ANNEXURE 5.6 MANAGED CARE

TABLE OF CONTENTS

List of figures

List of tables

1. Introduction

1. Managed health care developed as a systematic response to increasing costs and persistent quality concerns in healthcare markets. Health insurance providers (medical schemes) typically contract with managed care organisations (MCOs) to provide services to mitigate against cost and quality concerns. Managed care also seeks to address moral hazard, adverse selection and industry competitiveness. By combining consumer cost-sharing with a wide range of provider-side mechanisms, managed care can contribute to controlling moral hazard and reduce healthcare costs.

2. In South Africa managed care was introduced as a cost reduction mechanism in the 1990s[1]. The Medical Schemes Act (MSA) incorporated managed care for the first time in 2000. According to the MSA managed health care "means clinical and financial risk assessment and management of health care, with a view to facilitating appropriateness and cost effectiveness of relevant health services within the constraints of what is affordable, through the use of rules-based and clinical programmes".[2]

3. Managed care, within the South African context, typically includes one or a combination of consumer cost-sharing arrangements, preferred provider arrangements, reimbursement mechanisms, monitoring service utilisation, and the specification of benefits covered and level of those benefits. Managed care mechanisms differ in their stringency and design. Combinations of these mechanisms change constantly over time and vary significantly between MCOs.

4. The inquiry is interested in whether medical schemes contract with providers of healthcare services on the basis of value-for-money and/or consumer responsiveness. In this section we define the market for managed care and then assess the regulation of managed care and market structure. We then provide a review a selection of MCO contracts and stakeholders views. Succeeding these sections is the HMI's analysis which includes, barriers to entry and expansion, quality, managed care fees and risk transfer arrangements.

[1] Dr David Gotlieb. 2018. *Managed Care in South Africa*. Available at: http://www.arthritis.co.za/managed%20care.htm.
[2] Council for Medical Schemes (2003), Managed Health Care Policy Document, p 19.

2. Market definition

Product market

5. MCOs provide clinical and financial risk management solutions to medical schemes. The medical scheme may decide to conduct these clinical and financial risk management solutions in-house or contract to a third-party administrator (accredited as a MCO) and/or an independent MCO. Administrators providing managed care services must receive separate MCO accreditation even if the administrator and MCO is the same entity. Medical schemes can contract with medical scheme administrators for the entire administration and managed care services or a partial range of these services. Managed care services include hospital benefit management services, pharmacy benefit management services, active disease risk management services, disease risk management support services, dental benefit management services, managed care network services, and health care services (risk transfer).

6. The HMI found differentiation amongst manage care services, and that MCOs compete in distinct specialised markets to cater for the needs of the medical schemes. The different specialised services are not substitutable with each other. The MCOs offering these services will only compete with other firms offering the same specialist type of services and not with the MCO market as a whole. The administrators that offer managed care services compete in some instances directly with independent MCOs.

7. Given the varied nature of managed care services and the research question the MHI seeks to answer, the HMI decided to not define each service separately as independent markets. Thus, we also did not calculate market shares for the managed care market. The HMI has separated administration and managed care services for the purpose of defining the markets, but recognises that the two markets are often interrelated and this dynamic is considered in the analysis.

Geographic market

8. The HMI defines the geographical market for managed care service to be national. Managed care business clients are medical schemes, which have a national geographical market dimension. Therefore, MCOs are not limited geographically to providing services to their medical scheme clients.

3. Regulation of Managed Care

9. Where medical schemes require managed care services from third party providers, Regulation 15A of the MSA requires that they enter into a formal contract with the MCOs. These contracts must clearly stipulate the managed health care arrangement and that such arrangement must not absolve a medical scheme from its responsibility towards its members.[3]

