CIRCULAR 54 of 2011

Reference	:	Evaluation of contribution increase assumptions for 2012
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Evaluation of cost increase assumptions by medical schemes for the 2012 financial year

Purpose

This circular provides an evaluation of industry assumptions submitted by medical schemes for the 2012 financial year as provided in the benefit adjustment submissions. The purpose of providing this information is to increase transparency of scheme's pricing decisions and to increase the quality of provider negotiations.

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

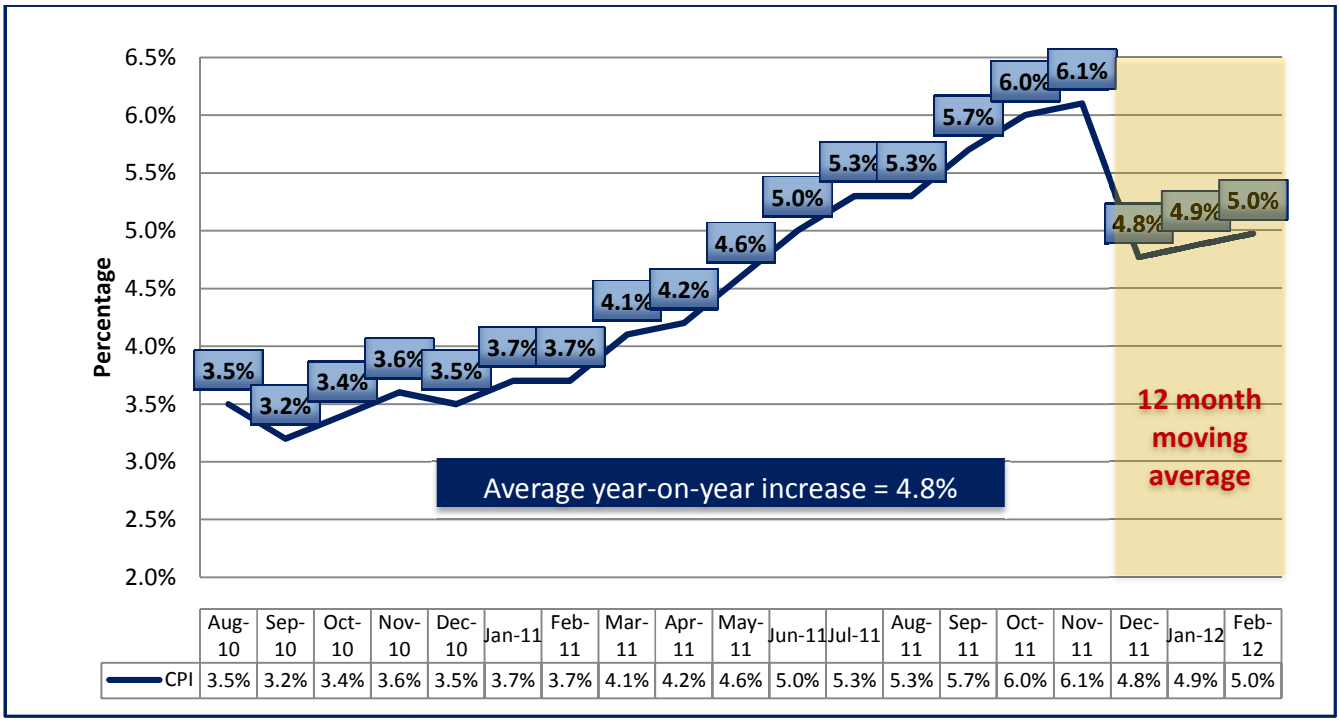
Overview

The analysis provided in this circular unpacks contribution increase assumptions into standard cost items stratified by facility type, professional services, medicine costs, non-health care costs, managed care arrangements and ex gratia payments.

Consumer Price Index changes for 2011

As illustrated in figure 1 below, average 12-month moving average increase for 2011 based on CPI releases from Statistics South Africa between January and November 2011 is 4.8%, whilst headline CPI inflation projection by the National Treasury for 2012/2013 is estimated at 5.3% (Economic Policy and Outlook). Whilst acknowledging the recently published November CPI of 6.1%, CMS maintains that reasonable weighted contribution increase assumptions in medical schemes for 2012 should range between 4.3% and 5.3%.

