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Reference	:	Evaluation of contribution increase assumptions for 2011
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EVALUATION OF COST INCREASE ASSUMPTIONS BY MEDICAL SCHEMES FOR THE 2011 FINANCIAL YEAR

Purpose

This circular provides a critical evaluation of contribution increase assumptions made by medical schemes for the 2011 financial year, as provided in their benefit adjustment submissions. The purpose of providing this information is to increase the transparency of scheme pricing decisions and to increase the quality of provider negotiations. The production of this information forms part of an initiative by the Council to more stringently interrogate medical scheme contribution and cost increases in order to limit the transfer of inappropriate cost increases onto beneficiaries.

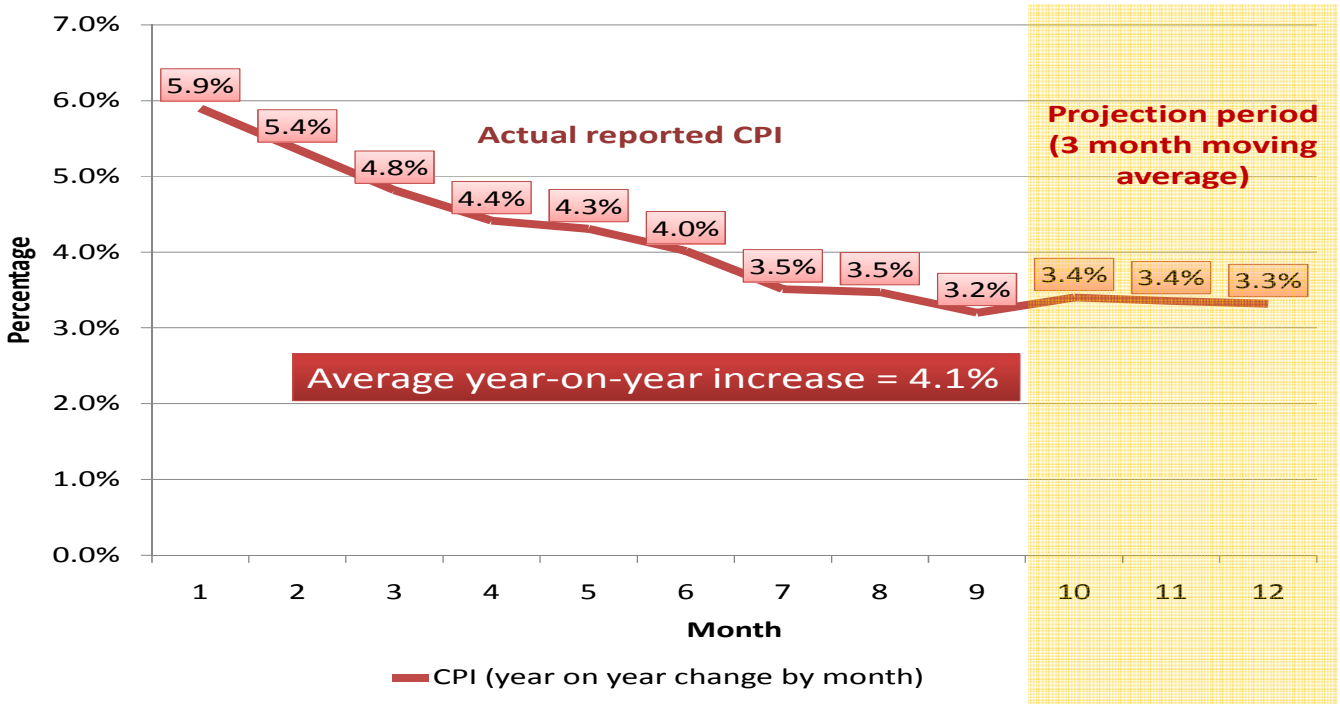
Overview

The analysis provided here breaks down the contribution increase assumptions into the standard items, including service provider and non-claims-related costs, that go to making up the total contribution.

Consumer Price Index changes for 2010

The latest consumer price index (CPI) release from Statistics South Africa provided information to October 2010. Taking into account this latest information and a projection to the end of the year based on 3 month moving averages, the overall CPI is expected to average an annual change of ***4.1%*** in 2010.

