CIRCULAR

Reference:	Guidance on benefit changes & contribution increases for 2017
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Circular 48 of 2016: Guidance on benefit changes and contribution increases for 2017

The Council for Medical Schemes (CMS) hereby prescribes to medical schemes the requirements for the assessment of the benefits and contributions for the 2017 benefit year.

The submission process remains largely the same when compared with the requirements for the 2016 submission.

1. The following process must be adhered to when submitting amendments in terms of section 31(3), Regulation 2(d) and Regulation 4(b) & (d) of the Medical Schemes Act 131 of 1998:

    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 done so already.

    1.3. All schemes with amendments taking effect from **1 January 2017** 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 2016, and again for all benefit options which the scheme intends to register in 2017.

1.7. **Appendix C or C(2)** must be completed for each benefit option which was registered in 2016, with different contribution rates based on income band or EDO sub-options, in an instance where the benefit option is to be registered for 2017.

1.8. **Appendix 1B** must be completed for the entire medical scheme for both 2016 and 2017. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row u) for 2016 and 2017 in Appendix B as per the approved business plan. The projected solvency ratio for 2016 and 2017 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 schemes 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 2017 benefit year. The Annexure has been updated in line with the annual report "Annexure F" 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	**2016**	**2017**	**% change**
E.g. day-to-day limit	E.g. R6 000 per beneficiary	E.g. R6 600 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 Medical Schemes Act and fair to beneficiaries.

4. Applications for all **new benefit options** taking effect from 1 January 2017 must reach the CMS by 1 September 2016 in terms of Section 33(1) of the Medical Schemes Act. Applications received after 1 September 2016 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.

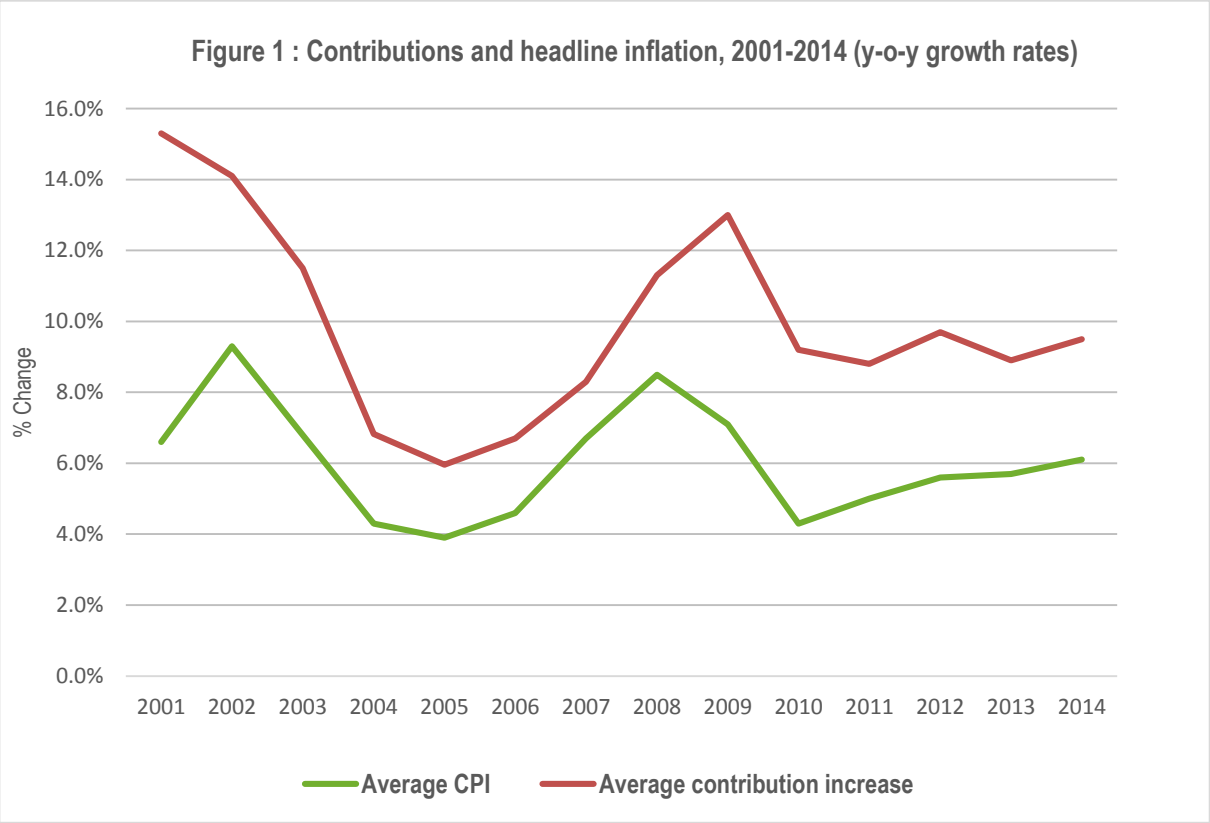
5. Schemes seeking to register **efficiency-discounted sub-options** must have obtained exemption from section 29(1)(n) of the Medical Schemes Act. Section 8(h) stipulates that only Council (the Board of the CMS) has the power to grant exemptions from any provision of the Medical Schemes Act. It should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

