CIRCULAR

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Circular 43 of 2014: Utilisation statistics in the Annual Report 2013/14

Submission of questionable data relating to Part 3.1 of the Annual Statutory Return by some medical schemes

At the recent launch of the Council for Medical Schemes (CMS) Annual Report, it was highlighted that the increase for private hospital expenditure was surprisingly low. The total amount paid per average beneficiary per annum increased by only 3.1% from year to year. During the roadshows, it was highlighted that the CMS was not comfortable with the data and would like to believe that the low increase was possibly as a result of managed care interventions.

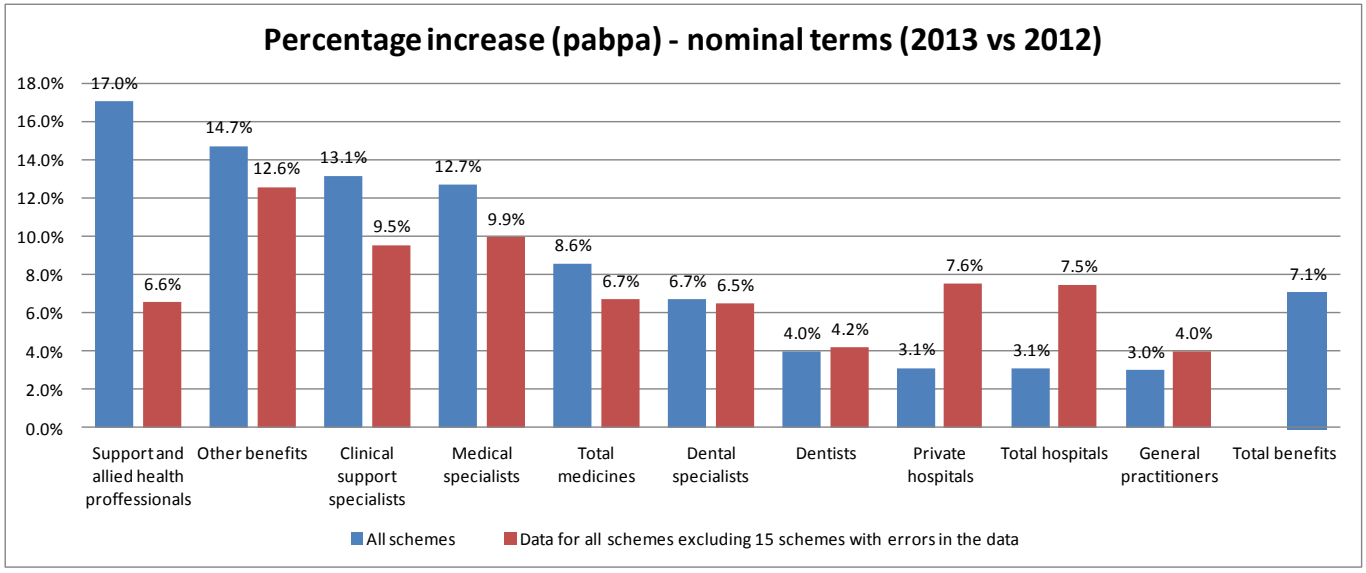
However, following further investigation by the Research and Monitoring unit, CMS subsequently became aware that inaccurate data from at least fifteen medical schemes was included in the analysis by CMS. The data relates to Part 3.1 (Analysis of benefits actually paid during the financial year) in the Annual Statutory Returns. After their initial submission, well before the publishing of the Annual Report, all schemes with anomalies in their data were engaged and informed that their data was questionable; and were required to explain the abnormalities in their submissions and, if necessary, to resubmit their data.

Two of these fifteen medical schemes with anomalies in their data are large schemes. One of the two large schemes resubmitted their data while the other scheme confirmed that their initial data submission was correct. Both schemes provided CMS with written confirmation that their data on the CMS system was accurate before CMS started with the analysis for the Annual Report. Unfortunately, this was later found not to be the case. One of these large schemes confirmed to CMS on 15 September 2014 that their data submission was flawed, and subsequently apologised to CMS. The fifteen schemes cut across different administrators and together represent just over 1 000 000 lives.

The proportional distribution changes were found to be insignificant when the fifteen schemes were excluded from the data set. However, some significant changes were observed for the average amount per beneficiary per annum (pabpa) paid to various disciplines : private hospitals increased from 3.1% to 7.6%, medical specialists' decreased from 12.7% to 9.9%;

support and allied health professionals decreased from 17% to 6.6%, general practitioners increased from 3% to 4% and medicines pabpa decreased from 8.6% to 6.7%. See figure 1 below.

Figure 1: Percentage increase of total healthcare benefits paid per discipline (used in presentations at roadshows)



The incorrect data submitted by these schemes also points to the shortcomings of the current outdated Annual Statutory Return system (ASR) used to collect the utilisation data. This system was not designed to collect data for research purposes. The CMS is currently in the process of designing a new system to collect utilisation data, which we intend rolling out for the 2014/15 financial year. The CMS has appointed *Insight Actuaries and Consultants* (formally known as The Health Monitor Company) to assist with the data specification for the anticipated new data collection system.

Data specification and new reporting platform

Historically, several utilisation measures have been poorly defined and/or open to interpretation in respect of utilisation indicators included in the ASR. As a result, several inconsistencies exist in the approaches adopted by medical schemes and/or administrators when these returns are populated. The new data specification published recently is open for public comment. All role players are encouraged to work with the CMS to finalise the data specification document on or before the 20th of October 2014, following which the development of the Information Technology (IT) system will commence. The proposed new system will not require schemes and administrators to manually type in data in the text fields as the collection of the data will be through web services technology which will hopefully limit typing errors by scheme users. Furthermore, the improved definitions ought to enhance the consistency and data quality in general. Once the data specification document is finalised, the industry will be informed of the technical specifications of the new system.

The fifteen schemes could be requested to resubmit their data. However, at this stage, the CMS is investing time and energy in the development of the new system. The CMS would like to caution the industry on the careful use of these statistics on the percentage increases per beneficiary per annum per discipline. The statistics without the fifteen schemes is probably closer to what the real industry averages should be.

The sections affected in the annual report are:

- Annexures G, H and I
- Chapter 2, Healthcare benefits, pages 150 to 154

Appointment of a Data Officer at scheme level

The utilisation data is complex and not all principal officers have the time and expertise to work through their schemes' data submissions before they sign-off the data. We request that all principal officers submit the name of a Data Officer (actuary, data manager, statistician, etc.) to CMS before 20 October 2014. Such a person could be an employee of the scheme or an administrator and must have a proper understanding of the utilisation data of the medical scheme. This said person will not only liaise with the principal officer, but also with CMS, specifically in the event of technical data discussions.

Conclusion

The CMS will ensure more vigorous and robust testing of such data in future. However, the responsibility of submitting accurate data which the regulator, industry and other stakeholders can rely upon rests squarely with the schemes and is one that should be taken seriously. In future, the CMS will also engage with hospital groupings to verify admissions data received from schemes in an attempt to improve the data quality and statistics reported upon in the annual report.

The CMS apologises for any inconvenience that this unfortunate event may have caused the industry.

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