Figure 1: Consumer Price Index changes for 2010



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

Council for Medical Schemes contribution increase Guidance Note

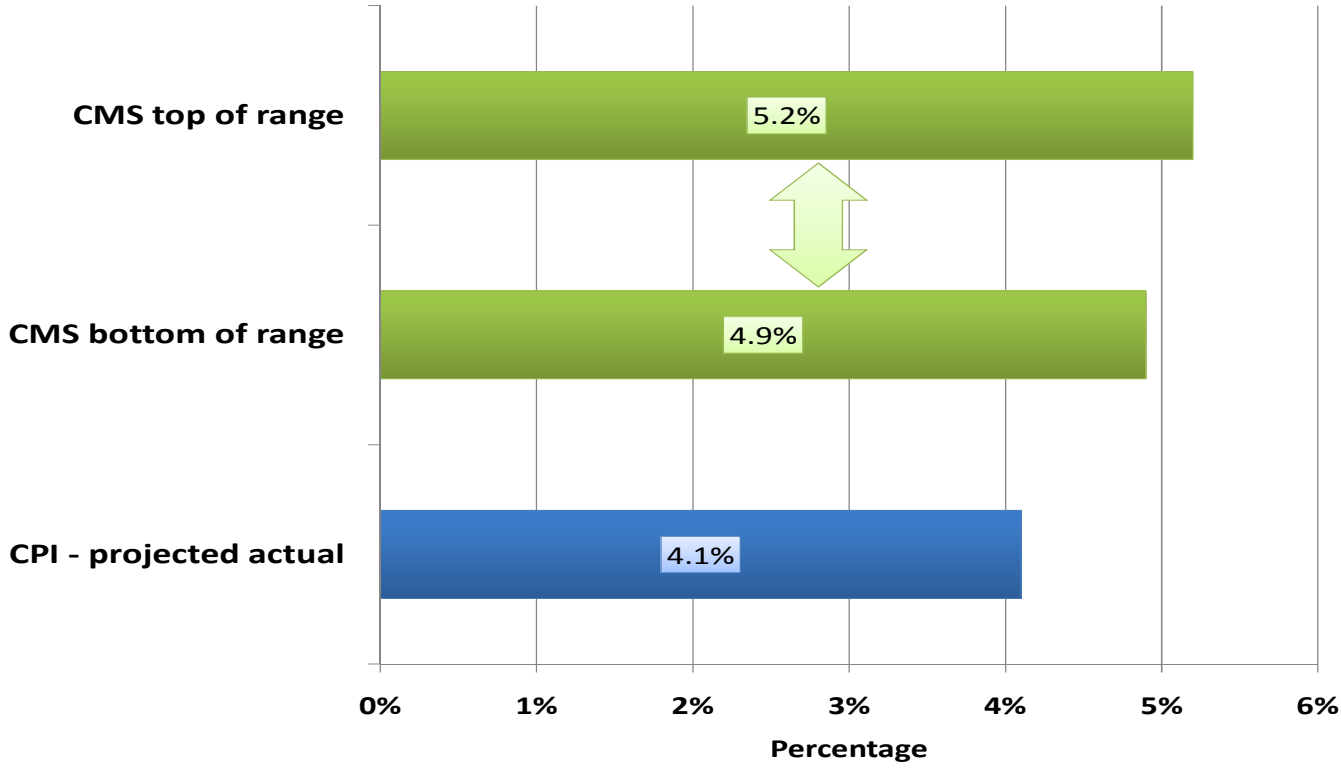
Circular 46 of 2010 published a range of indicators suggesting that contribution increases should reasonably fall into the range of 4.9% to 5.2%. In this guidance consideration was taken of the significant appreciation of the exchange rate and expected low increases for medicines. This guidance range now falls outside the projected CPI for 2010.

The guidance note also took note of the following:

- The overall age profile of medical scheme beneficiaries has not changed materially, and is presently not rising;
- The Minister of Health has awarded a 0% increase in the single exit prices for medicines applicable to the 2011 financial year, beginning 1 January 2011;
- There are no changes in the burden of disease for the medical scheme population expected; and
- Given the above, no utilization increases per beneficiary covered is expected.

Taking note of both the CPI and expected utilization changes, it would therefore be seen as worrying if increases in costs and contribution rates as submitted by medical schemes are significantly above general inflation.

Figure 2: Guidance on Contribution Increases for 2011 compared to the projected actual CPI for 2010



Medical scheme contribution increase evaluation

Table 1 provides a summary of the responses from medical schemes on their assumptions used to justify their contribution increases for 2011. Overall the results demonstrate a wide distribution of assumptions with the low averaging 5.3%, the median, 6.9% and the high 16.0%.

