CIRCULAR

Reference:	Guidance on benefit changes & contribution increases for 2021
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Circular 52 of 2020: Guidance on benefit changes and contribution increases for 2021

This Circular prescribes the requirements that must be adhered to by medical schemes for the assessment of annual medical scheme contribution increases, and benefit changes for the 2021 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 (131 of 1998), is to protect the interests of beneficiaries at all times and to control and co-ordinate the functioning of medical schemes in a manner that is complementary with the national health policy. To this end, CMS' key objective is to ensure that annual medical scheme contribution rate increases remain affordable to encourage equitable access to quality healthcare, and overall long-term sustainability of the medical schemes industry.

1. Macro-economic outlook

This section provides an abridged overview of key economic indicators such Gross Domestic Product (GDP), employment statistics, consumer price index (CPI), interest rates, exchange rate, household income and expenditure, corporate earnings, which have a bearing on the contribution increase in the medical schemes industry. Overall, these factors have a direct and indirect impact on the affordability of medical scheme contribution rates, the financial performance of schemes, risk pooling, cross subsidisation, membership growth and the long-term sustainability of the industry.

1.1. Global economic outlook

The global outbreak of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) which causes coronavirus disease 2019 (COVID-19), has disrupted global supply chains, and almost ground international trade to a halt save for essential services, as governments impose national lockdowns in an effort to curb the spread of the virus.

Despite countries easing lockdown restrictions, global economic recovery is mired by many uncertainities, as the worldwide rate of infections continues to surge unabated. The promise of the successful development of

a vaccine also remains murky. These factors may lead countries to revert to lockdown restriction measures again, causing a further delay in international trade recovery. Accordingly, the economic cost of the pandemic on the global output will remain bleak and uncertain.

1.2. South African economic outlook

The economic shock sparked by recessions followed by the onset of the COVID-19 pandemic and the subsequent sub-investment grading by credit agencies has exacerbated the country's economic distress. This happened when the South African economy was already mired by the impact of a technical recession from subsequent years including many other macro-economic challenges pre-COVID-19. Lockdown restrictions have also led to a sharp contraction of the economy. Although government interventions have, to some extent, cushioned the impact on workers and businesses, these have not offset the full impact of COVID-19 (National Treasury, 2020).

1.2.1. Domestic Gross product

According to the National Treasury: Economic Outlook, the Gross Domestic Product (GDP) is projected to contract by a hefty 7.2% in 2020, before increasing by 2.6% in 2021 (National Treasury, 2020). The table below provides economic growth projection between 2020 -2023

Table 1: Economic growth forecast

Percentage change	2010-2018[1]	2019	2020	2021	2022	2023
Real GDP growth	1.9	0.2	-7.2	2.6	1.5	1.5
GDP inflation	5.7	4.0	4.0	3.9	4.4	4.6
GDP at current prices (R billion)	3 811.9	5 077.6	4 900.2	5 227.9	5 536.1	5 873.4
CPI inflation	5.3	4.1	3.0	3.9	4.3	4.5

1. Average growth rates

Sources: National Treasury, Reserve Bank and Statistics South Africa

The rate and the speed of domestic economic recovery remains highly uncertain due to the current unfolding COVID-19 pandemic, and overall global weak investor confidence. Accordingly, the country's well-documented electricity supply constraints, the current sub-investment grade coupled with the burgeoning public sector debt, imply that economic recovery in South Africa is likely to lag behind those of its counterparts in other emerging economies.

1.2.2. Employment statistics

The unemployment rate correlates with the medical schemes membership increase or decrease. It has continued to increase over the past years. According to the Statistics South Africa: Quarterly Labour Force Survey, the number of employed persons decreased by 38 000 to 16,4 million in Quarter 1 of 2020, while the number of unemployed persons increased by 344 000 to 7,1 million compared to Quarter 4 of 2019 (Stats SA, 2020). The unemployment rate also increased by 1,0 percentage point to 30,1%, whilst the

labour force participation rate increased by 0,5 of a percentage point to 60,3%. The absorption rate decreased by 0,3 of a percentage point to 42,1% in the first quarter of 2020 compared to the fourth quarter of 2019 (Stats SA, 2020).

Stats SA also observed that *"..the largest employment decreases were observed in the formal sector (50 000), followed by the Agricultural sector with 21 000 in Q1: 2020. On the other hand, employment in the informal sector and Private households increased by 3 000 and 30 000 respectively in Q1: 2020 compared to Q4: 2019. The number of discouraged work-seekers increased by 63 000, with the number of people who were not economically active for reasons other than discouragement decreasing by 222 000 between the two quarters, resulting in a net decline of 159 000 in the not economically active population.."* (Stats SA, 2020)

Furthermore, Stats SA recently undertook a survey on the impact of COVID-19 on employment, hunger and income. The results of the study showed amongst others that 25,8% of respondents reported a decrease in their income whilst 5.2% reported that their business closed because of COVID-19, and 2% lost their jobs due to lockdown measures (Stats SA, 20 May 2020).

