



CIRCULAR

Reference: Evaluation of contribution increase assumptions for 2017
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CIRCULAR 23 OF 2017: EVALUATION OF COST INCREASE ASSUMPTIONS BY MEDICAL SCHEMES FOR 2017 FINANCIAL YEAR

Purpose

This Circular provides an evaluation of industry cost increase assumptions submitted by medical schemes for the 2017 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) states 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 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; and also promote public accountability and transparency.

Section 33 (2) states that the approval of benefit options will be subject to provision of prescribed benefits, self-supporting status in-terms of membership and financial performance, financial soundness, and further that the option should not jeopardize the financial soundness of any existing options within the medical scheme.

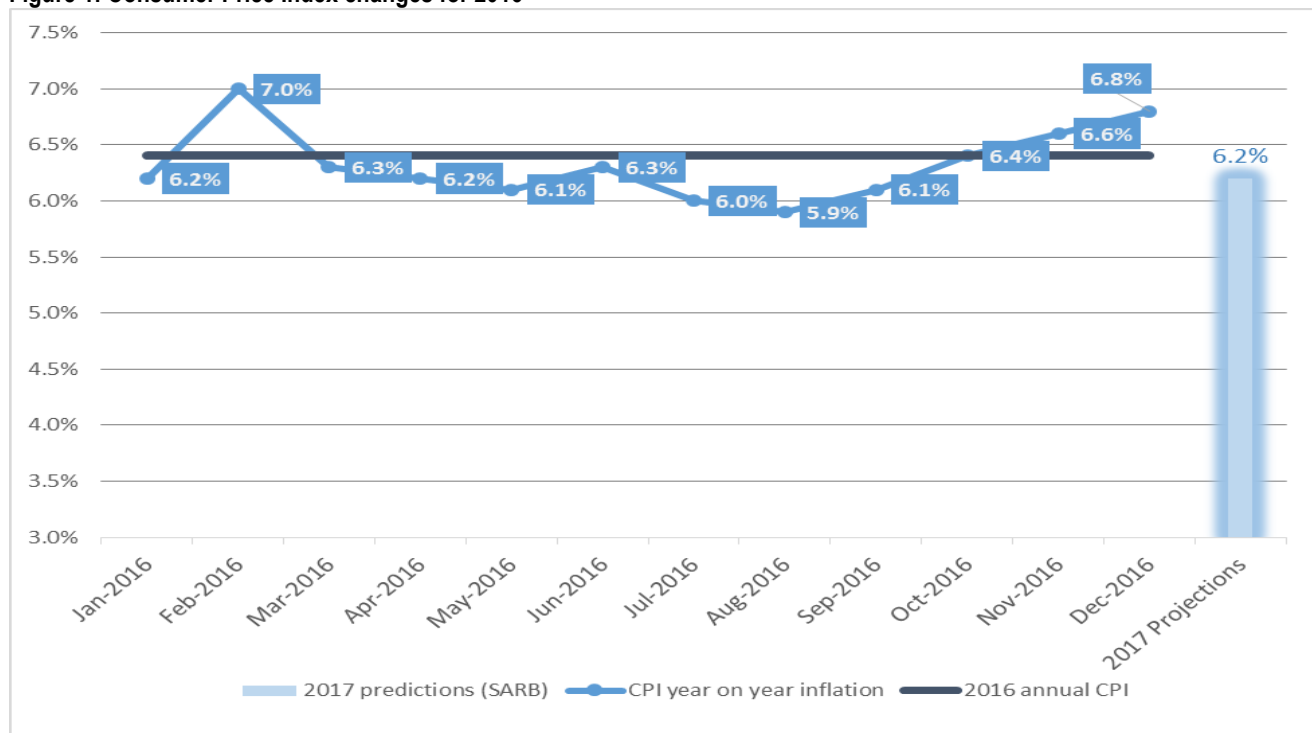
Overview

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 2016 advising medical schemes that cost increase assumptions for 2017 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 6.1% as at May 2016. The headline inflation for December 2016 was 6.8%, resulting in the annual average headline inflation for 2016 being at 6.4% (Figure 1). The 2017 annual average headline inflation is projected at 6.2% by the South African Reserve Bank (SARB MPC statement, January 2017).