The four largest contributors to the overall increase across the full range are:

- Medicines (out-of-hospital);
- Professional medical services;
- Private hospital ward fees; and
- Non-health costs (made up predominantly of administration costs and managed care).

The increases attributed to medicines, both in- and out-of-hospital, are surprising as these costs have been well contained over the past five years and will experience a zero percent increase for 2011. Medicine prices should in fact decline in real terms as the exchange rate appreciation has reduced the costs of manufacturing most medicines for South Africa. This suggests that medical schemes have over-compensated for this cost item, and consequently over-inflated their contribution increases for 2011 by this amount.

The proposed increases in non-health costs are remarkably high, despite the fact they are not in any way connected to medical costs. Given this, it would have been expected that these costs change in accordance with CPI. Medical

specialists are the second highest weighted cost increase with private hospitals a close third. In both instances utilization increases do not provide a rational explanation for the budgeted for costs as the population served is neither older nor sicker. To the extent that these represent genuine costs imposed on schemes it would suggest that they are unable or unwilling to properly manage these key provider costs.

Figure 3: Evaluation of the most important cost items contributing to the overall contribution increase for the 2011 financial year – weighted percentage increase

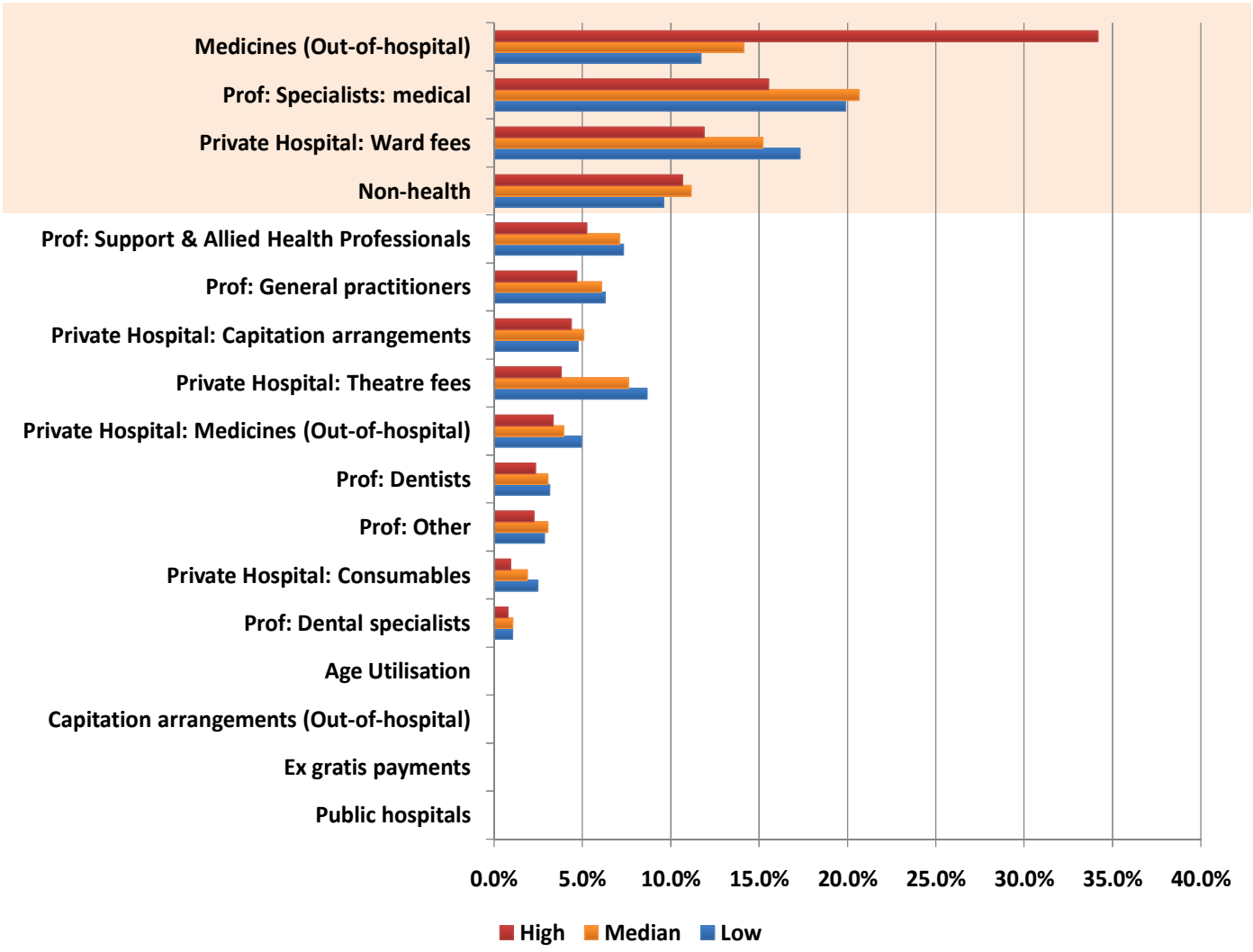
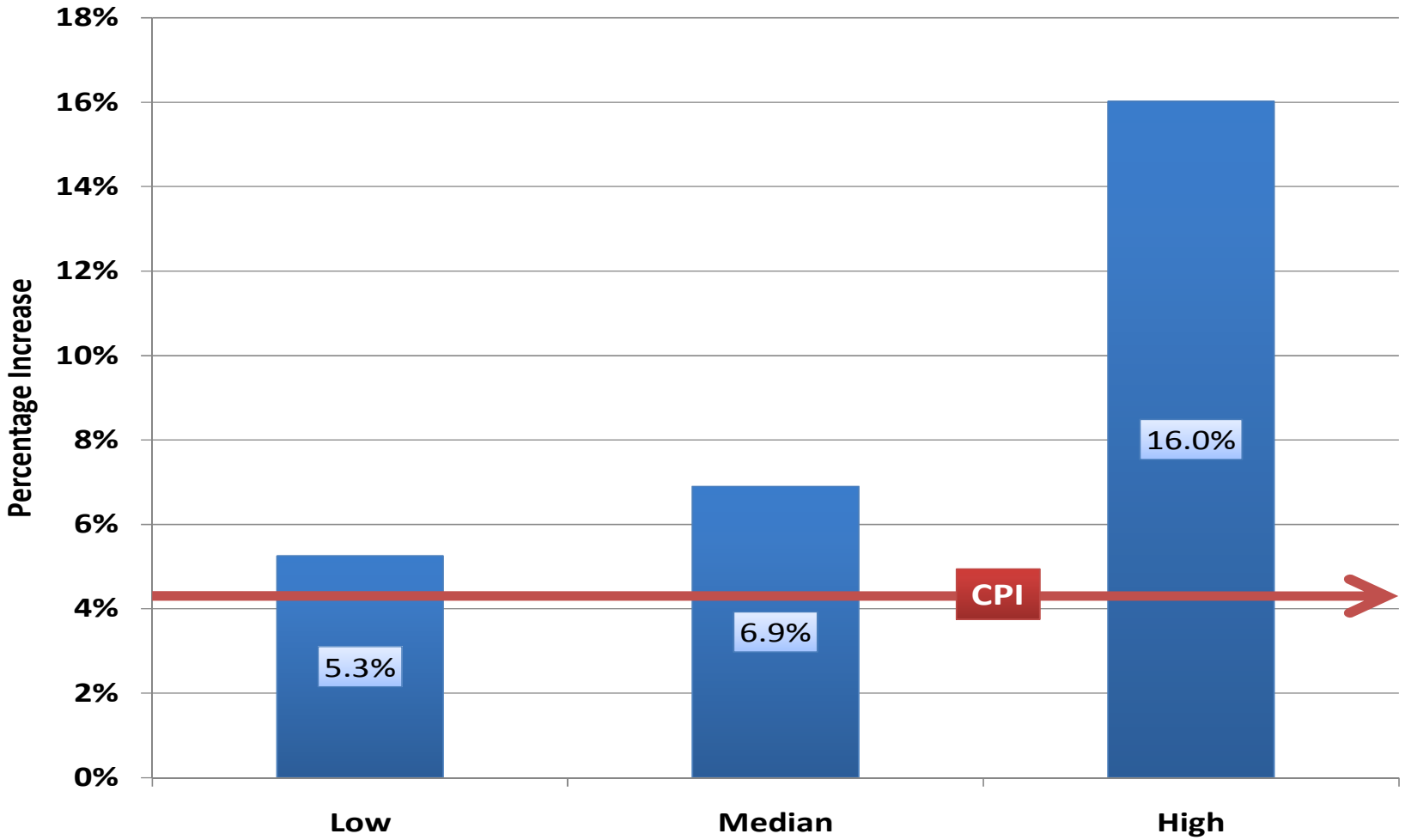


Table 1: Distribution of medical scheme cost assumptions in determining their proposed contribution increases for 2011