Due to the factors above, the economic cost on companies due to COVID-19 is likely to increase in the coming months, as some companies might be faced with increased production costs, stagnant or dwindling revenue, and increased pressure to service debt. These companies may also continue to lay off workers to cut operational costs. It is therefore expected that unemployment will continue to rise quickly, and might remain elevated.

1.2.3. The rand exchange rate

The domestic currency has also fared significantly worse compared to other emerging market currencies since the beginning of 2020. To this end, Treasury noted that *"…the rand has depreciated by 18.1 per cent against the US dollar since January. In comparison, an index of emerging-market currencies weakened by 4.6 per cent over the same period. South Africa's risk premium... stood at 5.2 per cent at 15 June 2020, compared with 3.2 per cent at the end of 2019..."* (National Treasury, 2020). The weak domestic currency is likely to add to the high input cost in the pharmaceutical sector where most of the active ingredients and new medical technologies are generally imported.

1.2.4. Interest rates

In response to the economic shock, the Reserve Bank has drastically reduced interest rates in the past few months, with the repo rate now at 3.75% and the prime rate at 7.25%. While indebted consumers and members of medical schemes have significantly benefited from the low interest-rate environment, medical schemes investments in money markets will experience a decrease in investment income. With inflation generally subdued, there may be possible further easing of monetary policy, as the Reserve Bank continues to cushion the economy against COVID-19 economic shock. The poor investment returns for medical schemes in 2020, is therefore likely to be further amplified by the volatility in the equity markets as companies either suspend or totally withhold dividend pay-outs, to preserve cash amid the uncertainty caused by the pandemic.

2. Severe Acute Respiratory Syndrome Coronavirus (2019)

2.1. The South African health system is currently dealing with an outbreak of coronavirus disease (COVID-19). It is estimated that 80% of people who are infected with COVID-19 will not have significant symptoms that require expensive inpatient treatment. WHO states that *"…10% to 15% of people under the age of 50 who are infected with COVID-19 are likely to have moderate to severe infections, some of these cases will require intensive care whilst older adults are particularly at a significant risk of severe infections with around 10% of COVID-19 cases in this segment of the population requiring intensive care unit admissions and 95% of deaths have occurred in those older than 60 years..."(WHO, 2020)*

International and local evidence suggests that people older than 60 years, and those with underlying medical conditions at any age, particularly if not well controlled, might be at a higher risk for severe illness from COVID-19. Studies also show that a significant number of patients with severe symptoms of COVID-19 are likely to have symptoms such as acute respiratory distress syndrome, acute respiratory failure, coagulopathy, septic shock, and metabolic acidosis. In some cases, these patients also have at least one of the following comorbidities: hypertension, diabetes, obesity, cardiovascular diseases, chronic lung diseases, chronic obstructive pulmonary disease (COPD), haemoglobin disorders, chronic kidney disease, liver disease and many other conditions that weaken the immune system (immunocompromised patients), including cancer treatment, bone marrow or organ transplantation, HIV (with a low CD4 cell count or not on HIV treatment), TB and prolonged use of corticosteroids and other immune weakening medications.

As such, COVID-19 was declared a Prescribed Minimum Benefit (PMB). To this end, the CMS has been providing the industry with PMB definition guidelines to clarify PMB entitlements for members of medical schemes ensuring alignment with the National Institute for Communicable Diseases (NICD) guidelines and medicine recommendations made by the National Essential Medicines List Committee (NEMLC).

2.2. COVID-19 incidence

In South Africa, the NICD recently reported that *"The incidence risk was highest among those in the 40-44-year age group (that is 48.0 cases per 100 000 persons), followed by those in the 35-39-year age group (47.3 cases per 100 000 persons), with the lowest incidence risk in the 5-9-year age group (3.5 cases per 100 000 persons.* NICD also noted that *...fifty-seven per cent (95% CI 56- 58 %) of the cases were female and the overall incidence risk was higher among females than males (29.5 cases per 100 000 persons [95%CI 28.9-30.1] versus 22.5 cases per 100 000 persons [95% CI 21.9-23.1). However, this varied by age group with the peak incidence risk among females aged 35-44 years and males aged 50-54 years…"* (NICD, May 2020). In 2018, the average age of the covered medical schemes population was 32.8 years whilst the proportion of pensioners —that is, beneficiaries aged 65 and older— increased to 9.0% from 8.4% in 2017. This represented 10.7% in the open schemes market and 6.9% in the restricted schemes.

