CIRCULAR

Reference:	Guidance on benefit changes & contribution increases for 2018
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Circular 45 of 2017: Guidance on benefit changes and contribution increases for 2018

The Council for Medical Schemes (CMS) hereby prescribes to medical schemes the requirements for the assessment of the benefits and contributions for the 2018 benefit year.

The submission process remains largely the same when compared with the requirements for the 2017 submission.

1. 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, No. 131 of 1998 (the Act):

1.1. 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.

1.2. 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.

1.3. All schemes with amendments taking effect from **1 January 2018** 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.

1.4. No text can be underlined in the original documents or copies of the rules of each medical scheme. The tracked changes or summary version is required for the purpose of reviewing the proposed amendments against the scheme's rules currently registered with the CMS.

1.5. 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.

1.6. **Appendix 1A or 1A(2)** must only be completed for each benefit option which was registered in 2017, and again for all benefit options which the scheme intends to register in 2018.

1.7. **Appendix C or C(2)** must be completed for each benefit option which was registered in 2017, with different contribution rates based on income band or EDO sub-options, in an instance where the benefit option is to be registered for 2018.

1.8. **Appendix 1B** must be completed for the entire medical scheme for both 2017 and 2018. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row u) for 2017 and 2018 in Appendix B as per the approved business plan. The projected solvency ratio for 2017 and 2018 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.

1.9. **Appendix D (revised)** requires information about the assumptions on cost increases and utilisation that medical schemes used in determining their respective contribution increases for the 2018 benefit year. The Annexure has been updated in line with the CMS Annual Report 2015/16 Annexure G 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 **once only**, and deviation(s) from the guideline assumptions must be explained in the motivation for increases.

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

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

2. 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	**2017**	**2018**	**% change**
E.g. day-to-day limit	E.g. R8 000 per beneficiary	E.g. R8 800 per beneficiary	10% increase

3. 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 Act, and are fair to beneficiaries.

4. Applications for all **new benefit options** taking effect from 1 January 2018 must reach the CMS by 1 September 2017 in terms of section 33(1) of the Act. Applications received after 1 September 2017 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.

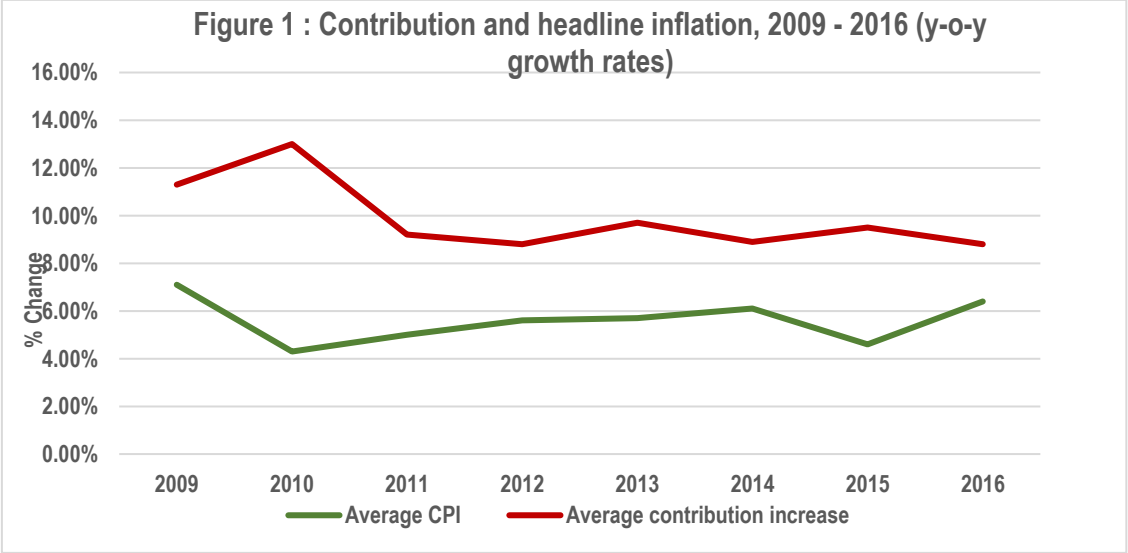
5. Schemes seeking to register **efficiency-discounted sub-options** must have obtained exemption from section 29(1) (n) of the Act. Section 8(h) stipulates that only Council (the Board of the CMS) has the power to grant exemptions from any provision of the Act. It should be noted that an exemption must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

6. In order to expedite the 2018 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 2018, for example the amendment of scheme tariffs for 2018.

