**PRESS RELEASE**

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# Press release 16 of 2013: Regulator of medical schemes launches Annual Report

The Council for Medical Schemes (CMS) launched its latest Annual Report earlier today.

The CMS is the regulator of the medical schemes industry. It derives its mandate from the Medical Schemes Act 131 of 1998.

The CMS Annual Report is known to provide a detailed analysis of the operations of medical schemes as well as highlights relating to policy developments in this complex environment.

The report can be viewed here (http://www.medicalschemes.com/files/extras/arflpbk/index.html) and downloaded here (http://www.medicalschemes.com/files/Annual%20Reports/f0868c30e186.html).

The standard Annexures with details on medical schemes are again available in both PDF (http://www.medicalschemes.com/files/Annual%20Reports/AR20122013AX.pdf) and Excel format (http://www.medicalschemes.com/files/Annual%20Reports/AR20122013AX.xls).

Some of the highlights in this Annual Report are:

**Policy and the Medical Schemes Act**

1. The Medical Schemes Act needs to be strengthened to ensure that the medical schemes system continues to serve the best interests of the national health system. The CMS therefore continued to work on the Medical Schemes Amendment Bill to enhance its provisions on the governance of medical schemes, the CMS complaints and appeals processes, and the prescribed minimum benefits (PMBs), to mention a few.

2. The Medical Schemes Act needs to be protected against health insurance products which threaten to undermine and even erode the provisions that speak to social security and protection of members' rights. The CMS believes that any products which encroach on the business of the medical schemes industry need to be duly registered and regulated by the CMS to ensure that the public interest is preserved and even enhanced. (More below.)

3. The prescribed minimum benefits stand and must be protected and strengthened to serve both beneficiaries and the entire health system. Non-compliance with PMB provisions in the Medical Schemes Act undermines the effectiveness and long-term sustainability of the medical schemes industry, and consequently threatens to

undermine the national health system, both public and private. Medical schemes must ensure that they fully comply with all the provisions of the Medical Schemes Act at all times.

**Highlights in the medical schemes industry in 2012**

*Number of medical schemes and beneficiaries*

4. The 2012 financial year of medical schemes saw the continuation of the trend where there are fewer medical schemes but more beneficiaries.

5. At the end of 2012, there were 92 medical schemes registered in South Africa, compared to 97 at the end of 2011.

6. From 144 schemes in 2000 to the current 92, the trend is likely to continue. However, the industry is far from being an oligopoly. Consolidation is the result of amalgamations and liquidations (voluntary and involuntary) due to the prevailing economic circumstances in the medical schemes industry; it is not driven by the CMS. The introduction of an internationally accepted system of risk adjustment would also go a long way in securing the stability and long-term sustainability of the medical schemes industry and thereby strengthening the entire health system, private and public.

7. In the 2012 financial year, the number of principal members increased by 2.3% to 3 815 431 and the number of dependants increased by 1.4% to 4 864 042, resulting in the number of beneficiaries increasing by 1.8% to 8 679 473 at the end of 2012.

8. The growth in principal members and beneficiaries is faster than the national population growth rate.

*Age of beneficiaries*

9. Medical schemes as a whole had the same age profile in 2012 as in 2000.

10. Between 2000 and 2006, restricted schemes were older than open schemes. This changed in 2007; restricted schemes were suddenly younger than open schemes, primarily due to the introduction of GEMS in 2006.

11. Open schemes continued to age and restricted schemes continued to grow younger thanks to GEMS until 2011.

12. But in 2012 open schemes grew marginally younger because the largest open scheme in the country, Discovery Health Medical Scheme, attracted younger beneficiaries. In the same year, GEMS aged because it took on beneficiaries who were older than its average age. The restricted schemes number is predominantly affected by GEMS due to its size.

*Contribution income and healthcare expenditure*

13. Medical schemes received 9.4% more in Gross Contribution Income in the 2012 financial year compared to 2011, or a total of R117.5 billion.

14. Of this, R103.7 billion was paid out in healthcare benefits. This was an increase of 10.7% on the R93.6 billion paid out in the previous year.

*Expenditure on hospitals and specialists*

15. Of the total benefits paid to healthcare providers, medical schemes spent R37.9 billion or 36.7% on hospital services. Expenditure on private hospitals accounted for R37.6 billion, which is an increase of 11.1% from 2011. Public hospitals were paid R334.7 million in the 2012 financial year.

16. Payments to medical specialists accounted for R24.0 billion or 23.3% of benefits paid in 2012, a year-on-year increase of 12.9%.

    These expenditure increases continued to be very high in 2012 and further substantiate the urgent need to regulate the fees of private hospitals and medical specialists.

    The vacuum left after the National Health Reference Price List (NHRPL) was set aside still needs to be filled.

    *Other healthcare expenditure*

17. General practitioners received R7.5 billion (7.2%) of the total benefits paid by medical schemes to healthcare providers. This was an increase of 9.2% on 2011.