10. Regulation 15B of the MSA set out the accreditation criteria. An organisation applying for accreditation must submit to the CMS copies of agreements between itself and the medical scheme. It must also submit information that the CMS may require to satisfy itself that:[4]

    a) The organisation is fit and proper- e.g. there must be no conflict of interest with regards to its shareholding or management structure, it must be a company registered within South Africa, it must provide a certificate of good standing from the South African Revenue Services, etc. and in general conduct its business in a professional and ethical manner;
    b) The organisation must have the necessary resources, system skills and capacity to render the managed healthcare services- e.g. the organisation must employ appropriate managed healthcare and financial systems, must have suitably qualified staff (including appropriate clinical staff), must have appropriate processes in place and maintain good internal controls. Compliance with this requirement is done by way of an on-site evaluation of the organisation, compliance with the managed care accreditation standards, which can be described as a combination of a systems, financial and process audit; and
    c) The organisation must be financially sound- i.e. it must be profitable, and its assets must be sufficient to meet its liabilities at all times. All managed care organisations' financial soundness is assessed every two years with the accreditation renewal application. In addition, the financial soundness of all MCOs that offer capitation services is assessed every six months.

11. Regulation 15C of the MSA sets out the criteria for suspension or withdrawal of the MCO. The Council may at any time suspend or withdraw the accreditation granted to a MCO.[5]

[3] Medical Scheme Act 131 of 1998 Regulations, p 119.
[4] Medical Scheme Act 131 of 1998 Regulations, p 120.
[5] Medical Scheme Act 131 of 1998 Regulations, p 123.

12. Regulation 15D sets out standards for managed care services. It places an obligation on the medical scheme to ensure that the MCO meets these standards. The regulation requires the medical scheme to ensure, amongst other things, that:[6]

    a) A written protocol is in place that describes all utilisation review activities. Procedures to evaluate the clinical necessity, and affordability of relevant health services, and to intervene where necessary. The protocol must also describe an organisational structure that periodically assesses managed health care activities and reports to the medical scheme.
    b) The managed health care programmes use documented clinical review criteria that are based upon evidence-based medicine, taking into account considerations of cost-effectiveness and affordability, and are evaluated periodically to ensure relevance for funding decisions.

4. Market structure

13. A total of 40 accredited managed care organisations and one self-administered medical scheme were issued with compliance certificates as at 31 March 2017.[7] Of these, 9 also had administration accreditation.

14. Within the large corporate structures identified in the section on cross ownership and cross directorship, there are administrators that also have MCO accreditation and they offer broad services. There are also separately registered specialised MCO services within the corporate structures. For example, Medscheme provides broad managed care services through Medscheme Holdings (Pty) Ltd (Medscheme) as well as specialised services such as AID for AIDS (Pty) Ltd. Within the MMI holding structure there are administrators with MCO accreditation, MMI Health, and Providence Healthcare Risk Managers and the other MCO MMI Dental Risk Management.

15. There are also entities in the managed care market that resemble MCOs, but are not registered or accredited by the CMS. These organisations contract with medical schemes for the provision of a variety of services. These includes services such as consulting and healthcare provision, but the MSA does not define these as managed care services.[8] The contracting of managed care services with non-accredited MCOs may raise concerns in some instances as they operate outside the regulatory

[6] Medical Scheme Act 131 of 1998 Regulations, p 124.
[7] CMS Annual Report 2016-2017.
[8] Email submission by the CMS dated 01 March 2018.

framework and the CMS can only take action against entities that fall within its jurisdiction.[9]

16. Table 1 shows the top ten MCOs based on the number of beneficiaries for the reporting period 2016/17. The MCO that had the highest number of beneficiaries is the South African Oncology Consortium Limited (SAOC) with a total of 6 207 833. This is followed by Medscheme and Discovery Health (Pty) Ltd (Discovery Health) with a total of 3 713 021 and 3 254 975 beneficiaries respectively.

Table 1: Top ten MCOs by beneficiaries

Accredited MCO	Beneficiaries	Medical schemes
South African Oncology Consortium Limited (SAOC)	6207833	27
Medscheme Holdings (Pty) Ltd	3713021	16
Discovery Health (Pty) Ltd	3254975	18
ISIMO Health (Pty) Ltd (previously (ICON)	2580235	33
Dental Information Systems (Pty) Ltd (DENIS)	2309812	10
Universal Care (Pty) Ltd	2037122	10
Thebe Health Risk Management (Pty) Ltd	1833137	1
Dental Risk Company (Pty) Ltd (DRC)	1249500	13
Mediscor PBM (Pty) Ltd	1146220	27

Source: Email submission by Council for Medical Schemes dated 22 January 2018.