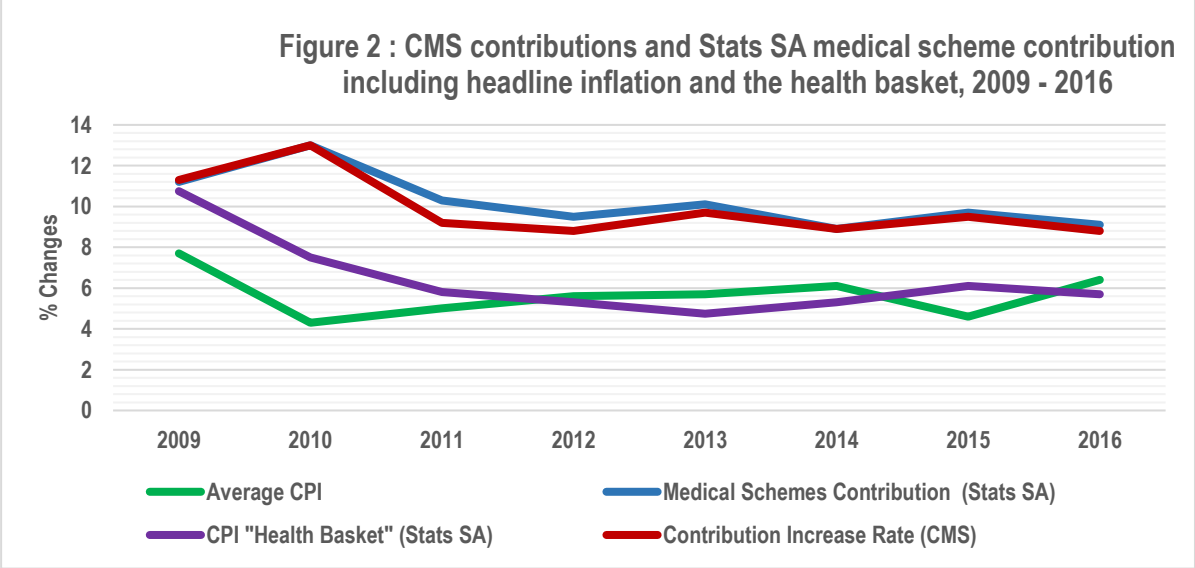
7. Guidance note on annual medical schemes' cost increase assumptions

The purpose of this section is to inform medical schemes of the key considerations which the CMS will take into account when assessing the industry cost increase assumptions for the 2018 benefit year. This is in line with the CMS mandate in terms of the Act to protect the interest of members by encouraging access to affordable quality healthcare, efficiency and long term sustainability within the industry. The CMS would therefore like to provide the following guidance on the assumptions upon which the determination of any proposed contribution increases should be based.

7.1. Historical contribution rate increases relative to consumer inflation



7.1.1. The graph above illustrates historical divergence between contribution rate increases as approved from 2009 to 2016 and headline inflation as measured by the Consumer Price Index (CPI). Similarly, figure 2 below, further incorporates medical scheme contribution increase and CPI "health basket" as reported by Statistics South Africa (Stats SA).



7.1.2. It is evident from figure 1 and 2 above, that overall medical scheme contribution rate increases have consistently outpaced both the CPI and the CPI "health basket". The Consumer Price Index is used as a proxy measure for affordability since most sectors within the economy experience CPI-linked salary increases, if any. The CMS remains concerned by the persistent high rate of contribution increase relative to the CPI, as this is clearly unaffordable and place an undue financial burden on members and their beneficiaries.