6. In order to expedite the 2017 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 2017, for example the amendment of scheme tariffs for 2017.

7. Guidance note on annual medical schemes cost increase assumptions

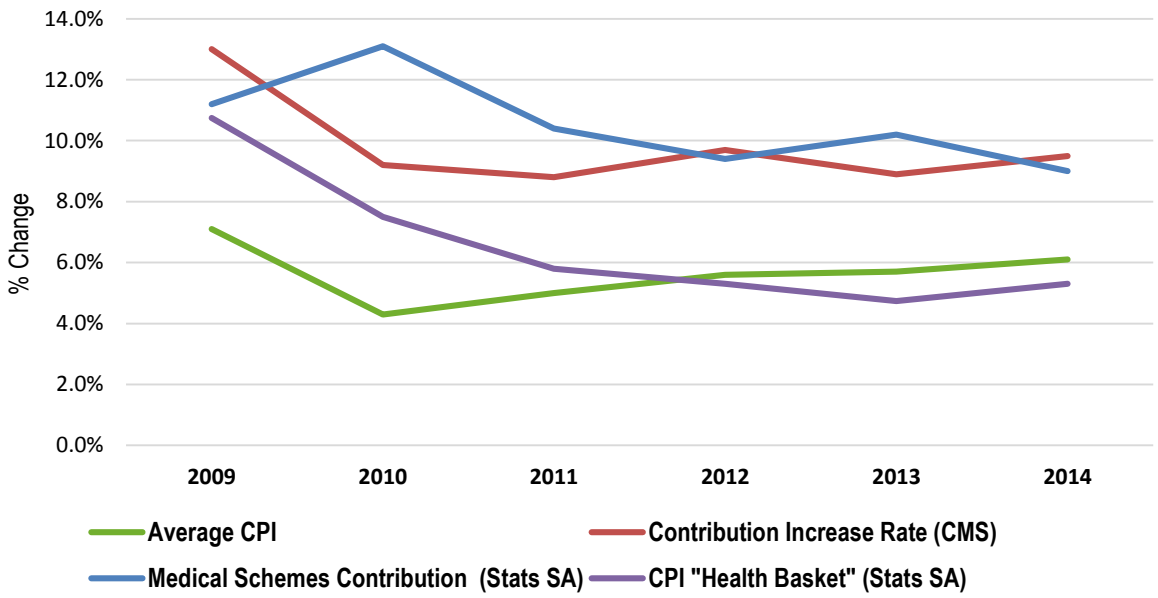
The purpose of this section is to inform medical schemes of the key considerations which the CMS will take into account when assessing the industry cost increase assumptions for the 2017 benefit year. The CMS would therefore like to provide the following guidance on the assumptions upon which the determination of any proposed contribution increases should be based on.