2.3. Demographic risk profile

As the pandemic unfolds, some medical schemes may experience a sudden spike in high-cost claims in the coming months although the overall economic cost of COVID-19 on the industry remains highly uncertain. The adverse impact of the pandemic on the medical schemes industry also depends on each scheme's demographic risk profile, the size of the population covered and the extent of existing cross-subsidies within the benefit options or schemes.

In addition, the individual financial position of a medical scheme pre-COVID-19 will determine the degree to which it is likely to absorb the possible high-cost claims related to the pandemic. The CMS believes that medical schemes with high accumulated reserves should be well insulated against this shock, while schemes that are already in a weak financial position, may potentially require other interventions including closure of non-performing benefit options or looking for potential amalgamation partners.

2.4. Deferred demand: elective surgeries and other non-urgent medical services

Since the declaration of the National State of Disaster published in Government Notice No. 313 of Government Gazette No. 43096 on 15 March 2020 to manage and curb the spread of the pandemic, hospitals began to postpone elective surgeries, as the health sector made provisions for additional capacity to cater for the expected surge of COVID-19 caseload. Consequently, the demand for elective surgeries and overall consumption of related medical services decreased significantly. According to the estimates by Emerman, deferred demand for these elective procedures can potentially reduce total healthcare costs by up to 4% in 2020, whilst Achilles noted that the deferral of elective services due to the COVID-19 pandemic will have a significant impact on claims both during and after the pandemic. Achilles also demonstrated that in some cases the reductions in claims may be offset by higher COVID-19 related costs, however, after all the COVID-19 associated expenditure, there is a probable expectation for an overall decrease in claims compared to the previous year (Emerman, 2020, Achilles, 2020). In addition, Milliman Inc. also found that while COVID-19 could lead to large cost increases, decreases in utilisation should be expected from health care services that have been deferred or forgone during the pandemic (Milliman Inc, 2020).

2.5. Impact on alcohol ban and healthcare expenditure

Alcohol and tobacco consumption have been identified as risk factors in the transmission and cost-effective management of COVID-19. In addition to exacerbating COVID-19 comorbidities, tobacco consumption as a demerit good is harmful to society due to the spill over effect on third parties. The negative externalities produced by tobacco use causes major health issues for the user, and greater adverse effects for society. In addition, excessive use of alcohol can lead to several other negative externalities such as an increase in crime rates, motor vehicle accidents, occupational injuries, home accidents, etc. This has a major impact on healthcare expenditure, and it also represents an opportunity cost within both the public and private sector. In this regard, CMS expects that the continued alcohol and tobacco ban by the government under the current regulations may likely result in fewer related disease treatment claims for medical schemes. This may therefore translate into additional savings by the medical schemes.

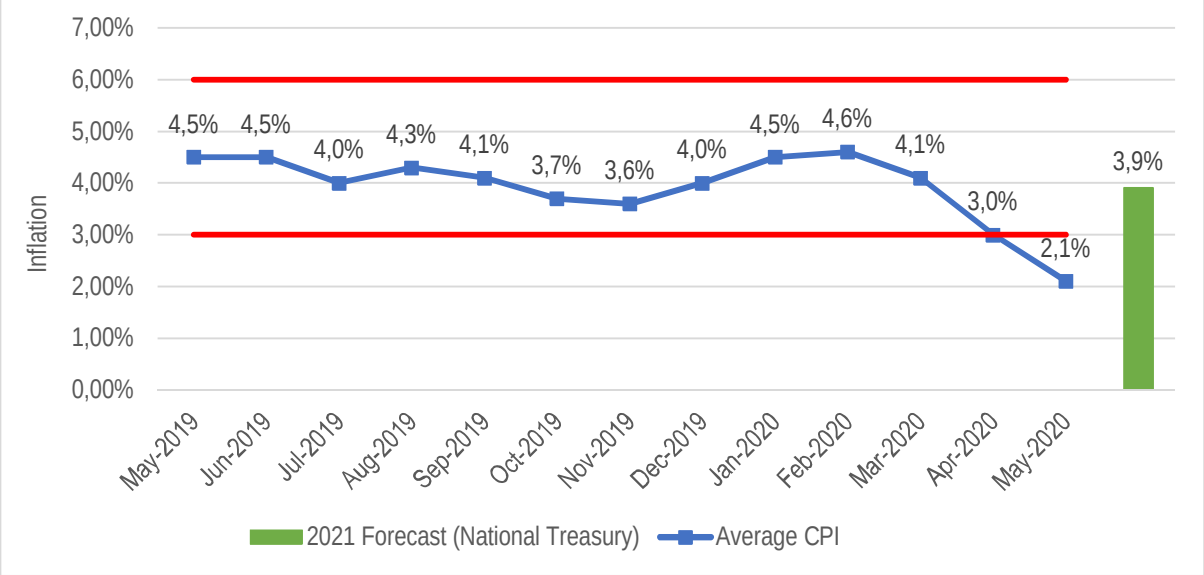
3. Guidance note on annual medical schemes cost increase assumptions