Figure 1: Consumer Price Index changes for 2011



	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12
CPI	3.5%	3.2%	3.4%	3.6%	3.5%	3.7%	3.7%	4.1%	4.2%	4.6%	5.0%	5.3%	5.3%	5.7%	6.0%	6.1%	4.8%	4.9%	5.0%

Source: Actual data is based on the routine CPI publications of Statistics South Africa

Contribution increases in excess of CPI tend to create affordability challenges for beneficiaries. And over the past years, CMS has observed positive correlation between contribution increase and downward migration of beneficiaries to cheaper benefit options or deregistration of dependants regardless of member's health status. Young and healthier beneficiaries tend to be highly sensitive to price changes therefore more prone to buying down or deregistering their membership than old and sick members. This behaviour contradicts the key principle of community rating envisaged in the Medicals Schemes Act.

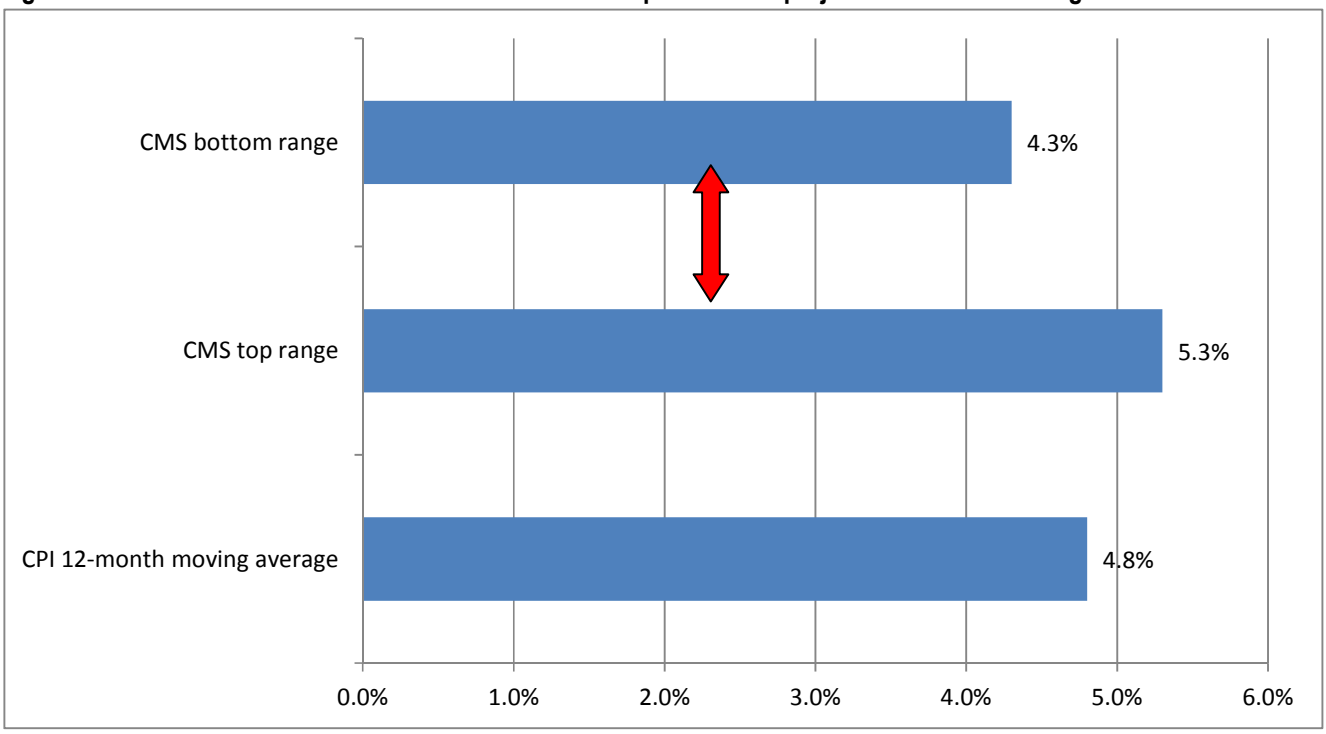
Council for Medical Schemes contribution increase Guidance Note