5. Review of contracts

17. The relationship between a medical scheme and MCO is governed by a contract. This contract stipulates the various services the MCO will provide to the medical scheme as well as the remuneration rate. The HMI selected a range of contracts to review based on the type of service the MCO provided, the fee structure, the size of the medical scheme, open and restricted medical schemes and self-administered and third party administered.[10]

18. The contracts contained sections that were common across the contracts such as date of appointment, duration, services supplied, breach of contract, termination, service levels and fees. For the most part the content and structure of the contract varied among the contractual parties. For example, some contracts duration was to continue indefinitely while others would be renewed after a specified period. The description and the detail of the individual services the MCO will provide to the medical

[9] Meeting with the Council for Medical Schemes on the 18th of January 2018.
[10] The focus of the review was on specific sections that are relevant to the competitive assessment, including the fee structure and the type of services.

scheme also varies across the contracts. The contracts stipulate the minimum service level requirements and requires the MCOs to provide feedback on their services through monthly reports. For example, the average number of calls that must be answered in a specified time, and the average percentage of work processed in a certain time. Apart, from these minimum service level requirements we found no measures of health outcomes (value) in contracts between MCOs and medical schemes.

19. There are different fee structures in the managed care market. Medical schemes may pay MCOs a monthly service fee for a set stipulated services. The service fee may also differ for the different benefit options. Some contracts include a capitation fee, which is a once off annual payment from the medical scheme to the MCO. The capitation fee may only apply to a specific service, for example, a capitation fee for medicine benefit management.

20. The capitation clause in the contract may also specify the profit sharing arrangement. If the amount claimed from members is less than the capitation fee, resulting in a profit, then the medical scheme and MCO share this profit based on the percentage in the contract. In contrast, if the amount claimed from members is more than the capitation fee, resulting in a loss then the MCO is liable for this.

6. Stakeholders Submissions

21. Hospital groups and administrators are concerned about the lack measurement of quality of service effects of managed care services. Mediclinic (Pty) Ltd (Mediclinic) argued, that the focus of managed care initiatives is on cost containment, with little consideration given to outcome indicators or the level of patient satisfaction achieved by the hospital.[11] Discovery Health argued systematic and public availability of quality and outcomes of care data will have a material impact on outcomes and efficiency.[12]

22. In the absence measures of value for managed care services, several stakeholders submitted their estimations of value for money derived for the managed care services they render to their respective medical schemes for 2013. Discovery Health reported cost savings of R36bn which represent a return on investment of 327%, for managed care services offered to Discovery Health Medical Scheme (DHMS).[13] MMI Health

[11] Mediclinic's submission to the HMI's call for submission, dated 01 August, p 103.
[12] Discovery Health's report titled "Submission to the Competition Commission Market Inquiry into the Private Health Sector" dated 17 November 2014, p 262.
[13] Discovery Health's report titled "Submission to the Competition Commission Market Inquiry into the Private Health Sector" dated 17 November 2014, p 254.

(Pty) Ltd (MMI Health) also quantified the impact of their managed care services for 2013 and found a cost savings of R316mn which represent a return on investment of 439%.[14]

23. Medical schemes are required to report on the performance of risk transfer arrangements. This is done by estimating claim costs that a scheme would have incurred in the absence of a capitation arrangement and calculating the difference between the capitation fee and the estimate.[15] Metropolitan Health Corporate (Pty) Ltd (Metropolitan) stated that neither the medical scheme nor the MCO should be making a significant loss under a capitation arrangement. Any significant difference between the estimate and the capitation fee should result in the recalibration of the arrangement.[16]

24. Life Healthcare Group (LHC) regarded the Fee for Service (FFS) system as unsustainable and, as a result, it introduced Alternative Reimbursement Models (ARMs) in the late 1990s. The share of ARMs in LHCs revenue increased substantially between the 1990s and 2014.[17]

25. LHC indicated that at the time of its submission (October 2014) the Government Employees Medical Scheme (GEMS) was using FFS. One of GEMS' challenges with respect to considering ARMs is the level of base data that is required in order to generate the ARM prices.[18]