Outlined below are key industry specific considerations that the CMS will consider when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost increase assumptions for 2021 benefit year:

3.1. Headline inflationary expectations

The graph below depicts historical consumer price index (CPI) data as published by Stats SA for the twelve months up to May 2020 and National Treasury CPI forecast for 2021, against the inflation targeting framework of the South African Reserve Bank (SARB).

Figure 1: Headline inflation 2019 – 2020



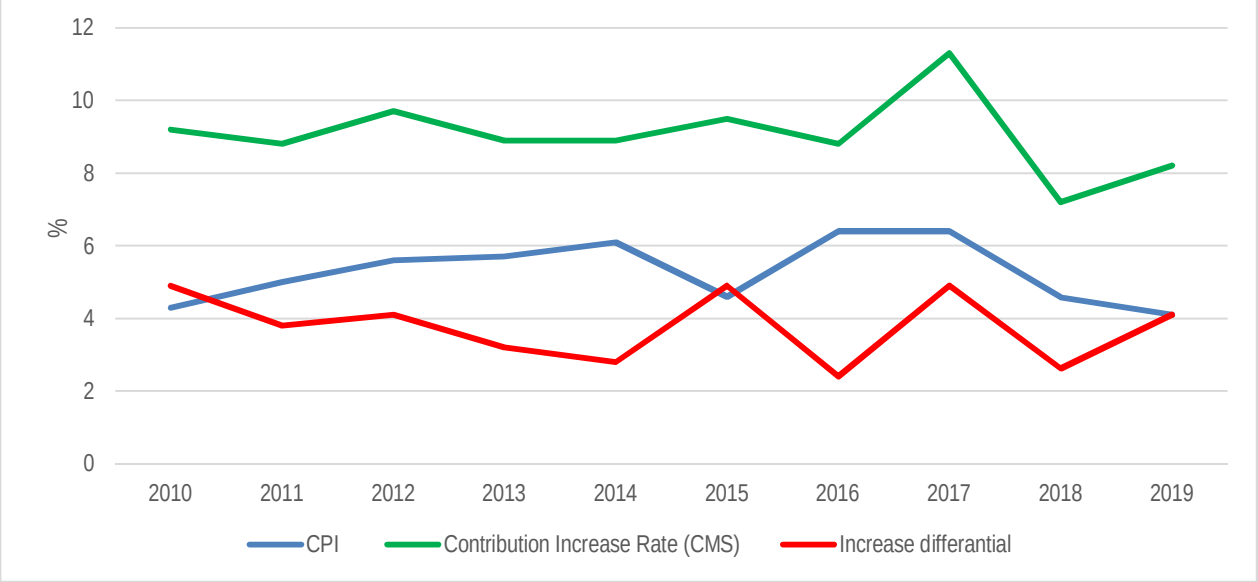
The year-on-year headline consumer inflation rate as measured by consumer price index (CPI) was 4.1% in March 2020, before a sharp decrease to 3.0% in April 2020 and then dipping further to 2.1% in May 2020, breaching the lower end of the SARB inflation target.

According to the latest inflation forecast of the SARB, as outlined in the May Monetary Policy Statement (MPC), headline inflation is expected to average 3.4% in 2020, before edging up to 4.4% in 2021 and 2022 (SARB, 2020). Similarly, accordingly to the National Treasury's Economic Outlook, consumer inflation is projected to average 3.0% in 2020, before increasing to 3.9% and 4.3% in 2021 and 2022 respectively (National Treasury,2020). The CMS uses CPI, as a proxy measure for affordability since most sectors within the economy experience CPI-linked salary increases, if any. Cost increase assumptions within the industry must therefore take into consideration the hardship experienced by the members due to financial distress first and consider headline inflationary expectations.

3.2. Medical scheme contribution dynamics and consumer inflation

The graph below (figure 2) provides an illustration of trends of the contribution increase rate as reported in the 2018/2019 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 2: Medical schemes contributions and headline inflation (2010-2019)



It is evident from figure 2 above, that the medical scheme contributions increase rate has consistently surpassed the CPI. The average contribution increase rate of 8.2 % for 2019, as reported by the CMS was double the average CPI of 4.1%. CMS remains concerned about this trend, as this places an undue financial burden on members of medical schemes and further serves as a barrier to entry for potential new members. The high increase differential between medical scheme contributions increase rate and CPI, poses a serious affordability challenge for members, especially in the current and post COVID-19 economy, where annual salary adjustment are unlikely to keep pace with medical schemes contribution increases.