Cost item	Weight(% of total)	Schemes with data	Expected price change			Weighted change		
			Low	Median	High	Low	Median	High
Private hospitals	32.0%	**73**	**6.3%**	**8.0%**	**13.6%**	**2.0%**	**2.6%**	**4.4%**
Ward fees	14.0%	11	6.5%	7.5%	13.6%	0.9%	1.1%	1.9%
Theatre fees	7.0%	9	6.5%	7.5%	8.7%	0.5%	0.5%	0.6%
Medicines	4.0%	12	6.5%	6.8%	13.4%	0.3%	0.3%	0.5%
Consumables	2.0%	7	6.5%	6.5%	7.5%	0.1%	0.1%	0.2%
Capitation arrangements	5.0%	10	5.0%	7.0%	14.0%	0.3%	0.4%	0.7%
Public hospitals	**0.0%**	**2**	**8.0%**	**8.3%**	**8.6%**	**0.0%**	**0.0%**	**0.0%**
Professional services	**38.0%**	**65**	**4.8%**	**7.0%**	**12.0%**	**1.8%**	**2.7%**	**4.6%**
General practitioners	6.0%	32	5.5%	7.0%	12.5%	0.3%	0.4%	0.8%
Specialists: medical	19.0%	33	5.5%	7.5%	13.1%	1.0%	1.4%	2.5%
Dentists	3.0%	30	5.5%	7.0%	12.5%	0.2%	0.2%	0.4%
Dental specialists	1.0%	24	5.5%	7.3%	12.5%	0.1%	0.1%	0.1%
Support & Allied Health Professionals	7.0%	23	5.5%	7.0%	12.0%	0.4%	0.5%	0.8%
Other	3.0%	14	5.0%	7.0%	12.0%	0.2%	0.2%	0.4%
Medicines (Out-of-hospital)	**15.0%**	**71**	**4.1%**	**6.5%**	**36.5%**	**0.6%**	**1.0%**	**5.5%**
Ex gratis payments	**0.0%**	**2**	**7.0%**	**7.4%**	**7.8%**	**0.0%**	**0.0%**	**0.0%**
Capitation arrangements (Out-of-hospital)	**0.0%**	**26**	**5.0%**	**7.0%**	**13.0%**	**0.0%**	**0.0%**	**0.0%**
Age Utilisation	**0.0%**	**30**	**0.6%**	**1.6%**	**3.5%**	**0.0%**	**0.0%**	**0.0%**
Non-health	**14.0%**	**55**	**3.6%**	**5.5%**	**12.2%**	**0.5%**	**0.8%**	**1.7%**
Overall	**100.0%**					**5.3%**	**6.9%**	**16.0%**

Figure 4: Weighted range of contribution increases expected based on medical scheme submissions for the 2011 financial year



The variations in price assumption overall reflect the following concerns:

- The variations in hospital cost increases suggest wide variations in the contracted tariff increases awarded by the three main hospital groups to different medical schemes. This variation cannot be explained by cost differentials as all hospital groups have a uniform costs structure that does not vary by medical scheme.
- The cost increases for private hospitals all exceed inflation, with the lowest showing a more than 2% real increase in cost. The median at 8% and the high at 13.6% are remarkable under the circumstances and cannot be rationally explained by cost push factors.
- The medicine price increase assumptions range from 6.5% to 13.4% for in-hospital, and 4.1% to 36.5% for out-of-hospital, despite an administered price increase of zero percent for 2011 and significant input cost reductions due to an appreciating exchange rate.
- In-hospital medical consumables are significantly above general inflation and cannot be explained by utilisation changes, or input cost-push factors.
- Capitation fee arrangements, whether in- or out-of-hospital vary significantly from inflation, with the range in prices largely the same as for fee-for-service costs. This reflects that managed care arrangements largely price their arrangements along the lines of ordinary fee-for-service without much in the way of cost saving. This is no doubt due to the fact that many capitation arrangements involve no risk transfer to providers, and still pay providers on a fee-for-service basis.
- The range for ex gratia payments is quite narrow, but caters for a remarkable minimum increase of 7%, i.e. a 2.9% real increase.
- The cost increases for medical specialists under circumstances where no changes in age structure and morbidity of the medical scheme population exist, as with private hospitals, cannot be rationally explained. The increases should have been far closer to the CPI. However, the median is twice the inflation rate (7.0%) and the high figure nearly three times the inflation rate (12.0%).

Overall the weighted median cost increase of 6.9% is still very high, with the low figure of 5.3% considerably more reasonable. However, the high figure of 16.0% has little justification on any grounds, and schemes with this level of increase may require further scrutiny.