Figure 1: Consumer Price Index changes for 2016



Slow economic growth remains a concern in South Africa. Economic growth has been volatile in 2016 with quarter 3 of 2016 recording an economic growth rate of 0.2%. The projected economic growth rate for 2017 has also been revised to 1.3% (National Treasury: Budget speech 2017).

The unemployment rate in quarter 3 of 2016 was 27.1% (Quarterly Labour Force Survey: Q3, 2016). According to the Quarterly Employment Survey (QES) in quarter 3 of 2016, formal sector employment increased by 0.9% year-on-year comparisons. The average earnings paid to employees increased by 6.7% year-on-year (Quarterly Employment Survey: Q3, 2016). These factors highlight the pressure on the economy to translate economic growth into job creation.

The weak domestic growth outlook, coupled with mixed/uncertain global economic outlook, might have a negative impact on medical schemes in general. South Africa's consumers remain under-pressure and consumer confidence is low. Slower wage growth along with stagnant employment growth and expected tax increases are also likely to dampen consumption expenditure (SARB MPC statement, January 2017). 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 2017 benefit year. In the analysis, the CMS undertook a quantitative review of the 2015-2016 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 2016, 83 medical schemes submitted cost assumptions data with the submission of benefit changes and contribution increases for 2017. The data from the submissions were consolidated, verified and analysed. Data from 75 medical schemes, representing about 96% 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 21 open and 54 restricted medical schemes with 4 809 699 (56%) and 3 709 537 (44%) 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	4	33 796	69.78%
	Medium	7	211 526	100.00%
	Large	7	969 969	89.47%
	Very Large	3	3 594 408	100.00%
Total open		21	4 809 699	97.39%
Restricted	Small	27	217 102	97.25%
	Medium	20	612 635	88.48%
	Large	5	606 476	88.91%
	Very large	2	2 273 324	100.00%
Total restricted		54	3 709 537	95.83%
All schemes	Small	31	250 898	92.35%
	Medium	27	824 161	91.18%
	Large	12	1 576 445	89.26%
	Very large	5	5 867 732	100.00%
Total all schemes		75	8 519 236	96.70%

*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 2017

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. Having considered the year-on-year CPI inflation rate and other key economic indicators, the CMS advised in Circular 48 of 2016 that cost increase assumptions for the 2017 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 2017 financial year

