes assumed an assumption increase greater than 10.0%. As noted in the previous year, the size of a medical scheme seems not to be related to cost increase assumptions, but it is worth noting that none of the very large medical schemes assumed a contribution increase assumption lower than 6%.

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

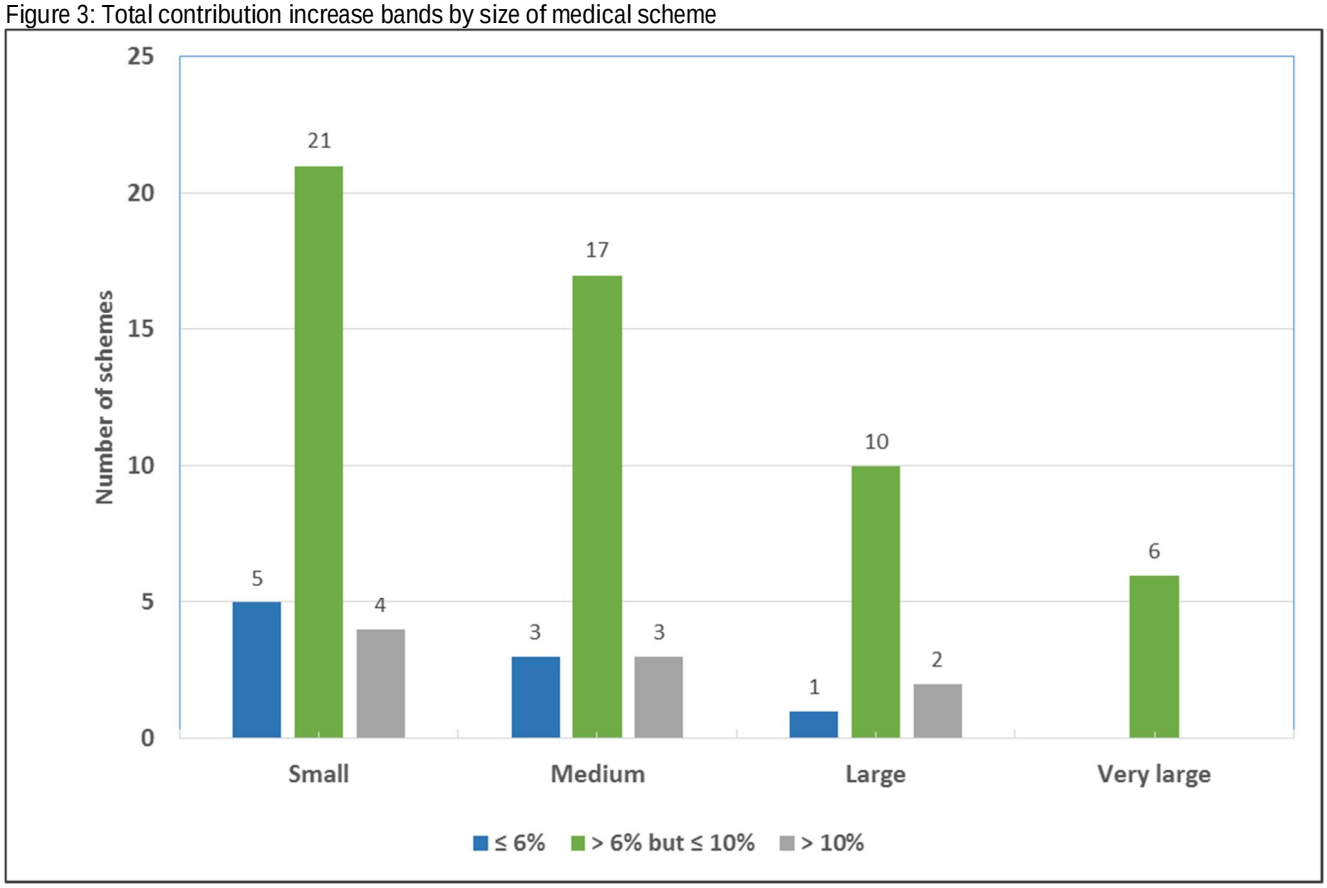


Figure 4 below, displays a summary of the most important assumptions for cost items incorporated into the overall contribution assumption increase for the 2016 financial year. The assumed tariff increase assumption for most of the cost drivers were below 6.0%. The weighted average assumed effect of utilisation 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 0.54% and 0.09%, respectively.