The recommended contribution increase assumption range of 4.3% and 5.3% as published in circular 29 of 2011 was based on a review of key economic and demographic indicators which lead CMS to conclude the following with regards to utilization and the cost of private health care:-

- Changes in the demographic profile as well as diagnostic technologies were viewed to be minimal or negligible, especially if medical schemes continue to manage utilisation of health care services by beneficiaries cost effectively.
- Between 2010 -2011 average age of beneficiaries is reported as 31.5 compared to 31.6 in 2009.
- The Pricing committee pronounced that the Single Exit Price for 2012 should range between 0% and just below 2.9%.
- Expected increase in administration expenditure to be within 4.3% and 5.3% since the population covered has remained relatively stable.

Based on these indicators and expected utilisation changes, it is expected that increases in costs and contribution rates as submitted by the medical schemes should fall within the recommended range.

Figure 2: Guidance on contribution Increase for 2012 compared to the projected 12-month average for 2011



Industry cost assumptions data

This section provides an outline of the cost assumption data submitted by medical schemes for the 2012 financial year.

- Data presented in this analysis represent 87 medical schemes and the number of lives covered by these schemes is 8 346 128.
- 10 schemes amalgamated and/or liquidated.
- 7 medical schemes submit their contribution increases midyear.

Medical Scheme contribution increase evaluation

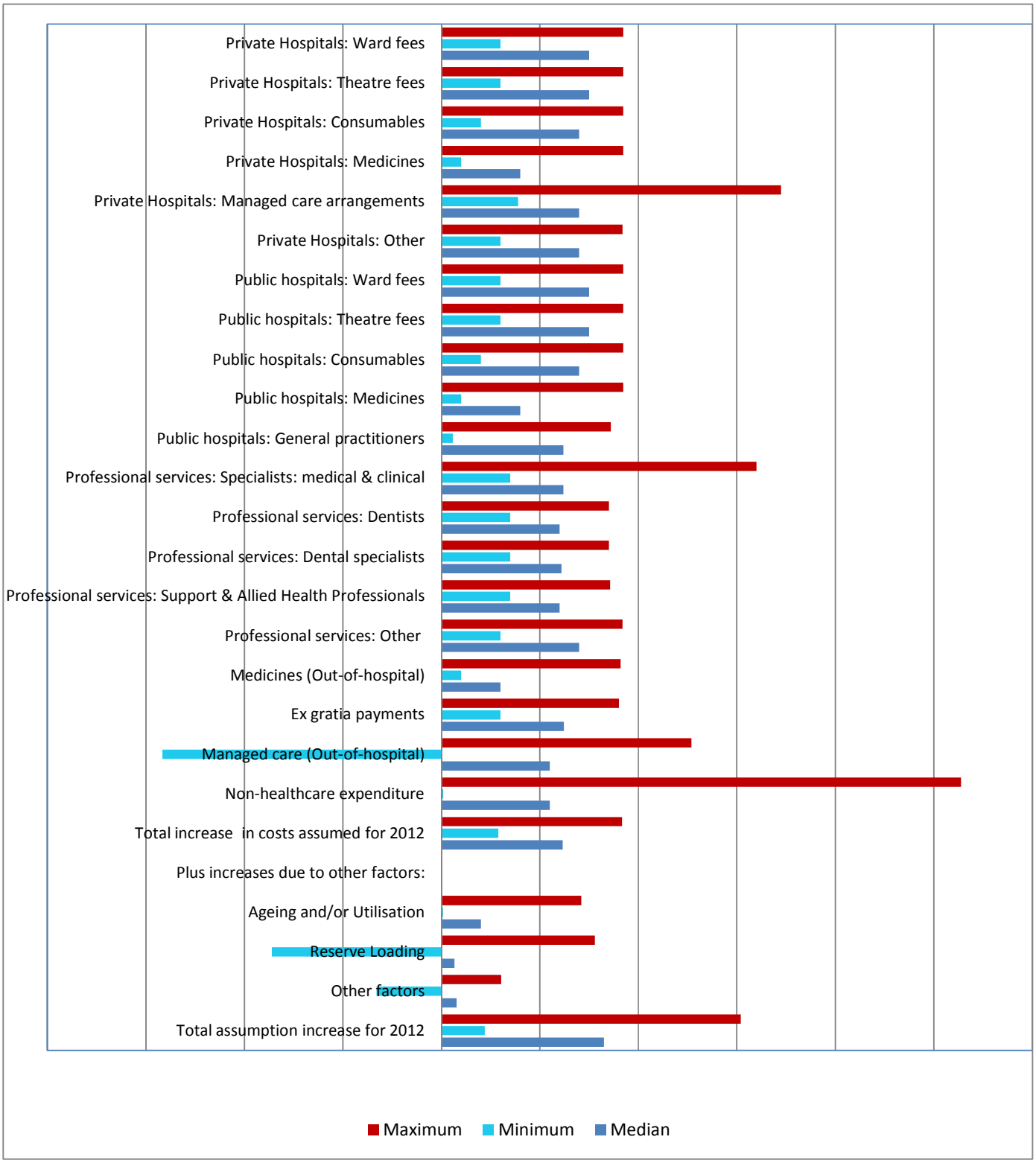
Table 1 below provides a summary of responses from medical schemes on the assumptions used to justify contribution increase for 2012. Figure 4 provides a graphical representation of cost increase assumptions as shown in Table 1. As can be noted, the overall results presented in this circular demonstrate a wide distribution of total increase assumptions with a median of 8.2% and the highest projected increase of 15.2% (see figure 4 below).