Cost item	Weighted average	25 th percentile	50 th percentile	75 th percentile	Weighted average	
					Open	Restricted
General practitioners	5.91%	6.00%	6.20%	6.50%	6.04%	5.75%
All Specialists	5.93%	6.00%	6.20%	6.71%	6.12%	5.70%
Anaesthetists	6.09%	6.00%	6.20%	7.00%	6.28%	5.84%
Pathology	5.59%	6.00%	6.20%	7.00%	5.61%	5.57%
Radiology	5.85%	6.00%	6.20%	7.00%	6.04%	5.59%
Medical Specialists	6.01%	6.00%	6.20%	6.95%	6.18%	5.79%
Surgical Specialists	6.02%	6.00%	6.20%	6.88%	6.21%	5.78%
Dentists	5.96%	6.00%	6.04%	6.50%	6.07%	5.81%
Dental Specialists	6.11%	6.00%	6.20%	7.00%	6.33%	5.83%
Supplementary and Allied Health Professionals	5.81%	6.00%	6.20%	6.50%	5.92%	5.66%
Medical Technology	5.84%	6.00%	6.00%	6.50%	6.03%	5.61%
Hospitals	6.15%	6.35%	7.20%	8.00%	6.31%	5.96%
Private Hospitals ('B' - Status) (058)	6.16%	6.35%	7.20%	8.00%	6.31%	5.97%
Private Hospitals ('A' - Status) (057)	6.16%	6.35%	7.20%	8.00%	6.31%	5.97%
Approved U O T U / Day clinics (077)	6.03%	6.30%	7.20%	8.00%	6.27%	5.72%
Mental Health Institutions (055)	6.08%	6.35%	7.20%	8.00%	6.31%	5.79%
Sub-Acute Facilities (049)	6.03%	6.24%	7.17%	8.00%	6.28%	5.70%
Private Rehab Hospital (Acute) (059)	6.03%	6.24%	7.17%	8.00%	6.27%	5.72%
Provincial Hospitals (056)	5.98%	6.00%	7.00%	8.00%	6.28%	5.59%
Drug & Alcohol Rehab (047)	6.02%	6.10%	7.10%	8.00%	6.27%	5.69%
Hospices (079)	6.03%	6.12%	7.17%	8.00%	6.27%	5.72%
Unattached operating theatres / Day clinics (076)	6.03%	6.30%	7.17%	8.00%	6.27%	5.71%
Other	5.87%	6.00%	6.20%	7.00%	6.09%	5.57%
Medicines Dispensed	7.60%	6.68%	7.60%	8.16%	7.33%	7.95%
Ex gratia payments	5.53%	6.00%	6.00%	6.30%	5.59%	5.45%
Managed care (Out-of-hospital)	6.30%	6.00%	6.00%	6.80%	6.40%	6.16%
Non-healthcare expenditure	5.94%	6.00%	6.20%	6.80%	5.77%	6.16%
Overall weighted tariff assumption increase	6.21%	6.32%	6.79%	7.28%	6.22%	6.20%

The overall weighted tariff assumption increase for 2017 was 6.21%. The overall weighted tariff assumption increase were almost similar between open schemes (6.62%) and restricted schemes (6.20%).

The weighted average assumed tariff increase assumption for hospitals was 6.15%, whilst the median assumed tariff increase assumption was 7.20%. The weighted average assumed tariff increase assumption for public hospitals was 5.98%, whilst the median assumed tariff increase assumption was 7.00%. The weighted average assumed tariff increase assumption for private hospitals (both A status and B status) was 6.16% which was higher than the weighted average assumed tariff increase assumption for other hospital types.

Hospitals' weighted tariff increase assumptions analysis by medical scheme size shows that for small medical schemes, the weighted average assumed tariff increase was 7.08% with a median of 7.17%. Medium medical schemes submitted average tariff increase assumption of 7.29%. Large medical schemes submitted average tariff increase assumption of 7.00% whilst very large medical schemes submitted average tariff increase assumption of 5.73%. Very large medical schemes had the lowest assumed tariff increase 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 5.59% and 6.11%. The median assumed increase assumption for majority of professional services cost items was 6.20%.

The average assumed tariff increase for medicines dispensed was around 7.60%, about 0.1 percentage point above the gazetted medicines Single Exit Price (SEP) increase for 2017 (7.50%). The 2017 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 7.60%.

Thirteen medical schemes assumed tariff increase above the SEP increase for medicines dispensed, whilst about 62 medical schemes assumed tariff increase less than the SEP increase for medicines dispensed.

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 5.94%, with the median of 6.20%. About 25% of the schemes assumed an increase in non-healthcare expenditure of above 6.80%. 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 for non-healthcare expenditure were 5.77% and 6.16% for open and restricted medical schemes, respectively. The weighted average assumed tariff increase in non-healthcare expenditure for 2017 (5.94%) was lower than the weighted average assumed tariff increase for 2016 (8.62%).

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

Type	Scheme count	Weighted average	25 th percentile	50 th percentile	75 th percentile
Open	21	5.77%	6.00%	6.00%	7.00%
Restricted	54	6.16%	6.00%	6.20%	6.80%
All schemes	75	5.94%	6.00%	6.20%	6.80%

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 small sized medical schemes (6.47%) was higher than in medium (6.45%) medical schemes as well as in very large (5.59%) medical schemes (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, scheme type and other operating factors need to be considered.