Figure 4: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2016 financial year

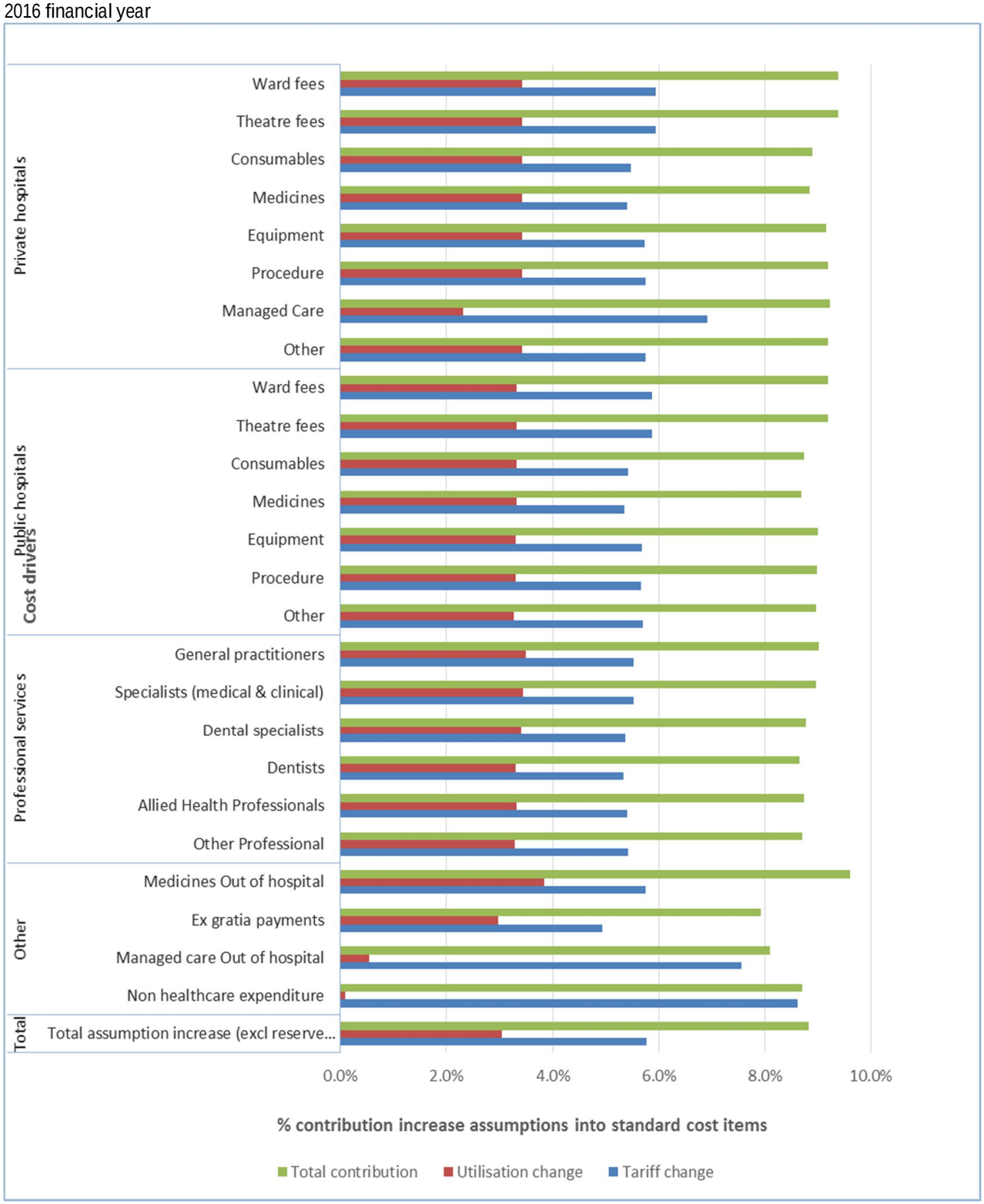


Table 8 below shows the difference between the total contribution increase assumptions made in 2015 and 2016 for the different cost drivers. The total contribution increase assumption (8.67%) made in 2016 was lower than the total contribution increase assumption made in 2015 (which was 9.20%) by 0.53 percentage points.

The effect of in-hospital managed care, seems to be more significant in 2016 than in 2015. The assumed increase for in-hospital managed care as a cost driver is 0.43 percent points higher in 2016.

Almost all cost assumption increases for private hospital cost items for 2016 were lower than 2015 assumptions. Managed care was the only cost item within private hospitals, which 2016 cost increase assumptions exceed the 2015 cost increase assumptions.

All professional services cost items in 2016 reported slightly lower cost increase assumptions. A slight decrease was also observed in medicines (out of hospitals), with cost assumptions for 2016 decreasing by about 0.51 percentage points compared to 2015 assumptions.