The five largest contributors to the overall increase include:-

- Private hospitals (ward fees, theatre fees, consumables, medicine, ,managed health care & other)
- Specialists (medical and clinical)
- General practitioners
- Dental specialists
- Support and Allied Health Professionals

These cost items contribute significantly to the rising costs in medical schemes environment. Access to healthcare is being eroded by such cost increases which have for some time exceeded not only CPI but also income growth. As a consequence this trend creates an affordability barrier to private health care.

Figure 3: Summary of the most important assumptions for cost items incorporated into the overall contribution increase for the 2012 financial year



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

- As was the case in 2011, cost assumptions for private hospitals are still above CPI across all components with the maximum cost assumption increase of 9.2% and in-hospital managed care arrangements as high as 17.2%. This trend cannot be justified nor explained by ageing population, burden of disease or progression of the HIV pandemic and improvements in medical technology. Also as hospital groups do not vary their cost structure by scheme, no other rational explanation for this variation can be discerned other than an exercise of excessive market power. Therefore failure to address this trend will lead to a continued deterioration in access to healthcare within the medical schemes industry.
- Similar to private hospitals, cost increases for medical specialists were expected to be closer to CPI because of insignificant changes in the demographic indicators. The median increase of 6.1% as well as the high projection of 16.0% cannot be rationally explained but might be attributed to market failures inherent within the private health care market (i.e. power imbalance between schemes and specialists when negotiating tariffs, conflict of interest influenced by ownership links, shares within hospitals and other inducements as well as tension between maximizing profit /public good/ patient benefit).
- Even though the median assumed increase of 3.0% of out-of-hospital medicine costs is within the recommended CPI range of 4.3% and 5.3% it is important to state that the highest range of 9.1% is unjustifiable considering the recent recommendation by the Pricing Committee that medicine prices for 2012 should be limited to 0% and < 2.9%.
- Out-of-hospital managed care arrangements also vary significantly with a median assumed increase of 5.5% and a maximum projected increase of 12.7%. As was indicated in 2011, these projections are still above CPI and this trend might reflect that managed care arrangements are still largely reimbursed through fee-for-service with minimal or no cost saving by the scheme. It is therefore recommended that medical schemes should evaluate these programs to ensure cost effectiveness in utilization management as well as value for money for beneficiaries. The large decrease in the assumption relates to a particular scheme restructuring its benefit offering the requirements in terms of these arrangements.
- Non-health care cost assumptions also vary significantly across all medical schemes with the highest cost assumption at 26.4% which is twice as high compared to the 2011 projections. This is a worrying trend since CMS expected increase in non-health care costs to be within the CPI range since the population covered has remained relatively stable ranging between 1.1% and just below 3.1%.
- The negative cost assumptions observed in Figure 3 for reserve loading and other demonstrate the reliance that schemes have on the reserves on the scheme to reduce the extent of the increases in costs from 2011 to 2012 that are passed on to the member of the schemes. This is in particular applicable to restricted schemes

that have solvency levels that are at a multiple of the minimum required level of 25%. The Boards of Trustees of these schemes have applied themselves to determining the target solvency level appropriate to the particular circumstances of the scheme and have used the excess reserving to cushion increases to members. This practice will continue until the boards are satisfied that a particular target solvency level has been attained and that the increase proposed going forward will ensure that the contributions remain affordable and the scheme remains sustainable.

