CIRCULAR

Reference:	Guidance on benefit changes & contribution increases for 2020
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Date:	09 July 2019

CIRCULAR 50 OF 2019: Guidance on benefit changes and contribution increases for 2020

This Circular serves to prescribe the requirements that must be adhered to by medical schemes for the assessment of annual medical scheme contribution increases, and benefit changes for the 2020 benefit year.

One of the primary statutory mandates of the Council for Medical Schemes (CMS) as enshrined in Section 7 of the Medical Schemes Act, is to protect the interests of beneficiaries at all times and to coordinate the functioning of medical schemes. To this end, CMS' key objective is to endeavour that annual medical scheme contribution rate increases remain affordable to encourage equitable access to quality healthcare, and overall long-term sustainability of the industry.

1. Macro-economic outlook for 2020

This section provides a brief overview of key economic indicators, employment statistics, household consumption expenditure and utilisation indicators, which have a bearing on the contribution increase in the medical schemes industry. Overall, these factors have a direct and indirect impact on affordability of medical scheme contribution rates, financial performance of a scheme, risk pooling, cross subsidisation, membership growth and the long-term sustainability of the industry.

1.1. Global outlook

An important element that contributes to an increase in Gross Domestic Product (GDP) for a country is health. According to the World Bank, global economic activity continued to soften at the start of 2019, with trade and manufacturing showing signs of weakness (Global Economic Prospects, 2019). Global growth in 2019 has been downgraded to 2.6%, which is a 0.3 percentage point below previous projections. This reflects the broad-based weakness observed during the first half of the year in 2019. Global growth is projected to edge up to 2.7% and 2.8% in 2020 and 2021, respectively (Global Economic Prospects, 2019).

In emerging market and developing economies (EMDEs), growth in commodity importers will remain strong, while the rebound in commodity exporters is projected to mature over the next two years (Global Economic Prospects 2019).

Table one below provides an illustration of Real GDP growth or contraction, for the period between 2016 – 2021 in BRICS countries.

Table 1: Real GDP: 2016-2012

	2016	2017	2018	2019	2020	2021
China	6.7	6.8	6.6	6.2	6.1	6
India	8.2	7.2	7.2	7.5	7.5	7.5
Russia	0.3	1.6	2.3	1.2	1.8	1.8
South Africa	0.6	1.4	0.8	1.1	1.5	1.7
Brazil	-3.3	1.1	1.1	1.5	2.5	2.3
BRICS	4.6	5.3	5.4	5.1	5.3	5.3

1.2. Domestic outlook

In addition to the above global changes, several domestic constraints continue to weigh negatively on the growth prospect of the South African economy. A decline in business confidence, weak consumer confidence, and a significant fiscal risk associated with the debt levels of certain state-owned entities, are poised to constrain the country's ability to reignite GDP growth. In addition, the concern over electricity supply will likely continue to cast a dark spell over the South African economy, going forward.

The escalation in global trade tension and tariff hikes, which could adversely impact global trade, will also continue to weigh negatively on the growth prospects for South Africa as a small open economy. The exchange rate market remains susceptible to periodic episodes of volatility mainly due to global risk aversion. As a result, the South African rand is forecast to remain weak going forward.

According to the National Treasury Economic Outlook, South Africa's GDP growth forecast for 2019 has been revised down to 1.5%, from an estimated previous forecast of 1.7 %. This weaker outlook projects a slow improvement in production and employment following poor investment growth in 2018, and a moderation in global trade and investment. In 2020 GDP growth is projected to be at 1.7%, while 2021 is expected to reach 2.1%. This is supported by an expected gradual improvement in confidence, more effective public infrastructure

spending, and a better commodity price outlook. Similarly, the South African Reserve Bank has also revised down the country's GDP growth for 2019 to 1.0% down from the previous 1.3%. The forecast for 2020 and 2021 is unchanged at 1.8% and 2.0%, respectively (SARB,2019).