7.1. Historical contribution rate increases relative to consumer inflation



7.1.1. The graph above illustrates historical divergence between contribution rate increases as reported in the 2014/2015 CMS annual report and headline inflation as measured by the Consumer Price Index (CPI). Similarly, figure 2 below, further incorporate medical scheme contribution increase and CPI "health basket" as reported by Statistics South Africa (Stats SA).

Figure 2 : CMS contributions and Stats SA medical scheme contribution including headline inflation and the health basket, 2009 - 2014



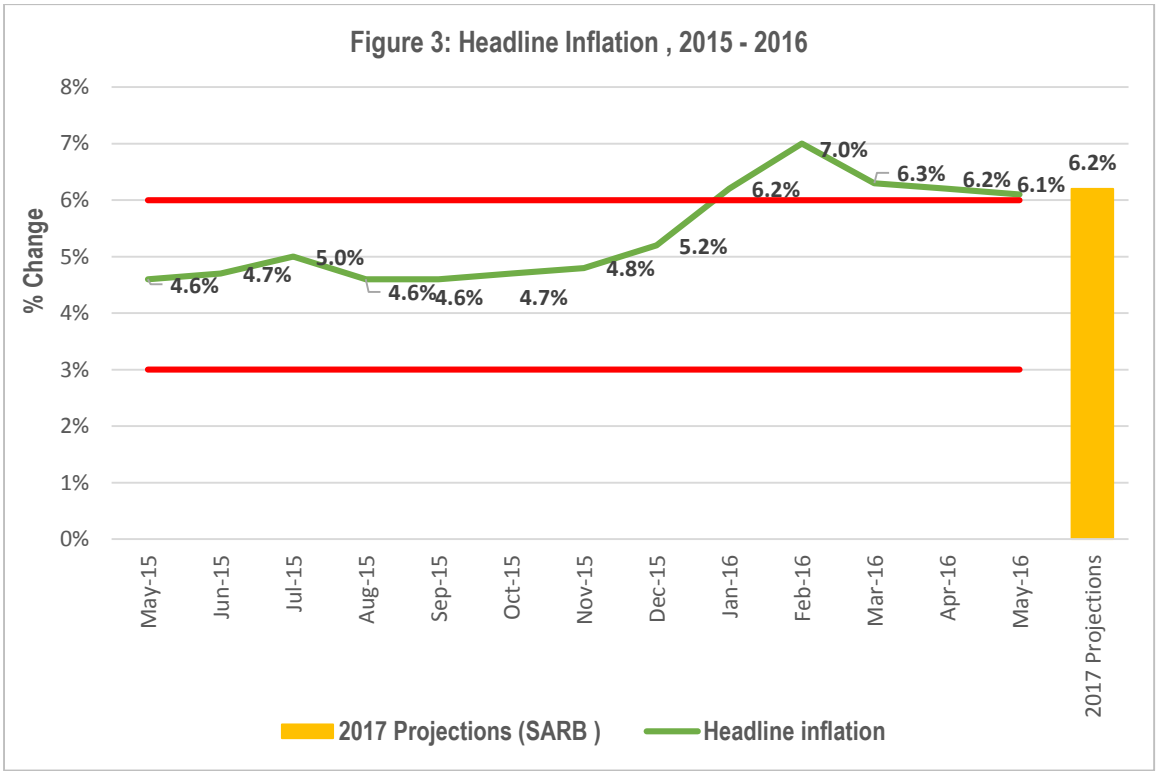
7.1.2. It is evident from figure 1 and 2 above, that overall medical scheme contribution rate increases have consistently outweighed both the CPI and the CPI "health basket". The Consumer Price Index is used as a proxy measure for affordability since most sectors within the economy experience CPI-linked salary increases. The persistent high rate of contribution increase relative to CPI is not sustainable and remains a major concern for the CMS.