Assumption increase analysis

This section describes and unpacks the distribution of total costs increases as compared to the recommended CPI range of 4.3 % and 5.3%. Figure 4 below shows the range of contribution increases for 2012, the lowest being 2.2% and the highest 15.2%.

Figure 4: Range of contribution increases expected based on medical scheme submissions for the 2012 financial year

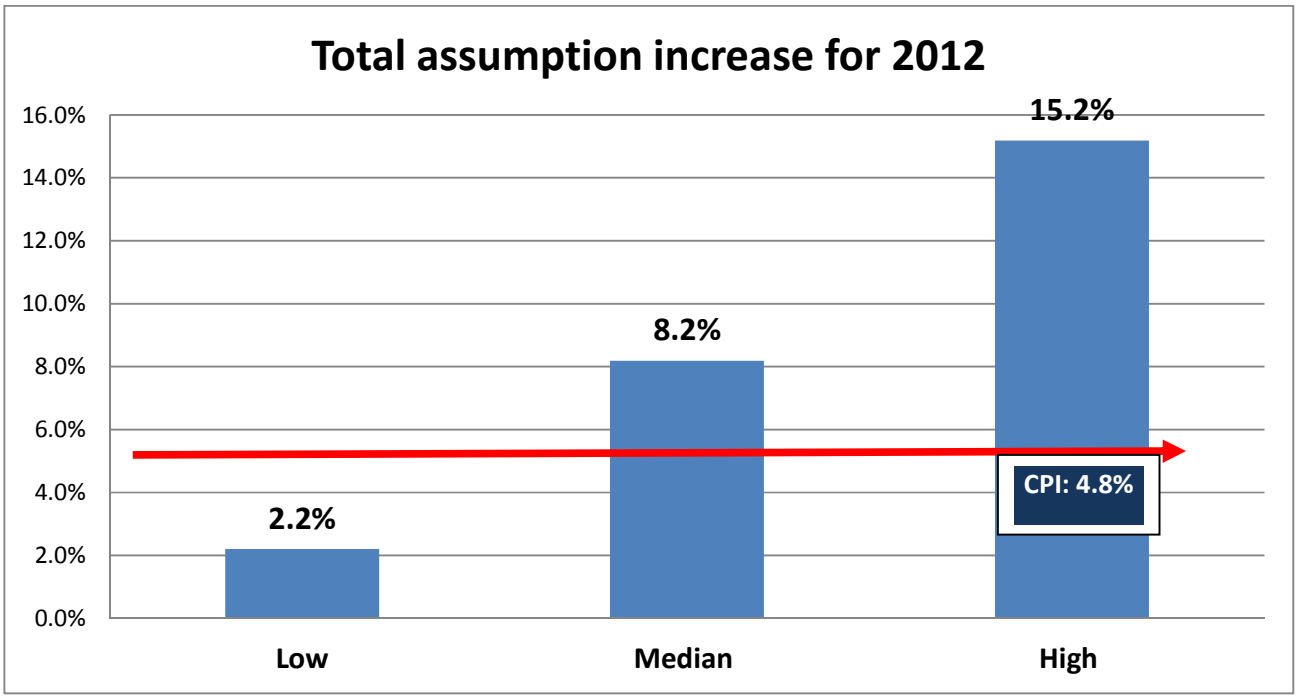


Figure 5: Proportion of lives affected by the assumed increase in costs before & after the allowance for ageing/utilisation and other effects for 2012