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

Scheme size	Scheme count	Weighted average	25 th percentile	50 th percentile	75 th percentile	Weighted average	
						Open	Restricted
Small	31	6.47%	6.00%	6.30%	7.00%	6.90%	6.39%
Medium	27	6.45%	6.00%	6.00%	6.50%	6.49%	6.43%
Large	12	6.88%	5.31%	6.28%	7.50%	7.19%	6.38%
Very large	5	5.59%	6.00%	6.00%	6.00%	5.32%	6.00%
All schemes	75	5.94%	6.00%	6.20%	6.80%	5.77%	6.16%

*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 2017

The weighted average assumed impact of utilisation and demographic changes on contribution increases across all medical schemes for 2017 was 3.96% which is higher than the 2016 assumed rate of 3.05%. The assumed impact of utilisation and demographic changes on contribution increases assumptions did not differ significantly between open medical schemes (4.11%) and restricted medical schemes (3.76%). About 26 medical schemes made assumptions of more than 3% on the impact of utilisation and demographic changes (Table 5).

Table 5: Summary of the utilisation & demographic assumptions incorporated into overall contribution increase for the 2017 financial year

Cost item	Weighted average	25 th percentile	50 th percentile	75 th percentile	Weighted average	
					Open	Restricted
General practitioners	4.53%	1.50%	2.56%	4.00%	4.84%	4.14%
All Specialists	4.61%	1.50%	2.56%	4.26%	4.94%	4.19%
Anaesthetists	4.65%	1.88%	2.75%	4.24%	4.98%	4.23%
Pathology	4.59%	1.50%	2.56%	4.26%	4.92%	4.17%
Radiology	4.62%	1.63%	2.63%	4.26%	4.91%	4.25%
Medical Specialists	4.63%	1.50%	2.70%	4.26%	4.96%	4.20%
Surgical Specialists	4.62%	1.59%	2.56%	4.26%	4.93%	4.21%
Dentists	4.41%	1.50%	2.56%	3.62%	4.71%	4.01%
Dental Specialists	4.47%	1.50%	2.56%	3.84%	4.73%	4.13%
Supplementary and Allied Health Professionals	4.53%	1.50%	2.75%	4.26%	4.84%	4.13%
Medical Technology	4.48%	1.50%	2.50%	3.62%	4.86%	3.99%
Hospitals	4.64%	1.63%	2.52%	3.64%	5.00%	4.17%
Private Hospitals ('B' - Status) (058)	4.64%	1.63%	2.52%	3.64%	5.01%	4.17%
Private Hospitals ('A' - Status) (057)	4.64%	1.63%	2.52%	3.64%	5.00%	4.17%
Approved U O T U / Day clinics (077)	4.61%	1.63%	2.52%	3.64%	4.95%	4.17%
Mental Health Institutions (055)	4.65%	1.63%	2.52%	3.64%	5.01%	4.17%
Sub-Acute Facilities (049)	4.64%	1.63%	2.50%	3.64%	5.01%	4.16%
Private Rehab Hospital (Acute) (059)	4.61%	1.50%	2.50%	3.62%	5.01%	4.10%
Provincial Hospitals (056)	4.48%	1.50%	2.05%	3.49%	4.92%	3.91%
Drug & Alcohol Rehab (047)	4.62%	1.50%	2.50%	3.62%	5.01%	4.11%
Hospices (079)	4.51%	1.50%	2.33%	3.49%	4.84%	4.07%
Unattached operating theatres / Day clinics (076)	4.58%	1.50%	2.05%	3.49%	4.98%	4.05%
Other	4.49%	1.50%	2.52%	3.64%	4.83%	4.05%
Medicines Dispensed	4.38%	1.50%	2.56%	3.64%	4.57%	4.14%
Ex gratia payments	4.10%	0.00%	1.11%	2.52%	4.63%	3.42%
Managed care (Out-of-hospital)	1.86%	0.00%	0.00%	1.50%	1.00%	2.98%
Non-healthcare expenditure	0.03%	0.00%	0.00%	0.00%	0.03%	0.03%
Overall weighted utilisation and demographic assumption increase	3.96%	1.44%	2.50%	3.74%	4.11%	3.76%