18. Benefits paid to dentists accounted for R2.8 billion in 2012, an increase of 10.1% on 2011.

19. Supplementary and allied health professionals received R7.9 billion from medical schemes in the year 2012, compared to R7.3 billion in 2011.

20. Expenditure on medicines dispensed by pharmacists and providers other than hospitals increased by 7.8% on 2011 to R16.3 billion. This amounted to 15.8% of scheme benefits paid in 2012.

    *Non-healthcare expenditure*

21. Administration expenditure of all medical schemes rose by 7.5%, from R8.2 billion at the end of 2011 to R8.8 billion at the end of 2012.

22. Expenditure on benefits management (managed healthcare management fees) grew by 9.6% to R2.7 billion in 2012.

23. Brokers were paid an additional 4.3% or a total of R1.4 billion in 2012.

24. Impaired receivables (previously known as bad debts) increased by a significant 81.2% to R189.7 million in 2012 compared to the R104.7 million recorded at the end of 2011.

25. Total non-healthcare expenditure (i.e. administration fees, fees paid for managed care, broker fees, impairments, and reinsurance) rose by 8.1% from R12.1 billion in 2011 to R13.1 billion in 2012.

    Since 2005, when the CMS started to apply more pressure on medical schemes to reduce their non-healthcare expenditure, there has been a gradual decline in non-healthcare costs in real terms (after adjusting for inflation). The CMS intends to further strengthen its efforts in this area.

    Key amendments to the Medical Schemes Act are also required to ensure that brokers are regulated more effectively.

    *Net healthcare results and impact on reserves*

26. The net healthcare result of all medical schemes in 2012 was a surplus of R25.7 million, a steep decline from the surplus of R1.0 billion that was observed in 2011. This substantial deterioration can be attributed to the fact that claims costs (net relevant healthcare expenditure) increased by 10.9% in 2012, meaning that the year-on-year financial performance of both open and restricted medical schemes worsened as a consequence.

27. Investment income and consolidation adjustments amounted to R3.6 billion in 2012 and resulted in medical schemes making a final surplus of R3.7 billion in the financial year under review.

28. Net assets or members' funds, defined as total assets less total liabilities, rose by 10.9% to R40.9 billion in 2012.

29. Accumulated funds (reserves as defined by Regulation 29 of the Medical Schemes Act) grew by 9.6% to R38.3 billion from the R34.9 billion recorded in 2011. This translated into an industry average solvency ratio of 32.6% at the end of 2012 compared with 32.5% in 2011, which is an increase of 0.3%. This level is higher than the prescribed solvency level of 25.0%.

30. The solvency ratio of open schemes increased by 1.4% to 29.1% while that of restricted schemes decreased from 38.3% in 2011 to 37.4% in 2012.

**Highlights for the CMS in the 2012-2013 financial year**

*Supporting the NHI process*

The CMS continued to support the strategic review of the South African health system in its 2012-2013 financial year.

It provided information relating to the proposed NHI policy to both the Department of Health and the parliamentary Health Portfolio Committee on Health.

The NHI White Paper is eagerly awaited.

*Promoting a medical schemes market that is efficient, orderly, and fair*

The jurisdictional delineation between the regulatory span of control of the CMS and that of the Financial Services Board (FSB) continued to be an important area of focus in the financial year under review.

The effective protection of beneficiaries and regulation of medical schemes are critically dependent on all entities and products seeking to do the business of a medical scheme being subjected to the rigorous oversight and strict protections contained in the Medical Schemes Act.

A serious threat continued to be posed to the sustainability of medical scheme risk pools and the NHI by the proliferation of insurance products which encroach negatively on socially protected health coverage.

The CMS therefore continued to participate in the process aimed at demarcating medical schemes from health insurance products which threaten to undermine the social solidarity principles enshrined in the Medical Schemes Act and offer inadequate benefits under the guise of a viable alternative to protection that can only be obtained from medical schemes.

Health insurance products such as gap and top-up cover discriminate against the most vulnerable groups in society. This is why the CMS continued to promote the protection of provisions aimed at protecting both the sick and the elderly.

One such provision is that on prescribed minimum benefits, or PMBs. Following the significant ruling against the Board of Healthcare Funders of Southern Africa (BHF) by the High Court and later the Supreme Court of Appeal, the CMS continued to protect and promote PMBs in all its endeavours.

PMBs speak to the very heart of the Medical Schemes Act as they protect beneficiaries against unforeseen health events that could otherwise ruin them financially. The undisputable, wide-reaching benefits of PMBs are discussed in

more detail in the Annual Report. The CMS also debunks some of the myths surrounding this key provision of the Medical Schemes Act.

Medical schemes in contravention of the requirements of the PMB provisions face the risk of being deregistered.

*13th unqualified audit*

The Auditor-General of South Africa (AGSA) provided the CMS with its 13th unqualified audit report in a row for the manner in which the CMS managed its financial affairs and complied with the requirements of the Public Finance Management Act 1 of 1999 (PFMA) and other applicable legislation.

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