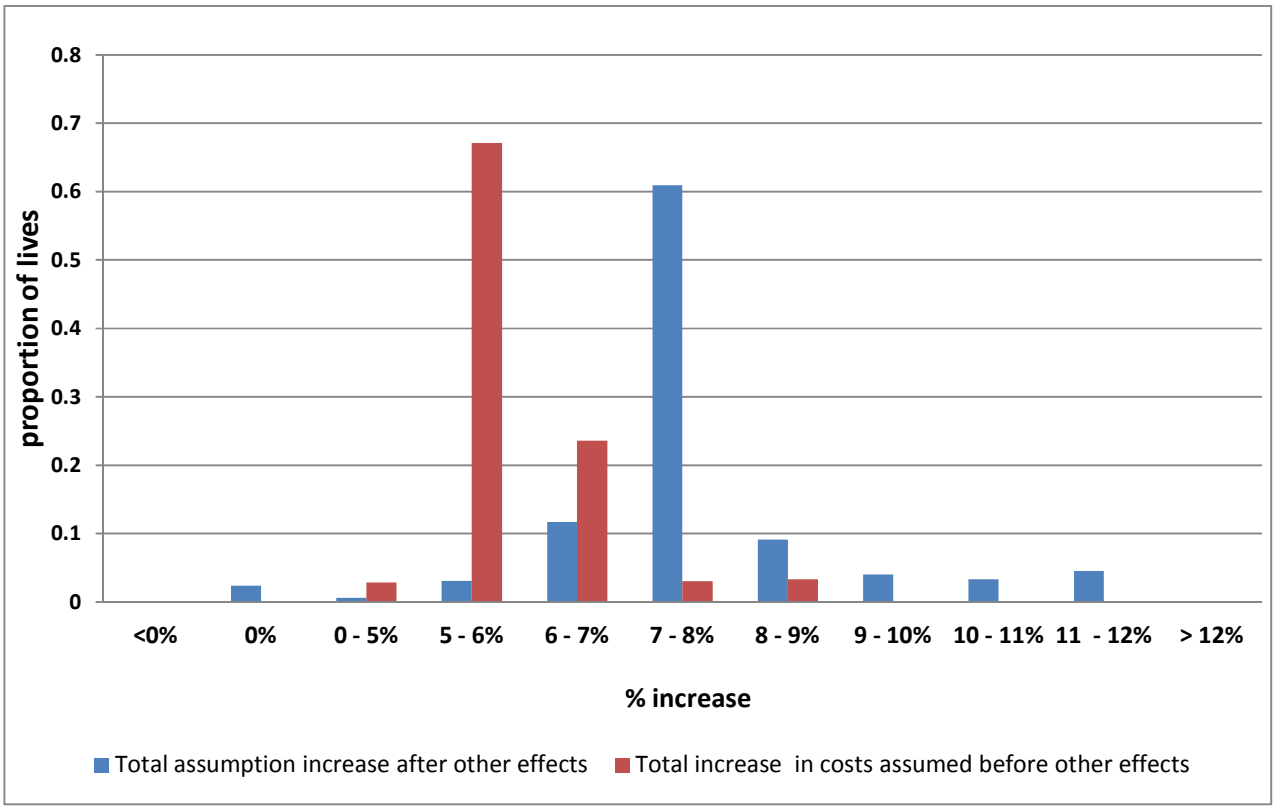


Figure 5 above shows a distribution of total increase in costs before and after the inclusion of the effects of ageing, reserve loading and other factors (which are scheme specific). The figure demonstrates that increases in costs assumed (before the other factors are incorporated) lie mainly between 5% - 6% as this represents schemes with 67.1% of the lives. It also shows that after inclusion of other factors, that increases range between 7% - 8% for the majority (61.0% of the lives). It is important to note that the 15.2% increase in contributions applies to a relatively small proportion of the lives observed i.e. increases above 12% represent 4.5% of the lives analysed after the inclusion of other factors, and represents a scheme that is in the process of complying with the requirement of the Act and its regulations.