Figure 3: Medical schemes contributions and Stats SA health insurance (2013-2019)

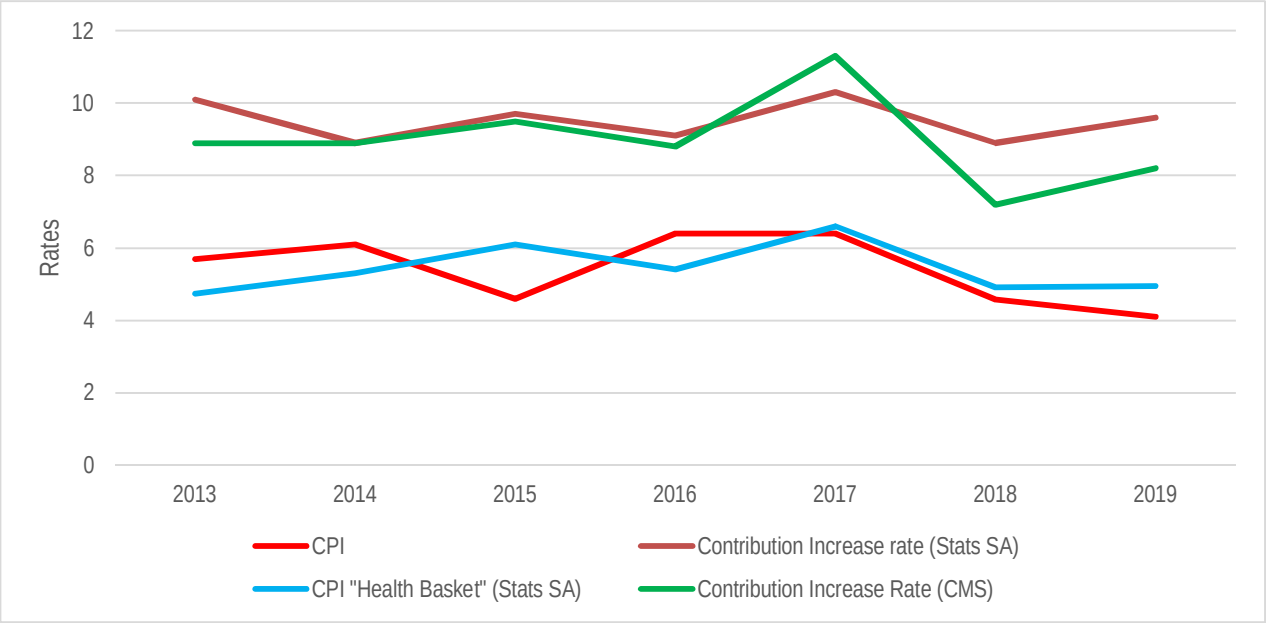


Figure 3 on the previous page shows that the CMS contribution increase rate of 8.2% for 2019 was relatively lower than 9.6% contribution rate increase as reported by Stats SA, representing a differential of 1.4 %. Moreover, the CPI "health basket" of 4.9%, remains higher than the average consumer inflation of 4.1% over the 12 months' period.

3.3. Pre-COVID-19 utilisation and contribution increase trends

Table 2 below depicts changes between the years 2012 to 2020 on the actual contribution increase in relation to projected tariff and utilisation increases.

Table 2: Actual contribution increase and assumed rates

	2012	2013	2014	2015	2016	2017	2018	2019	2020
Actual Contribution Increase rate	9,7	8,9	8.9	9.5	8.8	11.3	7.2	8.2	*
CPI	5,6	5,7	6.1	4,6	6,4	5.3	4.6	5.4	3.0
Assumed utilisation increase	2.0	2.8	2.3	2.9	3.05	3.9	3.3	3.9	3.7
Tariff	6.3	6.8	6.9	6.3	5.55	7.4	5.5	5.4	5.1
Total assumed increase	8.3	9.6	9.2	9.2	8.6	11.3	8.18	8.6	8.8

Note: *to be published in the 2019/2020 CMS Annual Report

The overall cost increase assumption associated with utilisation was 3.7%, while assumed tariff increase was 5.1%, resulting in a total cost increase assumption of 8.8% for the 2020 benefit year. Cost increase assumptions analysis for 2020 showed that the combination of demographic and utilisation factors are projected to add about 3.7% points to the total cost increases for medical schemes, marginally lower than 3.9% for 2019 benefit year.