7.1.3. Whilst the Council for Medical Schemes is cognisant of the impact of utilisation, reserve loading, and depreciation of the rand and other industry specific cost-push factors, contribution increases in excess of consumer inflation, place an undue financial burden on members. In addition, higher increases serve as a barrier to entry barrier for potential new members. It also leads to limited financial protection for the members, particularly considering the fact that young and healthy members tend to be more sensitive to excessive contribution increases. Limited growth in the industry also threatens the long term sustainability of the industry.

7.1.4. The South African economy is also currently mired in a myriad of macroeconomic challenges. Furthermore, the South African Reserve Bank (SARB) is faced with a "policy dilemma" trying to contain the higher inflation rate against the backdrop of slowing economic growth. The domestic currency has also depreciated significantly and remain susceptible to further volatility. According to the Quarterly Employment Statistics for the first quarter of 2016 released by Stats SA, it is evident that the economy continues to shed jobs. Job losses within the formal sector of the economy poses a huge challenge on growth within the industry. These macro-economic conditions have left consumers more vulnerable than in the previous years. Accordingly, in the context of the current domestic and global economic macroeconomic instability, medical scheme Trustees should be cognisant of the adverse effect of higher contribution increases on their members.

7.2. Headline Inflationary Expectations

The graph below depict historical Consumer Price Index data as published by Statistics South Africa for twelve month period up to May 2016.



7.2.1. The year-on-year inflation rate as measured by the Consumer Price Index (CPI) was 6.1% in May 2016. This rate was a little lower than the annual rate of 6.2% and 6.3% recorded in April and March 2016 respectively. Although inflation has moderated in recent months, after reaching 7% in February, it remains outside the 3% to 6% target range set by the SARB. According to the latest inflation forecast of the Monetary Policy Committee (MPC) as indicated in its May policy statement, headline inflation is projected to average 6.2% in 2017. The National Treasury on the other hand has projected the headline inflation to be marginally higher at 6.8% for the same period.

7.2.2. Having considered the year-on-year changes in the CPI and other key macroeconomic indicators, the CMS hereby advises that the cost increase assumptions of medical schemes for the 2017 benefit year should be limited to 6% for each individual cost driver.

7.2.3. Notwithstanding other unique healthcare industry specific challenges including the adverse effect of the current volatility in the exchange rate market, it remains the position of the CMS that the increase in hospital fees, pharmaceutical products and therapeutic appliances should also be limited to 6% in line with consumer inflation. Market participants and stakeholders must seek other efficient ways of curbing costs, as opposed to simply shifting the financial burden to medical scheme members.

7.2.4. Historical data shows that the year-on-year increases in non-healthcare expenditure (i.e. administration and managed care fees) have been below the CPI. Based on this trend, the assumed increase in non-healthcare expenditure for 2017 should **not** be greater than the CPI projections.

7.3. Single Exit Price (SEP)

The actual (and approved) adjustment to the Single Exit Price (SEP) is published by the Minister of Health towards the end of each year. The table below provides historical increases in SEP from 2010-2016, with the SEP for 2017 still to be published.

Table 1: *SEP Publications (2010-2016)*

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%	4.80%

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

The National Department of Health (NDoH) has published the proposed Single Exit Price for 2017 in Notice 759 in Government Gazette 40093 for public comments. The SEP of medicine and scheduled substance will be adjusted to a maximum of 5.7%. Even though the approved adjustment will be published later in the year, Medical Schemes are advised to take into account the current 5.7% as gazetted by the Minister of Health in their 2017 assumptions for medicine costs.

7.4. Healthcare utilisation indicators

The analysis that was performed on the changes to benefits and contributions for the 2016 benefit year showed that demographics and utilisation together added an average of 3.05% to the cost increases in medical schemes (see Circular 26 of 2016). The utilisation of healthcare services is driven by a variety of factors including demographic indicators, epidemiological changes, and diagnostic technology. 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.

A 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, and any deviation(s) from the guideline should be motivated.

8. 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 (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 Medical Schemes 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 Medical Schemes Act.

The deadline for medical schemes to submit their rule amendments scheduled to take effect from 1 January 2017 is **1 October 2016**, 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.

Daniel Lehutjo
Acting Chief Executive & Registrar
Council for Medical Schemes