7.2. Healthcare utilisation indicators

7.2.1. The table 1 below depict the actual contribution increase rate relative to assumed increases and utilisation estimates for the period 2012 to 2017. The analysis shows that demographic and utilisation together added on average between 2.0% and 3.9% to the cost increases in medical schemes between 2012 and 2017. The utilisation of healthcare services is driven mainly by a variety of factors including the impact of changes in demographic indicators, epidemiological changes, supply side challenges, diagnostic technology etc. However, as communicated in Circular 23 of 2017, the 3.9% assumed utilization for 2017 remains a major concern for the CMS as in some cases it did not correlate with worsening or improving demographic and disease profiles of the medical scheme. This brings into question the effectiveness and/or value of all cost pull interventions used by medical schemes in managing and channelling appropriate and cost effective use of healthcare services. It is for this reason that medical schemes are requested to submit a comprehensive analysis of these factors when motivating for their respective assumptions (Appendix D) used in determining contribution increases.

7.2.2. The differential between CPI and actual contribution increase for the same period ranged between 3.2% and 4.2%, and the divergence between assumed contribution increase for 2017 and CPI was excessively high. Whilst the National Treasury projected the average CPI for 2017 at 6.4%, the industry assumed contribution increase for the same period was 11.3%. This trend has a potential of affecting affordability for the current medical scheme members and further serves as a barrier to entry for new members who are necessary in order to improve risk pooling and cross subsidisation.

Table 1: Contribution increase and assumed rates

	2012 %	2013 %	2014 %	2015 %	2016 %	2017 %
Actual Contribution Increase rate approved	**8,8**	**9,7**	**8,9**	**9,5**	**8,8**	*
CPI	**5,6**	**5,7**	**6,1**	**4,6**	**6,4**	**6,4 #**
Total assumed increase	**8,3**	**9,6**	**9,2**	**9,2**	**8,6**	**11,3**
Assumed utilization increase	**2,0**	**2,8**	**2,3**	**2,9**	**3,1**	**3,9**

Note: *to be published in the 2016/2017 Annual Report (based on approved increases from 2016 to 2017),
National Treasury CPI 2017 forecast.

7.3. Single Exist Price (SEP)

The actual (and approved) adjustment to the Single Exist Price (SEP) is published by the Minister of Health towards the end of each year. The table below provides historical increases in SEP from 2010-2017, with the SEP for 2018 still to be published. Even though the approved adjustment will be published later in the year, Medical Schemes are advised to assume a reasonable estimate for 2018 based on the historical figures.

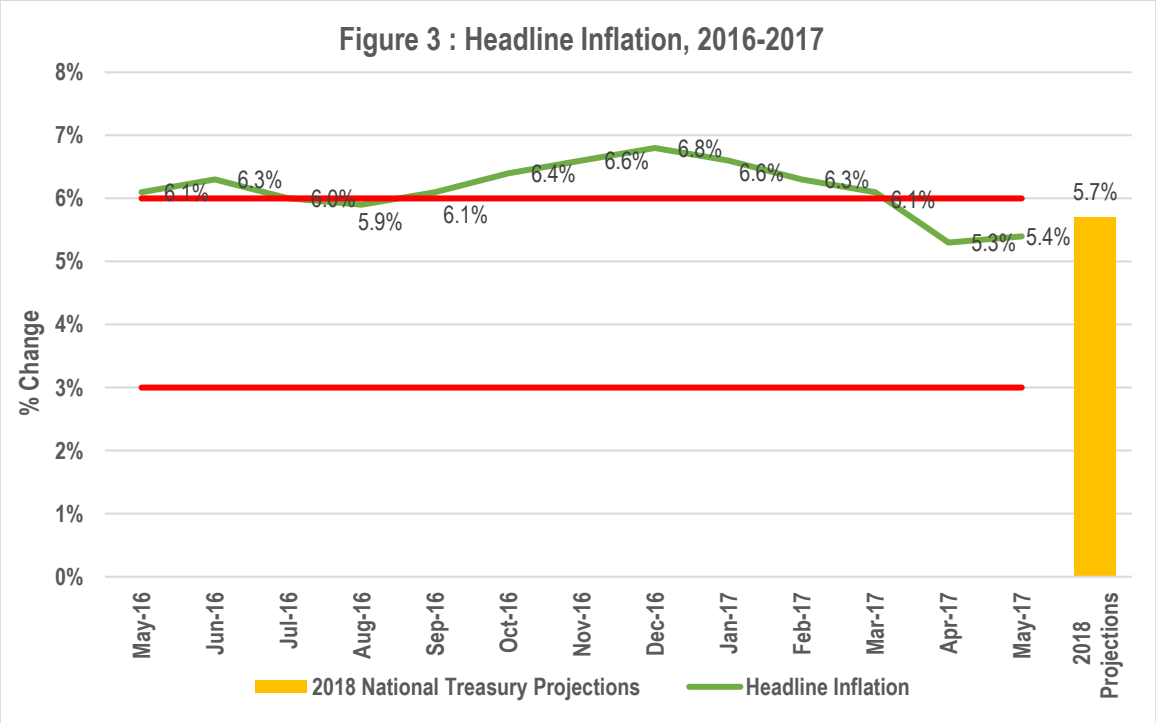
Table 2: SEP Publications (2010-2017)