Table 1: Distribution of medical scheme cost assumptions used in determining their proposed contribution increase for 2012 (the data of 87 schemes was used)

	Median Assumed increase for 2012	Minimum observed from data	Maximum observed from data	Minimum recommended by CMS	Maximum recommended by CMS
Private hospitals					
Ward fees	7.5%	3.0%	9.2%	3.9%	4.9%
Theatre fees	7.5%	3.0%	9.2%	3.9%	4.9%
Consumables	7.0%	2.0%	9.2%	3.9%	4.9%
Medicines	4.0%	1.0%	9.2%	3.9%	4.9%
Managed care arrangements	7.0%	3.9%	17.2%	3.9%	4.9%
Other	7.0%	3.0%	9.2%	3.9%	4.9%
Public hospitals					
Ward fees	7.5%	3.0%	9.2%	3.9%	4.9%
Theatre fees	7.5%	3.0%	9.2%	3.9%	4.9%
Consumables	7.0%	2.0%	9.2%	3.9%	4.9%
Medicines	4.0%	1.0%	9.2%	3.9%	4.9%
Professional services					
General practitioners	6.2%	0.6%	8.6%	4.9%	5.9%
Specialists: medical & clinical	6.2%	3.5%	16.0%	4.9%	5.9%
Dentists	6.0%	3.5%	8.5%	4.9%	5.9%
Dental specialists	6.1%	3.5%	8.5%	4.9%	5.9%
Support & Allied Health Professionals	6.0%	3.5%	8.6%	4.9%	5.9%
Other	7.0%	3.0%	9.2%	4.9%	5.9%
Medicines (Out-of-hospital)	3.0%	1.0%	9.1%	3.9%	4.9%
Ex gratia payments	6.2%	3.0%	9.0%	3.9%	4.9%
Managed care (Out-of-hospital)	5.5%	-14.2%	12.7%	3.9%	4.9%
Non-healthcare expenditure	5.5%	0.1%	26.4%	3.9%	4.9%
Ageing and/or Utilisation	2.0%	0.1%	7.1%	0.0%	0.0%
Reserve Loading	0.7%	-8.6%	7.8%	0.0%	0.0%
Other	0.8%	-3.3%	3.0%	0.0%	0.0%

Table 1 provides a summary of the cost increases assumed for the 2012 increase in contributions and shows the recommended range of increases provided by CMS in Circular 29 of 2010. These figures exclude the effect of the weighting of costs by the schemes as the weighting is scheme specific. The high price increases assumed over and above the recommended increase for hospital-based services suggest market failures in setting their fees.

Table 2: Distribution of medical scheme contribution increase assumptions for 2012 including scheme specific weighting

	Median Assumed increase for 2012	Minimum observed from data	Maximum observed from data	Minimum recommended by CMS	Maximum recommended by CMS
Increase in costs assumed for 2012	6.2%	2.9%	9.2%	4.3%	5.3%
Total assumption increase for 2012	8.3%	2.2%	15.2%	4.3%	5.3%

Table 2 provides a summary of the increase in costs assumed (that excludes the other factors) and the total increase assumption including the other factors. The median, minimum and maximum have been provided including the recommended increases by CMS for 2012. These increases are based on the particular weighting between cost factors within the scheme and not the industry average as provided in Circular 29 of 2010.

The table indicates that the median increase of 6.2% being above the recommended range of between 4.3% and 5.3%. A median increase set using the reasonable increase assumptions as recommended by CMS in Table1 for 2012 would have resulted in a significantly lower increase and would have enhanced affordability of contributions. However the incorporation of the other factors have increased the median assumption by 2.1% to 8.3%.

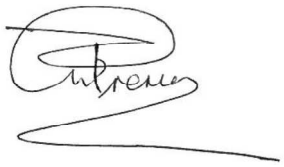
Overall the weighted median cost increase of 8.3% is still very high even when compared to CMS maximum recommended increase assumption of 5.3% with the low figure of 2.2% being is more reasonable considering the recommendations of CMS. Also we note that the high figure of 15.2% is due to regulatory requirements as explained in figure 5 above.

Concluding remarks

The variation from reasonable cost assumptions by medical schemes as concluded during our analysis in Circular 67 of 2010 remain for 2012. CMS observes with concern that a majority of cost assumptions reviewed in this analysis are significantly above the recommended range of 4.3% and 5.3%.

The median of the contribution increases being 2.1% higher than the maximum recommendation is a worrying observation. It implies that there are market imperfections in the determination of provider and non-health costs.

Overall, however, it is the view of the CMS that contributions could have increased by less than the median increase observed. This trend puts a barrier to affordability for members as well as stagnating the real increase in the number of dependents covered by medical schemes.



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