3.4. Single Exist Price (SEP) for medicines

The medicine prices are regulated and determined by the SEP. Table 3 below depicts historical Single Exist Price (SEP) for the period 2012-2020 relative to consumer inflation. 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 Gazetted increase for 2020 is 4.53% whilst the SEP for 2021 will be published later in the year. Medical schemes are advised to assume a reasonable estimate for 2021 based on the table below.

Table 3: SEP Publications

Year	Average CPI	Approved SEP Increase
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%
2020	3.0%	4.53%

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

4. National Health Insurance (NHI)

4.1. Medical scheme risk pool consolidation

On 26 July 2019, the Minister of Health released the National Health Insurance Bill. This Bill was then tabled in parliament in August 2019 where parliament called for written submissions between September and November 2019. The Portfolio Committee on Health also held public hearings on the National Health Insurance (NHI) Bill across different provinces.

The NHI Policy states that progress towards universal health coverage requires transformation and reconfiguration of institutions for pooling of funds and purchasing of services within both public and private healthcare to achieve income and risk cross-subsidisation, whilst improving the efficiency and effectiveness in purchasing of personal health services.

The NHI Bill as well as the Medical Schemes Amendment Bill further indicated that once the NHI Fund is fully implemented medical schemes will not be allowed to provide duplicative cover but rather they will only offer complimentary cover. Considering the above, the CMS initiated the following projects on risk pool consolidation:

- Standardisation of benefit options
- Review of Secondary Data including Working Papers, Circulars, and other published reports on NHI & Low-Cost Benefit Options
- Public Sector Consolidation Forum

4.2. Risk-Based Solvency (RBC) framework

The current solvency requirement in terms of Regulation 29(1) is that schemes must maintain a minimum level of accumulated funds which may not be less than 25% of gross annual contribution income. The main purpose of the requirement is to protect the interest of beneficiaries in ensuring the medical schemes continue operations and to cushion against the unexpected increase in expenditure or adverse market movement. The criticism of the current regime is that it does not consider the actual risk faced by a medical scheme. For instance, schemes that price for deficits (deliberate under-pricing) can hold lower reserves as holding high reserves is inefficient and costly. Additionally, the framework is not keeping with global trends.

Furthermore, the inclusion of savings account contributions as part of gross contributions but then excluding the funds held from savings accounts as part of reserves is problematic. It is postulated that a move to a risk-based capital framework (RBC), would set requirements for some schemes above, and others below the current 25% requirement. The CMS is currently evaluating existing and other RBC types of models, to assess the impact of both at the global and individual scheme level. The next phase of the work is to engage the respective schemes to solicit feedback on the performance of these models and possible impact on members. Consideration of an RBC framework in the sector will seek to ensure sustainability, adequate access to care and ensuring that members of medical schemes are protected.

5. Statutory requirements for submission of rule amendments

Due to the extra ordinary circumstances relating to the COVID-19 pandemic, all the 2021 rule submissions must be done electronically here. Users must first complete this authorization form to be granted access.

To expedite the rule registration process, schemes are required to submit amendments to rules relating to the changes to the contributions, and benefit changes only. Changes to the main rules will not be prioritised unless they have a material impact on the benefit and contributions, for an example being an amendment relating to scheme tariffs. The rest of the changes to the main rules must only be submitted once the amendments to contribution and benefits changes have been approved by the Registrar

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:

5.1. 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 the changes and a of copy of rules 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.

5.2. Any rule amendments that the CMS requested in previous submissions must be incorporated into the current amendments, if not effected already.

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

5.4. Appendix 1A or 1A (2) must only be completed for each benefit option which was registered in 2020, and again for all benefit options which the scheme intends to register in 2021.

5.5. Appendix C or C (2) must be completed for each benefit option which was registered in 2020, 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 2021.

5.6. Appendix 1B must be completed for the entire medical scheme for both 2020 and 2021. Please note that schemes under close monitoring by the CMS need to provide input on the approved solvency ratio (row y) for 2020 and 2021 in Appendix B as per the approved business plan. The projected solvency ratio for 2020 and 2021 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.

5.7. Appendix D requires information about the assumptions on cost increases and utilisation that medical schemes used in determining their respective contribution increases for the 2021 benefit year. The Annexure has been updated in line with the CMS Annual Report 2018/19 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.

5.8. 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 on the CMS website.

5.9. Schemes seeking to register efficiency-discounted sub-options must have obtained an exemption from Section 29(1) (n) of the Medical Schemes Act. Section 8(h) stipulates that only the 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.

5.10. Applications for all new benefit options including efficiency-discounted sub-options taking effect from 1 January 2021 must reach the CMS by 1 September 2020 in terms of section 33(1) of the Medical Schemes Act. Applications received after 1 September 2020 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.