Year	CPI	Approved SEP Increase
2010	4,30%	7,40%
2011	5,00%	0,00%
2012	5,60%	2,10%
2013	5,73%	5,80%
2014	5,82%	5,82%
2015	4,60%	7,50%
2016	6.20%	4.8%
2017	6.40%	7.5%

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

7.4. Headline inflationary expectation

The graph below depicts the South African Reserve Bank (SARB) inflation targeting against historical Consumer Price Index data as published by Stats SA for the twelve month period up to May 2017.



7.4.1. The year-on-year (y-o-y) headline consumer (CPI) inflation as measured by Stats SA moderated to 5.3% and 5.4% in April and May respectively, after reaching 6.1% in March 2017.

7.4.2. According to the inflation forecast of the SARB as indicated in its May Monetary Policy Committee (MPC) statement, headline consumer price inflation is projected to average 5.7% in 2017, before easing further to 5.3% in 2018. Similarly, according to the Bureau For Economic Research (BER) in its Economic Prospects, second quarter 2017, inflation is expected to average between 5.8% and 5.5% in 2017 and 2018 respectively. Furthermore, the National Treasury has projected the CPI to be marginally higher at 6.4% for 2017 and 5.7% for 2018.

7.5. Economic and turbulent labour market conditions

7.5.1. The South African economy has slipped into technical recession after the GDP shrank by 0.7% in the first quarter of 2017, following a 0.3% contraction in the fourth quarter of 2016 (Stats SA, 2017). Within an environment of subdued growth, the economy continues to shed jobs with employment plummeting by 48 000 quarter-on-quarter according to Stats SA, Quarterly Employment Statistics 2017. Furthermore, the unemployment rate has also edged up to 27.7% from 26.5% .7%, in the first quarter of 2017. This is the highest unemployment rate since 2004. This comes against the backdrop of South Africa losing its investment grade to sub-investment grade ("or "junk status").

7.5.2. In addition, the job losses in the formal sector and the persistently high unemployment rate poses a long term viability risk to the medical scheme industry, especially since growth has been almost stagnant in the past few years. The impact of the recession and the ratings downgrade will further dampen consumer confidence and consumers will remain vulnerable going forward. These adverse macro-economic conditions will likely have a spillover effects into the medical scheme industry such as possible member downgrades from comprehensive options to lower options and the risk of a surge in dropout rate. It is also important to highlight the findings of the healthcare consumer survey conducted by the Health Market Inquiry (HMI) in 2016, which shows that amongst other things about 65% of individual interviewed highlighted affordability and job losses as a reasons for leaving the medical schemes environment, whilst 5.6% complained about value for money (HMI, 2016).