Employment growth remains an area of concern; with more informal sector jobs being created, than formal sector jobs in the fourth quarter of 2018. This had a direct impact on sustained membership growth within the medical schemes industry. The Quarterly Labour Force Survey (Q1) also noted that the number of employed persons decreased by 237 000 to 16,3 million in Q1: 2019, while the number of unemployed persons increased by 62 000 to 6,2 million compared to Q4: 2018. This marks a decrease of 176 000 (0,8% decline) in the number of people in the labour force. The absorption rate decreased by 0,7 of a percentage point to 42,6% and the unemployment rate increased by 0,5 of a percentage point to 27,6% compared to the fourth quarter of 2018.

Figure 1

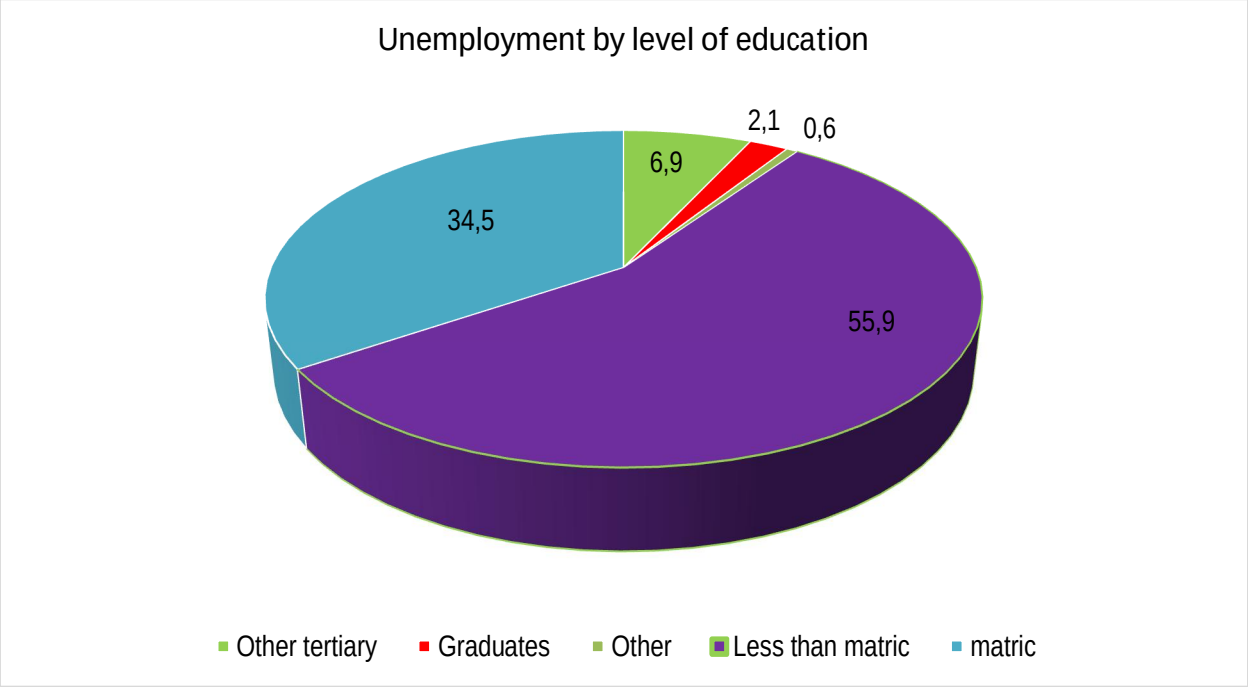


Figure 1 above shows that of the 6,2 million unemployed persons in Q1: 2019, almost 56% had an education level below matric, followed by those with matric at 34,5%. Only 2,1% of unemployed persons were graduates, while 6,9% had other tertiary qualifications as their highest level of education.