5.11. 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), as follows:

Name of benefit option			
Benefits / services	2020	2021	% change
E.g. day-to-day limit	E.g. R10 000 per beneficiary	E.g. R11 000 per beneficiary	10% increase

5.12. 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.

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

6. Key CMS recommendations

The long-run macroeconomic consequences of the current COVID-19 global pandemic is likely to be dire. The COVID-19 induced economic recession is likely to be prolonged with muted demand, lower corporate earnings, higher government debt, rising unemployment rate and dwindling household earnings.

The impact on the domestic economy that was already struggling from a technical recession pre-pandemic, is likely to be worse. The private healthcare industry will not be immune to the COVID-19 economic contagion. In the aftermath of the COVID-19 pandemic, the industry is likely going to experience a significant drop in membership, as households grapple with shrinking household budget or total loss of income. The expected drop in medical schemes membership and the subsequent loss in contribution income is likely to be exacerbated by poor investment returns as companies preserve cash and withhold payment of dividends and the lower interest rates in the capital markets.

Moreover, the national lockdown has led to a significant decrease in the demand for elective surgeries and other non-essential medical, surgical, and dental procedures, including other routine ongoing care. This has led to an overall drop in healthcare utilisation within the private sector, resulting in "cost savings" for medical schemes in the short-term, whilst in the long-term there is a potential of serious second-order effects that can increase expenditure as the pandemic continues to increase.

Deferred demand also poses a health risk for some patients which will lead to financial risk for medical schemes. CMS also notes that not all deferred demand will lead to pent-up demand since some of the procedures might be permanetly cancelled by patients who are risk-averse unless their medical condition become critical. It is also important to consider that some of the deferred demand can be attributed to provider induced demand and consumer moral hazard. Accordingly, this form of waste and abuse cannot be priced into contribution increase for 2021 by medical schemes.

Finally, as the pandemic approaches its peak, there is uncertainity about the potential cost to medical schemes as a result of COVID-19 related claims. It is against this backdrop of economic contraints and a high degree of uncertainity, that the CMS recommends the following :

6.1. Providing financial relief to members in distress due COVID-19 economic contagion

The CMS has already undertaken several regulatory interventions to provide financial relief to members grappling with economic fallout due to COVID-19. To this end, the Council has granted medical schemes exemption in terms of Section 8 (h), allowing qualifying members to use funds in the Personal Medical Savings Accounts (PMSA), to offset monthly contributions. Similarly, qualifiying Small Medium and Micro Enterprises (SMMEs) and individual members in financial distress have also been granted an exemption to defer contribution payable for longer than three days as required in the Act.

To further insulate members facing financial hardship induced by the COVID-19 crisis, the CMS recommends that medical schemes that are in a strong financial position, must consider freezing contribution rate increases for 2021 benefit year. The board's decision to freeze the contribution must, however be substantiated by an independent actuarial evaluation, clearly demonstrating that there is no risk to the long-term financial sustainability of the scheme, despite the risk posed by the current devastating COVID-19 pandemic.

6.2. Inflationary -linked contribution increases amidst COVID-19

The CMS is aware that despite the cost savings accrued to most schemes in recent months due to noticeably decrease in utilisation, there is a probable risk that the savings might be wiped-out in the coming months as the pandemic approaches its peak including the impact of pent-up demand. Accordingly, certain schemes may need to increase their contribution to mitigate against the risk of high-cost claims and subsequent reserves erosion. It is therefore expected that Trustees will also take into account affordability constraints faced by members who are also in financial distress due to the pandemic as well as the impact of other macro-economic factors on their household budget.

In cases where schemes are unable to freeze their contribution increase for 2021, CMS recommends that schemes should limit their increases to 3.9% in line with CPI. In the context of the current COVID-19 induced

economic turmoil, it is the CMS' view that above inflationary contribution increases, are simply above the budget line for most consumers and are therefore unaffordable for the majority of members of medical schemes. Similarly, notwithstanding the unique industry-specific cost-push factors such as the impact of the weaker rand exchange rate, the burden of diseases etc., it remains the position of the CMS that the increase in hospital fees and therapeutic appliances should also be limited to 3.9% in line with inflation.

6.3. Medical schemes that were already in financial distress pre-COVID-19

While the CMS is cognizant of the unique industry-specific cost-push factors, some medical schemes that where in financial distress pre-COVID-19, have traditionally relied on burdening members with unstainable above inflationary contribution increases coupled with the reduction of discretionary benefits. It is CMS' view that such operating models are undesirable and inefficient especially within the current context of COVID-19 and in the post-COVID-19 economy.