Medical scheme total¹ increase assumptions for 2017

The weighted average total assumed increase for 2017 across all medical schemes was 10.17%, excluding the allowance for reserve loading by medical schemes. When allowing for reserve loading, the overall weighted average assumed increase for 2017 across all medical schemes was 11.31%, which is higher than the 2016 total cost assumption increase. The average total assumed increase for 75% of schemes was 10.93% 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 2017 financial year

Cost item	Weighted average	25 th percentile	50 th percentile	75 th percentile	Weighted average	
					Open	Restricted
General practitioners	10.44%	8.00%	9.00%	10.18%	10.88%	9.89%
All Specialists	10.54%	8.05%	9.00%	10.41%	11.05%	9.88%
Anaesthetists	10.74%	8.12%	9.20%	10.70%	11.26%	10.06%
Pathology	10.18%	8.06%	9.00%	10.47%	10.53%	9.74%
Radiology	10.46%	8.05%	9.00%	10.90%	10.95%	9.83%
Medical Specialists	10.63%	8.05%	9.00%	10.70%	11.14%	9.98%
Surgical Specialists	10.64%	8.10%	9.20%	10.70%	11.14%	9.99%
Dentists	10.36%	8.00%	9.00%	10.18%	10.78%	9.82%
Dental Specialists	10.58%	8.09%	9.00%	10.45%	11.06%	9.95%
Supplementary and Allied Health Professionals	10.34%	8.00%	9.00%	10.18%	10.76%	9.79%
Medical Technology	10.33%	7.60%	8.69%	10.00%	10.88%	9.60%
Hospitals	10.80%	9.00%	9.83%	10.67%	11.31%	10.13%
Private Hospitals ('B' - Status) (058)	10.80%	9.00%	9.83%	10.67%	11.31%	10.14%
Private Hospitals ('A' - Status) (057)	10.80%	9.00%	9.82%	10.75%	11.31%	10.15%
Approved U O T U / Day clinics (077)	10.64%	9.00%	9.80%	10.75%	11.22%	9.89%
Mental Health Institutions (055)	10.73%	9.00%	9.80%	10.75%	11.32%	9.96%
Sub-Acute Facilities (049)	10.67%	9.00%	9.80%	10.75%	11.29%	9.86%
Private Rehab Hospital (Acute) (059)	10.65%	8.93%	9.80%	10.67%	11.28%	9.82%
Provincial Hospitals (056)	10.46%	8.33%	9.50%	10.60%	11.20%	9.50%
Drug & Alcohol Rehab (047)	10.64%	8.75%	9.50%	10.75%	11.28%	9.80%
Hospices (079)	10.54%	8.75%	9.50%	10.67%	11.12%	9.79%
Unattached operating theatres / Day clinics (076)	10.60%	8.63%	9.50%	10.67%	11.26%	9.76%
Other	10.36%	8.00%	9.10%	10.30%	10.93%	9.62%
Medicines Dispensed	11.98%	8.68%	10.10%	11.62%	11.90%	12.09%
Ex gratia payments	9.63%	6.00%	7.11%	8.80%	10.22%	8.87%
Managed care (Out-of-hospital)	8.16%	6.00%	6.80%	8.64%	7.40%	9.14%
Non-healthcare expenditure	5.97%	6.00%	6.23%	7.00%	5.80%	6.18%
Reserve loading	1.53%	-0.19%	0.00%	0.00%	0.40%	3.00%
Overall weighted assumption increase	11.31%	8.19%	9.33%	10.93%	10.34%	12.58%