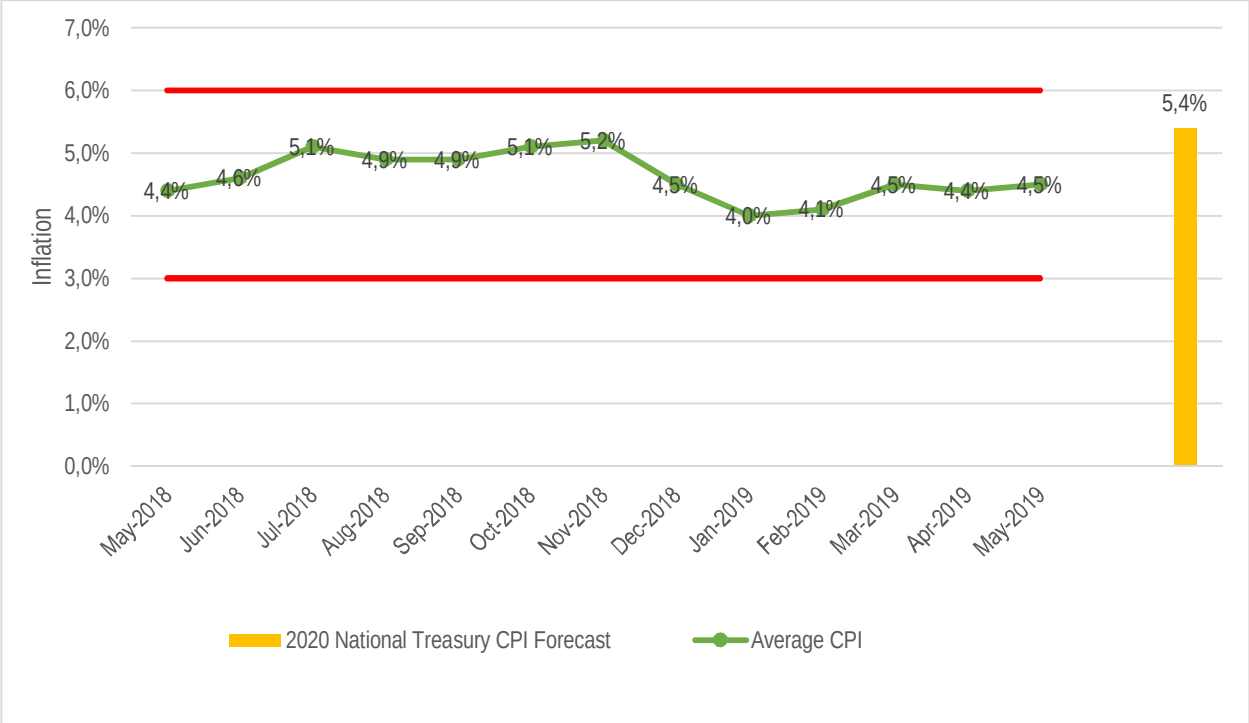
2. Guidance note on annual medical schemes cost increase assumptions

Outlined below are key considerations that the Council for Medical Schemes will take into account when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost industry increase assumptions for 2020 benefit year.

2.1. Headline inflationary expectations

The graph below depicts the South African Reserve Bank (SARB) inflation targeting against historical consumer price index (CPI) data as published by Statistics South Africa (Stats SA) for the twelve-month period up to May 2019 and National Treasury forecast for 2020.

Figure 2: Headline inflation 2018 – 2019



The year-on-year headline consumer inflation rate as measured by consumer price index (CPI) was 4.5% in March 2019, before a slight decrease to 4.4% in April 2019, and then edging up marginally to its previous level of 4.5% in May 2019.