Table 8: Difference between the total contribution increase assumptions made in 2015 and 2016 for the different cost drivers

Variable	Weighted average		Percentage points difference
	2015	2016	
Private hospitals			
Ward fees	9.68%	9.38%	-0.30%
Theatre fees	9.46%	9.38%	-0.08%
Consumables	9.90%	8.90%	-1.00%
Medicines	9.35%	8.84%	-0.51%
Equipment	9.37%	9.15%	-0.22%
Procedure	9.36%	9.19%	-0.17%
Managed Care	8.80%	9.23%	0.43%
Other	9.28%	9.19%	-0.09%
Public hospitals			
Ward fees	9.45%	9.19%	-0.26%
Theatre fees	9.23%	9.19%	-0.04%
Consumables	9.67%	8.74%	-0.93%
Medicines	9.20%	8.68%	-0.52%
Equipment	9.14%	8.99%	-0.15%
Procedure	9.14%	8.98%	-0.16%
Other	9.10%	8.98%	-0.12%
Professional services			
General practitioners	9.61%	9.02%	-0.59%
Specialists	9.68%	-	-
Dentists	9.51%	8.64%	-0.87%
Allied health professionals	9.93%	8.73%	-1.20%
Other professional	9.69%	8.71%	-0.98%
Medicines out-of-hospital	10.11%	9.60%	-0.51%
Ex gratia payments	8.19%	7.92%	-0.27%
Out-of-hospital managed care	8.95%	8.09%	-0.86%
Non-healthcare expenditure	6.74%	8.71%	1.97%
Reserve loading	-0.05%	-0.15%	-0.10%
Total Assumption Increase	9.20%	8.67%	-0.53%

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 are on average about 3 percentage points higher than the maximum cost increase assumption as guided in Circular 48 of 2015. The private hospitals' average utilisation assumption of around 3% remains 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, since 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. Within this background it is implied that, whilst very large medical schemes might be benefiting from economies of scale and their dominance, other medical schemes are still price takers within a fee-for-service environment. However, as indicated afore, 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 and other operating factors need to be considered.

Private hospital groups have become more powerful due to consolidation over time, leading to diminished bargaining power for some schemes. Medical schemes are therefore encouraged to continue undertaking 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 healthcare costs, whilst demonstrating quality health outcomes. In an effort to contain hospitalisation costs, medical schemes are encouraged not to only monitor the number of hospital admissions and length of stay, but also to focus on the utilisation of services once beneficiaries are admitted. Failure to monitor utilisation of services may lead to a situation where the number of admissions and overall length of stay is low, but the overall costs of hospitalisation are high.

Pharmaceutical costs assumptions within the hospitals decreased when compared to 2015 cost assumptions. Medicine pricing is assumed to increase by about 5.41% on average, which is higher than the approved SEP increase of 4.8% for 2016. The effect of utilisation caused an increase of about 8.84% on the average cost of medicines in private hospitals. Although 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 of healthcare costs. The weighted average cost increase assumption of 8.97% (tariff increase of 5.53%; utilisation component of 3.44%) for medical and clinical specialists is partly responsible for the larger than CPI increase in medical scheme contributions. In addition, specialist driven care with

a limited role for GPs is not cost effective and contributes to a large extent 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. Although the challenges encountered by medical schemes in influencing the entire continuum of care is acknowledged, 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 8.95% in 2015 decreased to 8.09% in 2016. It is acknowledged that there are several factors influencing managed healthcare expenditure within the medical schemes industry, but medical schemes are encouraged to continue undertaking active steps to influence member health-seeking behaviour, as well as the care-providing behaviour of doctors and other health professionals, while at the same time 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 8.71% compared to the average cost assumption increase of 6.74% in 2015. This increase represents about 1.97 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, in order to identify any suboptimal administrative operations and processes. Improved administrative efficiency has a potential to free up 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's funds are not spent on goods and services not involving medical services.

Conclusion

It is encouraging to observe that the assumed tariff increase assumption for many schemes is now closer to the advised tariff increase assumption of 6% provided in Circular 48 of 2015. The reported weighted average assumed tariff increase for different cost drivers ranged between 4.94% and 8.62%, with the overall weighted average assumed tariff increase being 5.77%.

The impact of assumed utilisation changes, which was 3.05%, 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 profiles 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 8.67% for 2016. This is lower than the 2015 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 in addressing cost factors, will lead to a continued affordability challenge in accessing healthcare, thereby threatening the long term sustainability of the industry, since members are price sensitive. Furthermore, in an effort to contain hospitalisation costs, medical schemes are encouraged to not only monitor the number of hospital admissions and length of stay, but also to focus on the utilisation of services, once beneficiaries are admitted. Failure to monitor utilisation of services may lead to a scenario where the number of admissions and overall length of stay may below, but the overall cost of hospitalisation is high.

High input costs continue to be one of the barriers to entry for new members and will cause further challenges to future growth in the industry.

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