Medical schemes that were already in financial distress pre-COVID-19, and are likely to be in a precarious position, may consequently require contribution increases higher than the recommended 3.9%. Such schemes must provide the CMS with a detailed motivation for such increase. Furthermore, schemes must revise their current business plans, taking into account the shock of the pandemic and demonstrate their long-term viability. Trustees must be conscious that amidst the current corona-led recession, households are experiencing stagnant, reduced or lost incomes, and thus steep contribution increases are likely to add more financial strain to members who are also grappling with the economic cost of the pandemic.

In instances where it is evident that the pandemic may pose an existential threat to the long-term sustainability of a scheme, Trustees must be proactive. They can seek efficiency to enhance risk pooling and cross-subsidisation through other measures, including consideration of closure of non-performing options, and amalgamating in line with the prescripts of Section 63 of the Medical Schemes Act (MSA).

6.4. Conflict of interest

Board of Trustees (BoT) and Principal Officers are expected to promote the interests of members during the determination on contribution increases for 2021. The BoT should be aware of any cross-ownerships and directorships that may exist between the schemes, third parties and providers during contracting and tariff negotiations. The BoT should always ensure that their fiduciary duties are intact, and not convoluted by a conflict of interests. This expectation is consistent with the Medical Schemes Act and HMI findings which expects that the Board of trustees shall take reasonable steps to ensure that the interest of beneficiaries are protected at all times.

6.5. Increase in managed care and administration fees

To further cushion medical schemes members, the CMS would like to impress on Principal Officers and Trustees to engage their business partners, to forego any increase for 2021 benefit year. As such, in the best interest of the long-term sustainability of the industry, the CMS recommends that the assumed increases in non-healthcare expenditure (i.e. administration and managed care fees) for 2021 benefit year, must be kept constant at the current 2020 prices.

6.6. Short to medium term cost increase assumptions for contribution increases

To assist the industry with future planning, the CMS will from now on provide a three-year forward-looking guidance for contribution increases. To this end, cost increase assumptions for contribution increase for 2021 benefit year, must be limited to 3.9% in line with the projected CPI, before increasing to 4.3% and 4.5% for 2022 and 2023, respectively. These projections are subject to revision in line with the CPI inflation forecast by both the National Treasury and the South African Reserve Bank.

6.7. Application for registration of new benefit options

As evidenced by the Health Market Inquiry finding, (2019), the current high number of benefit options and complex benefit design have an adverse effect on consumers and competition in the market. Consequently, the industry must continue to review their benefit options and consolidate those options that are not sustainable in terms of both membership and financial performance. In the aftermath of the COVID-19 economic meltdown and the likelihood drop in membership, consolidation of benefit options is even more critical.

The CMS is aware of the severe market disruptions caused by the onset of the COVID-19 pandemic and the need for the industry to innovate and evolve to adjust to the new normal and economic realities. As such, CMS will only consider the application for registration of new benefit options under exceptional circumstances. At the core of the medical scheme's business plan must be the need to improve risk pooling, cross-subsidisation, and affordability, while simultaneously offering members quality healthcare services, including virtual care benefits. The delivery model must be premised on the principles of strategic purchasing of healthcare through value-based contracting with cost-efficient providers.

6.8. Augmented actuarial evaluation and COVID-19

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*."

In the context of the uncertainty and unquantifiable impact of the COVID-19, all the 2021 actuarial reports accompanying each submission, must include an additional segment providing detailed sensitivity analysis of the possible financial impact of COVID-19 pandemic on the short to long-run sustainability of each medical schemes. 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.

6.9. Deadline for submission and possible review and resubmission

The deadline for medical schemes to submit their rule amendments scheduled to take effect from 1 January 2021, is 1 September 2020 for new options or EDOs and 1 October 2020 for contribution and benefit changes. The CMS is, however, cognizant that the 2021 pricing decision will be fraught with a high degree of claims uncertainty, as the rate of transmission, the peak of the pandemic and the development of a vaccine remain highly uncertain. Accordingly, a scheme that may require additional time to finalise their 2021 pricing decision, must submit a request for an extension to the Registrar citing their unique individual circumstances. Nonetheless, the CMS still welcomes early submissions.

Trustees are further advised to constantly monitor their claims experience in the next coming months. Should the scheme's experience material change, with a possible deterioration of the scheme's financial position, the board is advised to review and revise their contribution increases and resubmit to the Registrar, in line with Section 31(1) of the Act.

Queries may be directed to the Benefits Management Analyst responsible for your scheme at the CMS.

The CMS looks forward to your cooperation.

Yours sincerely,

Dr Sipho Kabane
Chief Executive & Registrar
Council for Medical Schemes