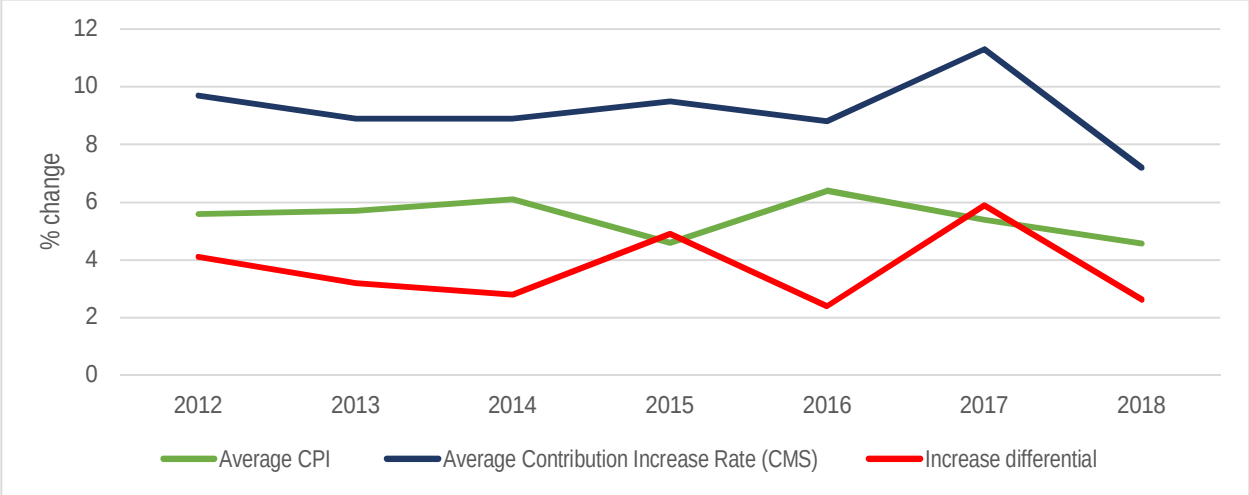
According to the inflation forecast of the SARB Quarterly Projection Model (QPM), as outlined in the May Monetary Policy Statement (MPC), headline inflation is expected to average 4.5% in 2019, before increasing to 5.1% in 2020 (SARB, 2019). Almost similar to the forecast of the SARB, accordingly to the National Treasury's Economic Outlook, consumer inflation is projected to average 5.2% and 5.4% in 2019 and 2020, respectively.

The CMS use CPI, as a proxy measure for affordability since most sectors within the economy experience CPI-linked salary increases, if any. Accordingly, cost increase assumptions within the industry must be anchored in line with headline inflationary expectations.

2.2. Medical scheme contribution dynamics and consumer inflation

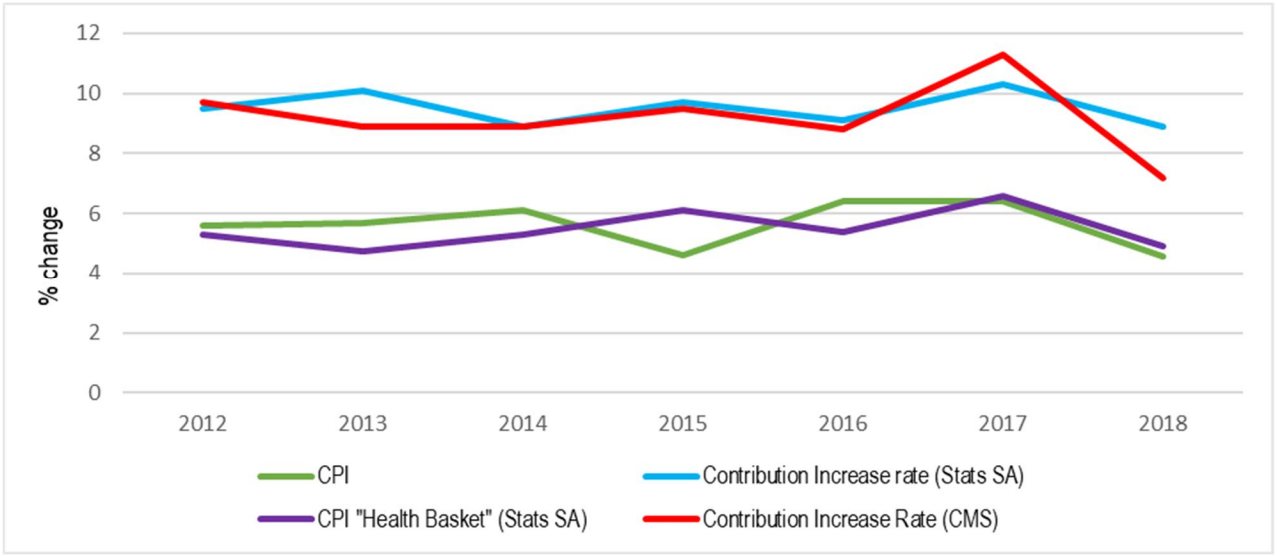
The graph below (figure 3) provides an illustration of trends of the contribution increase rate as reported in the 2017/2018 CMS Annual Report, relative to CPI. In addition, figure 3 incorporates medical schemes' contribution increases and CPI "health basket" as reported by Stats SA.