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

The 11.85% total contribution increase assumption by very large medical schemes was the highest when medical schemes are stratified by size. Medium medical schemes assumed a slightly lower increase of 11.45%. The lowest assumed total contribution increase was assumed by small medical schemes (8.96%). The overall assumed contribution increase in open medical schemes and restricted medical schemes was 10.34% and 12.58%, 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	25 th percentile	50 th percentile	75 th percentile	Weighted average	
						Open	Restricted
Small	31	8.96%	7.27%	8.70%	9.56%	8.71%	9.00%
Medium	27	11.45%	8.50%	9.45%	12.53%	11.71%	11.36%
Large	12	9.60%	8.86%	9.48%	11.04%	9.36%	9.98%
Very large	5	11.85%	10.20%	10.50%	10.79%	10.53%	13.94%
All schemes	75	11.31%	8.19%	9.33%	10.93%	10.34%	12.58%

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

Figure 2 below, depicts that only three medical schemes reported a contribution increase assumption of 6.0% or less. Only one open scheme reported a contribution increase assumption of 6.0% or less. Most medical schemes (48) assumed an increase of between 6.0% and 10.0%. About 24 medical schemes assumed an overall contribution 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 2: Total contribution increase bands by size of medical scheme

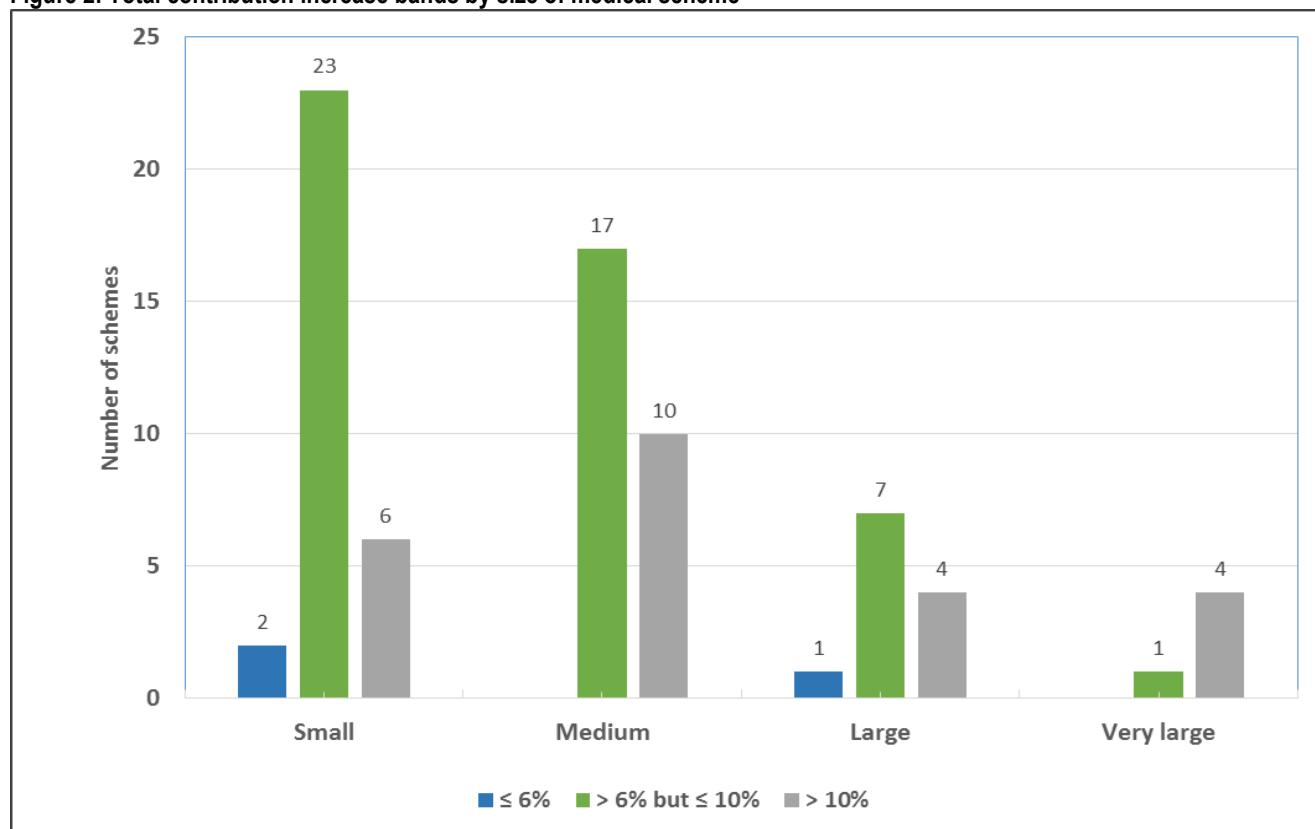


Figure 3 below, displays a summary of the most important assumptions for cost items incorporated into the overall contribution assumption increase for the 2017 financial year. The weighted tariff increase assumption for most of the cost drivers were close to 6.0%. The weighted average assumed effect of utilisation and demographic changes was between 3.96% and 4.65% for most cost drivers. The effect of utilisation on out-of-hospital managed care and non-healthcare costs was 1.86% and 0.03%, respectively.

Figure 3: Summary of the most important assumptions for cost items incorporated into overall contribution increase for the 2017 financial year