7.6. CMS recommendation

7.6.1. Having taken into account the current macro-economic indicators including year-on-year changes in the consumer inflation and affordability constraints, the CMS hereby advises that the cost increase assumptions of medical schemes for the 2018 benefit year should be limited to 5.7% for each individual cost driver. Notwithstanding the impact of the fluctuation in the currency market, it remains the position of the CMS that the increase in hospital fees, pharmaceutical products and therapeutic appliances should also be limited to 5.7% in line with consumer inflation. Similarly, the assumed increases in non-healthcare expenditure (i.e. administration and managed care fees) for 2018 should **not** be greater than the CPI projections.

7.6.2. Whilst the Council for Medical Schemes is conscious of the unique industry specific cost-push factors besetting the healthcare sector, such as new technology, exchange rates volatility and utilization; the impact of other market inefficiencies driving up costs in the industry cannot be ignored. Accordingly, Trustees and Principal Officers must continuously review their business delivery models and seek other efficient ways of curbing costs, as opposed to merely shifting the financial burden onto members with contribution increases in excess of the CPI or by simply reducing the benefits offered to members.

7.6.3. Amidst the current technical recession, and the threat of possible further job losses and affordability constraints, it is evident that medical scheme members and the public in general will remain under immense financial pressure going forward. The Trustees must accordingly take into consideration the current macro-economic climate and more importantly, member affordability constraints in their pricing decision for 2018. Any deviation from the CMS guideline provided in 7.6.1 above must be accompanied by a detailed motivation.

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.

8. A report that is required to be sent together with the proposed amendments must take into account the requirements of the Advisory Practice Note (APN) published by the Actuarial Society of South Africa (ASSA), and specifically APN303 – *Advice to South African Medical Schemes on Adequacy of Contributions* (replaces PGN303).

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 expenses
- assumptions
- financial projections

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

9. 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 Act. The marketing of amendments that have not been approved and registered is strictly prohibited, and would amount to a transgression in terms of Section 66 of the Act.

10. National Health Insurance

The CMS would also like to sensitise the industry to the recently gazetted National Health Insurance (NHI) policy as published by the Minister of Health (NDoH, 2017). Amongst others, the White Paper provides an opportunity for the industry to consolidate in a manner that will improve efficiency within benefit option designs and configurations whilst also addressing fragmentation of the current risk pools. The main objective being to deepen cross subsidization, risk pooling and social solidarity, which will improve affordability of the current environment. The proposed policy interventions seeks to assist consumers when purchasing medical schemes cover, and are amongst other things aimed at limiting buy-down behavior by members of medical schemes, which affects contributions increases.

According to the World Health Organization (WHO), "…Large risk pools are better *than small ones because they can increase resource availability for health services. ....The larger the pools, the bigger the share of contributions that can be allocated exclusively to health services. In addition, large risk pools can take advantage of economies of scale in administration and reduce the level of the contributions required to protect against uncertain needs, while still ensuring that there are sufficient funds to pay for services*…" (WHO, 2008)

The Competition Commission's (CC) HMI also identified information asymmetries as one of the theories of harm as well as challenges with regards to multiple benefit options. Amongst others, the HMI is also investigating the impact of section 33(2) of the Act on risk pooling and cross-subsidization (Competition Commission, 2016b).

The CMS is also concerned by the impact of product proliferation of benefit options especially since a significant number of these options are running at a loss. It is against this background that the CMS will be undertaking research with regards to risk pooling and consolidation, analysis of the Efficiency Discounted Options (EDO's), and benefit option classification. These research initiatives will be supported by a review of the Amendments to the Act. Until then, medical schemes are cautioned against further fragmentation of their current risk pools through the introduction of additional benefit options including EDO's.

Schemes are also reminded that in terms of the prescripts of section 33(2) of the Act, the Registrar shall not approve any benefit option under this section unless the Council is satisfied that the benefit option:

a) Includes the prescribed minimum benefits
b) Shall be self-supporting in terms of membership and financial performance
c) Is financially sound, and
d) Will not jeopardise the financial soundness of any existing benefit option within the scheme.

The deadline for medical schemes to submit their rule amendments scheduled to take effect from 1 January 2018 is **1 October 2017**, 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 S Kabane
Acting Chief Executive & Registrar
Council for Medical Schemes