Figure *3*: Medical schemes contributions and headline inflation (2012-2018)



It is evident from figure 3 above, that the medical scheme contributions increase rate has consistently surpassed the consumer inflation rate. This creates a financial burden on members of medical schemes. The difference between medical scheme contributions increase rate and CPI, has implications for long term affordability for members, as annual salary adjustments may not necessarily keep pace with contribution increases.

Figure *4*: Medical schemes contributions and Stats SA health insurance (2012-2018)



The average gross contribution increase for all medical schemes, as reported by CMS for the 2018 benefit year was 7.2%. Figure 4 above shows that the 7.2% average contribution rate increase, was relatively lower than the 8.9% for health insurance within urban arears as reported by Stats SA for the same period. Furthermore, the CPI "health basket" was 4.9%, compared to the average consumer inflation rate of 4.6% over a 12 months period.

2.3. Health Care utilisation trends

Table 2 below depicts changes between the years 2012 to 2019 on the actual increase in contributions in relation to projected tariff and utilisation increases.

Table 2: Actual contribution increase and assumed rates

	2012	2013	2014	2015	2016	2017	2018	2019
Actual Contribution Increase rate	9,7	8,9	8.9	9.5	8.8	11.3	7.2	*
CPI	5,6	5,7	6.1	4,6	6,4	5.3	4.6	5.4
Assumed utilisation increase	2.0	2.8	2.3	2.9	3.05	3.9	3.33	3.9
Tariff	6.3	6.8	6.9	6.3	5.55	7.4	5.5	5.4
Total assumed increase	8.3	9.6	9.2	9.2	8.6	11.3	8.18	8.6

Note: *to be published in the 2018/2019 Annual Report

Cost increase assumptions analysis for 2019 showed that the combination of demographic and utilisation factors are projected to add about 3.9 percentage points to the total cost increases for medical schemes. This projection is marginally higher than 3.3 estimate for the 2018 benefit year. As was the case in the previous year, the CMS remains concerned that the utilisation estimates submitted by the schemes do not always correlate with the changes in demographic and risk profile of a scheme. In fact, as can be noted in table 2 above, utilisation estimates have consistently been increasing between 2012 and 2019.

There are a variety of supply and demand side factors that can explain this trend. Some of these factors have been investigated by the Health Market Inquiry. The CMS is also highly concerned about fraud, waste and abuse within the industry since it also has a direct impact on claims experience for medical schemes, negatively affecting premium increases, as well as availability of benefits for beneficiaries. Medical schemes are requested to submit a comprehensive analysis of these factors when motivating for their respective cost increase assumptions (Appendix D).

2.4. Single Exist Price (SEP)

Table 3 below depicts historical Single Exist Price (SEP) for the period 2011-2019 relative to consumer inflation. The actual adjustment to the SEP is published by the Minister of Health towards the end of each year. The gazetted increase for 2019 is 3.78% while the SEP for 2020 will be published later in the year. Medical schemes are cautioned to assume a reasonable estimate for the 2020 benefit year, based on the historical figures.