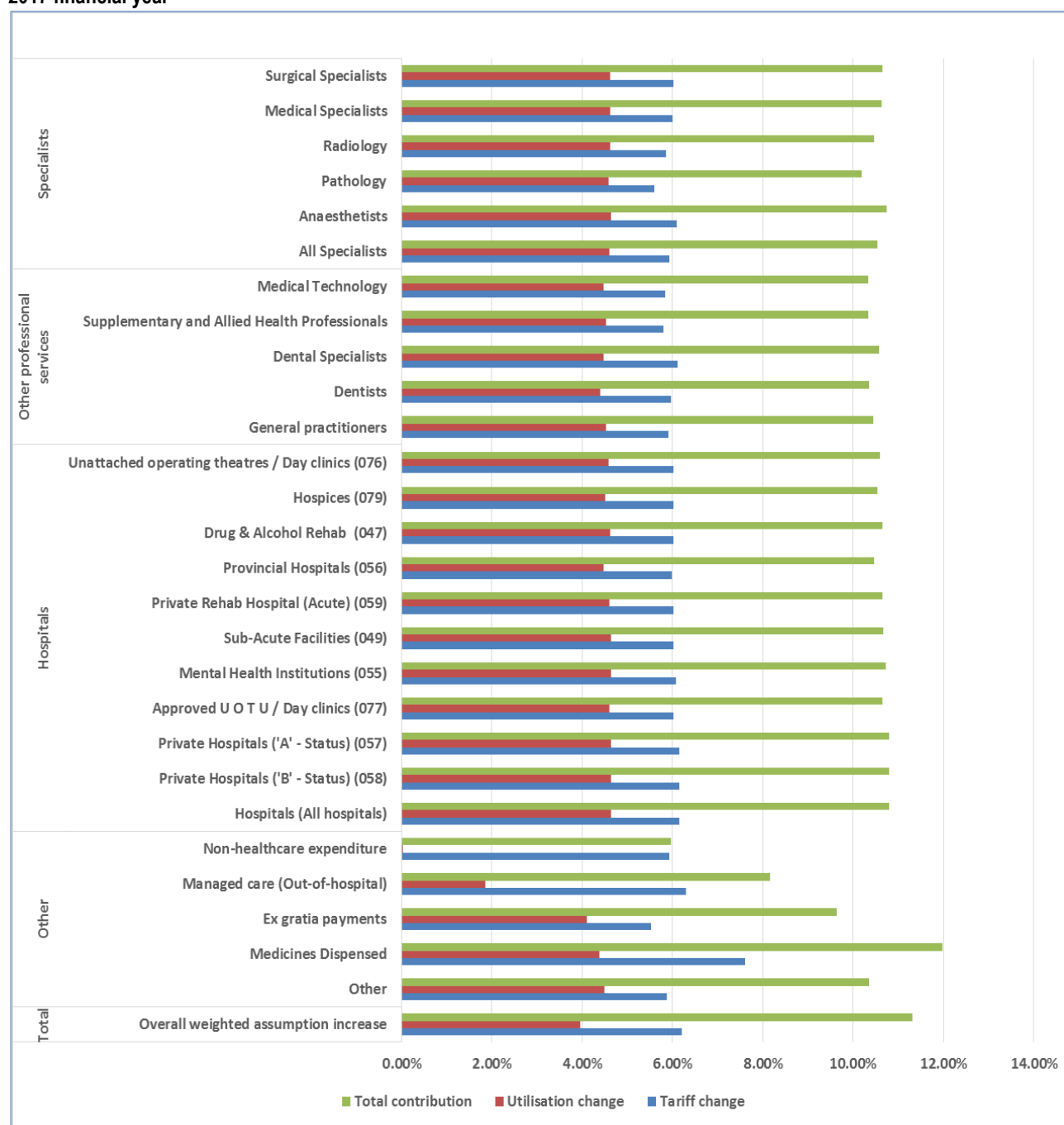


Table 8 below shows the difference between the total contribution increase assumptions made in 2016 and 2017 for the different cost drivers. The total contribution increase assumption (11.31%) made in 2017 was higher than the total contribution increase assumption made in 2016 (which was 8.67%).

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
	2016	2017	
General practitioners	9.02%	10.44%	1.42%
All Specialists	-	10.54%	-
Anaesthetists	-	10.74%	-
Pathology	-	10.18%	-
Radiology	-	10.46%	-
Medical Specialists	-	10.63%	-
Surgical Specialists	-	10.64%	-
Dentists	8.64%	10.36%	1.72%
Dental Specialists	8.77%	10.58%	1.81%
Supplementary and Allied Health Professionals	8.73%	10.34%	1.61%
Medical Technology	-	10.33%	-
Hospitals	-	10.80%	-
Private Hospitals ('B' - Status) (058)	-	10.80%	-
Private Hospitals ('A' - Status) (057)	-	10.80%	-
Approved U O T U / Day clinics (077)	-	10.64%	-
Mental Health Institutions (055)	-	10.73%	-
Sub-Acute Facilities (049)	-	10.67%	-
Private Rehab Hospital (Acute) (059)	-	10.65%	-
Provincial Hospitals (056)	-	10.46%	-
Drug & Alcohol Rehab (047)	-	10.64%	-
Hospices (079)	-	10.54%	-
Unattached operating theatres / Day clinics (076)	-	10.60%	-
Other	-	10.36%	-
Medicines Dispensed	-	11.98%	-
Ex gratia payments	7.92%	9.63%	1.71%
Managed care (Out-of-hospital)	8.09%	8.16%	0.07%
Non-healthcare expenditure	8.71%	5.97%	-2.74%
Reserve loading	-0.15%	1.53%	1.68%
Overall weighted assumption increase	8.67%	11.31%	2.64%

***Assumption increases for 2016 unavailable due to changes in data classification. Comparisons will only be available in the 2018 report*

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

The hospitals' total cost increase assumptions are on average about 4 percentage points higher than the maximum cost increase assumption as guided in Circular 48 of 2016. The hospitals' average utilisation assumption of around 4% remains a concern, as 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.

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.

Medicines dispensed tariff pricing is assumed to increase by about 7.60% on average, which is closer to the approved SEP increase of 7.5% for 2017. The effect of utilisation caused an increase of about 9.63% on the average cost of medicines dispensed. 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, practitioners should also continue to manage medicine utilisation, 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 10.54% (tariff increase of 5.93%; utilisation component of 4.61%) 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 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 8.09% in 2016, and increased to 8.16% in 2017. 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 5.97% compared to the average cost assumption increase of 8.71% in 2016. This decrease represents about 2.74 percentage points decrease 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 2016. The reported weighted average assumed tariff increase for different cost drivers ranged between 5.53% and 7.60%, with the overall weighted average assumed tariff increase being 6.21%.

The impact of assumed utilisation changes, which was 3.96%, 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 11.31% for 2017. This is higher than the 2016 figure of 8.67%.

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 be low, 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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