Appropriate scheme contribution increases with more reasonable cost assumptions

If a more appropriate set of cost assumptions were assumed, some of the variation in cost assumptions would diminish significantly. Although it is accepted that certain schemes may face adjustment requirements that have little to do with the underlying health service supply costs, the market as a whole should face very similar pricing and cost conditions. The failure to establish a rational set of price increase would be suggestive of systemic market failures requiring of government intervention.

To provide some guidance on a more rational set of cost increases the market increases are compared to a recommended set of cost assumptions. These are:

- Medicine prices are set to zero, reflecting the administered price increase as well as the possibility that some manufacturers may reduce their prices during the year (they will not be permitted to increase them.

- Non-health costs are escalated at CPI, as no rationale exists for their increase beyond this. Increases beyond the CPI reflect structural changes in the funding of administration and related costs which should not be accommodated in a general inflation adjustment.
- Ward fees and theatre fees are escalated at CPI as no cost push factors exist to justify a higher amount. It is worth noting that imported equipment (replacement and maintenance) should reduce in cost because of the appreciation of the exchange rate. Staff costs should keep pace with inflation. Utilisation should not change as the morbidity of the medical schemes population is remaining constant.
- Professional services should not escalate more than 1% above inflation and the assumption for 2011 should be a maximum increase of 5.2% (this would be at the upper range of the CMS guidance in circular 46). The rationale for this is that a general inflator should not be used to achieve structural changes in fees.
- Ex gratia payments should not escalate beyond other health-care costs.
- Capitation arrangements should escalate below fee-for-service cost increases on the assumption that they contain costs better. For this reason the increases should be restricted to general inflation (which in any case should reflect their changes in underlying costs).

Table 2: Evaluation of the appropriate contribution increases for 2011 based on reasonable cost assumptions

Cost item	Weight (% of total)	Price change	Weighted price change
Private hospitals	**32.0%**		**1.1%**
Ward fees	**14.0%**	4.1%	0.6%
Theatre fees	**7.0%**	4.1%	0.3%
Medicines	**4.0%**	0.0%	0.0%
Consumables	**2.0%**	0.0%	0.0%
Capitation arrangements	**5.0%**	4.1%	0.2%
Public hospitals	**0.0%**	**4.1%**	**0.0%**
Professional services	**38.0%**		**2.0%**
General practitioners	**6.0%**	5.1%	0.3%
Specialists: medical	**19.0%**	5.1%	1.0%
Dentists	**3.0%**	5.1%	0.2%
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Other	**3.0%**	5.1%	0.2%
Medicines (Out-of-hospital)	**15.0%**	**0.0%**	**0.0%**
Ex gratis payments	**0.0%**	**4.1%**	**0.0%**
Capitation arrangements (Out-of-hospital)	**0.0%**	**4.1%**	**0.0%**
Age Utilisation	**0.0%**	**0.0%**	**0.0%**
Non-health	**14.0%**	**4.1%**	**0.6%**
Overall	**100.0%**		**3.6%**

Table 2 indicates that the medical scheme contribution increases would be lower than CPI at 3.6% were these assumptions used and materialized in practice. The very high price increases assumed by medical schemes for hospital-based services and medicines suggest market failures in setting their fees, as do non-health costs and medical specialist fees. On the whole it should be possible for schemes that have taken higher contribution increases than required for 2011 to make savings which should accrue to reserves. The variation from reasonable cost assumptions by medical schemes however remains worrying and suggests that a more stringent process for reviewing contribution increases each year is needed.

Concluding remarks

Medical scheme contribution cost increases proposed for 2011 point to market imperfections in the determination of provider and non-health costs. Making use of a set of reasonable inflators for the 2011 financial year applied to the various cost items of a medical scheme suggests a significantly lower increase than has been submitted to the Council for approval. A significant error in the assumptions occurs in the case of medicines where prices are not envisaged to increase at all. However, the cost ranges for all other items vary significantly and inexplicably. In particular hospital-based costs, show variations which suggest that hospital tariff escalation is very different between different schemes. As no hospital group varies their cost structure by scheme, no rational explanation for this variation can be discerned other than an exercise of excessive market power. It is therefore possible that many medical schemes are price takers here and are being over-priced. Overall, however, it is the view of the Registrar that contributions could have increased by no more than 3.6%. However, the range of actual contribution increases is higher than this, with a potential range from 5.3% to 16.0% and a median of 6.9%.

Dr M Gantsho

Chief Executive and Registrar