Table 3 : SEP Publications (2011-2019)

Year	Average CPI	Approved SEP Increase
2011	5,0%	0,00%
2012	5,6%	2,10%
2013	5,7%	5,80%
2014	6.1%	5,82%
2015	4,6%	7,50%
2016	6.4%	4.8%
2017	5.3%	7.5%
2018	4.6%	1,26%
2019	4.6%	3.78%

Note: *SEP formula is published by the Pricing Committee*

3. National Health Insurance (NHI)

On the 19 October 2018 the CMS published Circular 42 inviting stakeholders within the industry to comment on the proposed framework for medical schemes consolidation. This research was initiated after the publication of the National Health Insurance White Paper in 2017 where paragraph 322 stated the following:

"*Amendments to the Medical Schemes Act will be initiated as part of the broad phased implementation. Medical schemes will evolve and consolidate during this phase to provide complementary cover. In the initial stages, all benefit options in the various schemes will be consolidated from the current 323 benefit options in 83 schemes to one option per scheme. Schemes covering state employees will be consolidated into one scheme, the Government Employee Medical Scheme (GEMS). The other activities to be undertaken will involve the creation of a uniform information system and standardisation of healthcare services across the medical schemes to be aligned to comprehensive healthcare services for NHI.*"

The CMS received 23 responses from different medical schemes, administrators, research institutes and unions. A variety of views were presented, ranging from complete support for some form of risk pool consolidation within the industry, to no support at all. In addition, some stakeholders preferred the CMS to consider HMI recommendations, although not in totality.

This review prompted the CMS to undertake additional analysis on small schemes and on the Low-Cost Benefit Options, resulting in Circular 28 of 2019. This Circular sought to enhance aspects of Circular 42 of 2018 based on the comments received. The descriptive analysis presented within Circular 28 showed that membership is an insufficient metric to identify schemes which could be considered for consolidation, although Regulation 2 (3) specifies the expected membership per scheme.

Industry-wide analysis of all medical schemes has been recommended, based on a more holistic set of parameters and economic simulation, given the varying characteristics of medical schemes; from their operations and business models, to financial and clinical perspectives. The CMS also recognizes that certain market mechanisms within a wide range of industries can allow small players to operate sustainably, and in fact, enhance competition and innovation. The CMS has also seen the positive impact of amalgamations between small schemes and large schemes, or between medium sized schemes and large schemes, and the positive effects of such consolidations where cross subsidisation and better financial protection are concerned.

Whilst the CMS waits for the final publication of the Health Market Inquiry report, MSAB and NHI Bill, research and publication of outputs on risk pool consolidation will continue.

In this current financial year, CMS will be collecting the following primary data from the industry:

- Chronicity
- Demographic factors of beneficiaries added each month
- Average claim sizes by the factors included in this report
- Information on eligibility criteria and subsidy policies

The Council will also publish a discussion document on benefit option standardisation and the medical schemes Umbrella Fund.

4. Statutory requirements for submission of medical schemes rule amendments

The submission process remains largely the same when compared with the requirements for the 2018 submission. The following process must be adhered to when submitting amendments in terms of section 31(3), Section 33 (1) (2) (5), Regulation 2(d) and Regulation 4(b) & (d) of the Medical Schemes Act:

4.1. All schemes must submit a dated and certified resolution of their respective Board of Trustees with the wording "Certified as having been adopted in terms of the rules" together with a summary of, or copy with tracked changes of the proposed amendments to the respective benefits and/or contributions to fast track the review process. The format for tracked changes can either be shown in the margin in balloons or as underlined/strikethrough of the text to ensure that the submission is apparent.

4.2. All schemes must submit an original plus one copy of the amendments to their respective benefits and/or contributions. Any rule amendments that the CMS requested in previous submissions must be incorporated into the current amendments, if not effected already.

4.3. All schemes with amendments taking effect from 1 January 2020 are advised to adhere to the submission deadline which applies to the receipt of signed hard copies of the amendments, and NOT the electronic copy.

4.4. No text should be underlined in the original documents or copies of the rules of each medical scheme.

4.5. All submissions must be printed in black and white on one side of an A4-size paper. The printed text must not be highlighted in anyway, punctured and/or bound in any form.

4.6. Appendix 1A or 1A (2) must only be completed for each benefit option which was registered in 2019, and again for all benefit options which the scheme intends to register in 2020.

4.7. Appendix C or C (2) must be completed for each benefit option which was registered in 2019, with different contribution rates based on income band or efficiency-discounted (EDO) sub-options, in an instance where the benefit option is to be registered for 2020.

4.8. Appendix 1B must be completed for the entire medical scheme for both 2019 and 2020. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row y) for 2019 and 2020 in Appendix B as per the approved business plan. The projected solvency ratio for 2019 and 2020 in Appendix 1B will be assessed in terms of the solvency ratio outlined in the business plan approved by the CMS, and any deviation must be explained in the scheme's submission.

4.9. Appendix D requires information about the assumptions on cost increases and utilisation that medical schemes used in determining their respective contribution increases for the 2020 benefit year. The Annexure has been updated in line with the CMS Annual Report 2016/17 Annexure J and O which separated the total risk benefits paid by discipline codes to be consistent with the schemes' annual return submissions. Each medical scheme must complete the spreadsheet one time only, and deviation(s) from the guideline assumptions must be explained in the motivation for increases.

4.10. Both hard and soft (electronic) versions of all the Appendices must be submitted by the deadline date. Only the spreadsheet template provided should be used for the submission. The spreadsheet is available here and on the CMS website.

4.11. Schemes seeking to register efficiency-discounted sub-options must have obtained exemption from section 29(1) (n) of the Medical Schemes Act. Section 8(h) stipulates that only Council (the Board of the CMS) has the power to grant exemptions from any provision of the Act. It should be noted that an exemption must be granted by the CMS for each efficiency-discounted sub-option. An exemption is not granted at scheme level.

4.12. Applications for all new benefit options including efficiency-discounted sub-options taking effect from 1 January 2020 must reach the CMS by 1 September 2019 in terms of section 33(1) of the Medical Schemes Act. Applications received after 1 September 2019 will not be attended to until the CMS has considered all the benefit and contribution amendments of those medical schemes that submitted their amendments by the stipulated deadline.

4.13. Schemes are further required to indicate percentage changes on any benefits that are being amended in a tabular form (submitted in word/excel format electronically) and hardcopy, as follows:

Name of benefit option			
Benefits / services	2019	2020	% change
E.g. day-to-day limit	E.g. R10 000 per beneficiary	E.g. R11 000 per beneficiary	10% increase

4.14. In instances where registered rules or rule amendments impose monetary limits on benefits, an explicit condition must be included indicating that the limit does not apply to the prescribed minimum benefit (PMB) conditions; and further stating that PMBs are paid in full when making use of a designated service provider (DSP). The submission of rule amendments with limits on PMB conditions will be amended to highlight the fact that the PMBs are provided at no cost to beneficiaries. This is to ensure that rule amendments are compliant with the Medical Schemes Act and are fair to beneficiaries.

4.15. To expedite the 2020 rule registration process, schemes are requested to submit amendments to rules relating to the changes to the contributions, and benefit changes only. Any changes to the scheme's main rules will not be given priority except for changes that have an impact on the changes to benefit and contributions for 2020, for example the amendment of scheme tariffs for 2020.

4.16. Schemes are also required to submit proof of advance written notice to members of any changes in contributions and benefits in terms of Section 29(1)(l) of the Medical Schemes Act.

Any submission without all the above requirements will be deemed non-compliant and will not be attended to.

5. Key CMS recommendations for 2020 benefit year

The South African economy is currently plagued by myriad of maladies stemming from both global and domestic factors. The real GDP growth plummeted the most in the first quarter of 2019, the worst since the 2008 global financial crisis. The unemployment rate remains sticky high, with more potential job losses still simmering in some sectors of the economy. The rand remains weak and the exchange rate market is expected to remain highly volatile, mainly due to global trade and tariff wars. The petrol price has increased in recent months and this trend is poised to continue going forward, mainly due to the weaker domestic currency, coupled with persistently high Brent crude oil price. The annual medical scheme contributions increase rate has stubbornly outpaced CPI over the past years, to the detriment of members of schemes. Overall, consumers are expected to remain in a precarious financial position going forward, as multiple factors conspire to keep a lid on real income growth.

Against this backdrop, medical schemes are are advised to limit their cost increase assumptions for contribution increases for the 2020 benefit year to 5.4 %, in line with CPI. In the context of the current economic climate in the country, it is the CMS' view that above inflationary cost increases, are simply above the budget line for most consumers and are therefore unaffordable for the majority of members of medical schemes.

Lower medical schemes contribution rates linked to appropriate benefit offerings offer beneficiaries good financial protection with positive spill overs for social solidarity. This ensures that members do not drop out of the medical scheme industry, due to budget constraints and/or shrinking benefits. This is particularly important for the sick and elderly, who may then burden the public healthcare system, if they are priced out of the of the medical scheme industry. In addition, affordable medical scheme contribution rates reduce barriers to entry for younger members, contributing towards the long-term sustainability of the industry, currently plagued by stagnant membership growth for the past few years.

Notwithstanding the unique industry specific cost-push factors such as the need for reserve loading, the impact of the weaker rand exchange rate, burden of diseases etc., it remains the position of the CMS that the increase in hospital fees, pharmaceutical products and therapeutic appliances should also be limited to 5.4% in line with CPI. Similarly, the assumed increases in non-healthcare expenditure (i.e. administration and managed care fees) for 2020 should not be greater than the CPI projections for 2020.

As communicated in Circular 47 of 2019, the assumed 3.86% percentage point price increase attributed to changes in the utilisation of healthcare services for 2019 benefit year, remains a major concern for the CMS. In some cases, it does not always correlate with worsening or improving demographic and disease profiles of the medical scheme. Accordingly, medical schemes are required to submit a comprehensive analysis of these factors when motivating for their respective assumptions (Appendix D) used in determining contribution increases.

Medical schemes Trustees and Principal Officers are also encouraged to continuously review their contractual agreement with their service providers in order to better managed healthcare and non-healthcare related costs. Where third-party entities have failed to demonstrate value for money in respect of services, the Board of Trustees are called upon to review and take the necessary remedial action. Medical schemes must also continuously explore innovative solutions in the market that can improve efficiencies in terms of costs and efficacy, without compromising quality of patient care.

Any submission for benefit changes and contribution increases premised on a pricing model that shifts the financial burden onto members, via unreasonable higher contribution increases or reduction of discretionary benefits offered

by schemes, will be rejected by the CMS. Furthermore, due to the adverse effect of the number of existing benefit options on consumers and related complexities, the CMS will only consider application for registration of new benefit options in exceptional circumstances.

A detailed motivation for the required changes to benefits and contributions must accompany all submissions. The guidance provided above regarding the limit on the cost increase assumptions should be taken into consideration when determining the adequacy of contribution increases. As indicated in Circular 29 of 2012, a report that is sent together with the proposed amendments must take into account the requirements of the Advisory Practice Note (APN303) published by the Actuarial Society of South Africa (ASSA) called: "*Advice to South African Medical Schemes on Adequacy of Contributions*."

The report must be prepared by a person with the appropriate actuarial and/or statistical skills, and should include the following detailed information:

- benefit changes
- contribution increases
- non-healthcare expense
- assumptions
- financial projections

The Advisory Practice Note mentioned above can be accessed on the ASSA website (http://www.actuarialsociety.org.za).

No amendments to the rules of a medical scheme will be valid unless they have been approved and registered by the CMS in terms of Section 31(2) of the Medical Schemes Act. The marketing of amendments that have not been approved and registered is strictly prohibited and will constitute a transgression in terms of Section 66 of the Medical Schemes Act.

The deadline for medical schemes to submit their rule amendments scheduled to take effect from 1 January 2020, is 1 September 2019 for new options or EDOs and 1 October 2019 for contribution and benefit changes, although the CMS welcomes early submissions.

Kindly refer any queries you may have to the Benefits Management Analyst responsible for your scheme.

Your cooperation is always appreciated.

Dr Sipho Kabane
Chief Executive & Registrar
Council for Medical Schemes