26. Mediclinic submitted that the greatest risk facing medical schemes is utilisation. Medical schemes have preferred to switch from ARMs back to fee-for-service because ARMs such as per diem models do not mitigate against the risk of over-utilisation.[19]

27. Independent MCO's argue that they lose business to MCOs affiliated with administrators.[20] Administrators that offer managed care services are able to sell a combination of their administration and managed care services. Consequently medical schemes find it difficult assess value of managed care services they purchase. MCOs that offer stand-alone specialised services need to prove value to

[14] Submission by Momentum titled "MMSA Managed Care Interventions "dated 08 December 2014, p 3.
[15] Submission by Metropolitan titled "Submission to the Health Market Inquiry" dated 18 December 2014, p 5.
[16] Submission by Metropolitan dated 18 December 2014, p 5.
[17] Life Healthcare submission to the HMI titled "Life Healthcare Group's First Submission to the Panel in the Competition Commission Inquiry into Private Healthcare", dated 31 October 2014, p 32.
[18] Life Healthcare submission to the HMI titled "Life Healthcare Group's First Submission to the Panel in the Competition Commission Inquiry into Private Healthcare", dated 31 October 2014, p 44, para 8.5.2.
[19] Per diems are a fixed amount per day, so they don't mitigate against overutilization where overutilization can be defined as excessive length of stay. Patients remaining in hospital for extended periods of time will still incur substantial costs to the funder.
[20] Evidence from Mediscor at the Health Market Inquiry's public hearings held on the 5th of May 2016, p 241.

medical schemes before they can secure managed care business.[21] If a medical scheme's administrator offers managed care services, the medical scheme is likely to procure managed care services from the administrator.

28. Furthermore, independent MCO argue that medical scheme that moves administration services to an administrator that offers managed care services is also likely to move managed care services to that administrator.[22]

7. HMI Analysis on MCOs

29. The HMI analysis will deal with the following four subjects: barriers to entry and expansion, quality, managed care fees and risk transfer.

Barriers to entry and expansion .

30. The HMI did not find any significant barriers to entry for the MCO market. During the period 2012 to 2016, there were 10 MCOs that entered the market and 10 MCOs that exited the market, as listed in Table 2.

Table 2: Entry and exit in the MCO market

Year	Entry	Exit	No. of MCOs
2016	Iyeza Health	Medicross Healthcare Group, Managed Healthcare Systems	40
2015	Ulwazi Health Solutions, Thebe Risk Management Services, Zeal Health Innovations	Centre for Degenarative Joint Disease	41
2014	No information	No information	39
2013	Knowledge Objects Solutions, Knowledge Objects Healthcare, My Care Health Solutions, Strata Healthcare Management	Dentpro, Resilience Health Services, KwaZulu Natal Managed Care Coalition	40
2012	Aids for Aids Management, Right to Care Health Services,	Sanlam Healthcare Management, Faranani Healthcare Management, Emerging Market Healthcare,	39

[21] Evidence from Mediscor at the Health Market Inquiry's public hearings held on the 5th of May 2016, p 233.
[22] Evidence from Mediscor at the Health Market Inquiry's public hearings held on the 5th of May 2016, p 241.

		UDIPA Holdings and ECIPA Healthcare	

Source: CMS annual reports.

31. The HMI is of the view that the accreditation process, while it may be cumbersome for the applicant, is necessary to provide some protection to the medical scheme and its members. Furthermore, the CMS makes its decision on applications in a relatively short period.

32. Even though starting an MCO require high levels of human capital and technology these capital requirements are not insurmountable.

33. The HMI agrees with independent MCOs that medical schemes are more likely to procure managed care and administration services from the same provider. There may be economies of scope for those who offer numerous services.

Quality

34. The ultimate goal of healthcare is to improve the health status of patients. MCOs can contribute to this by implementing mechanisms to maintain or improve quality of healthcare. They can also contribute by helping members in gaining access to the most appropriate treatment interventions and by developing standardised treatment approaches.[23]

35. There is no systematic measurement and reporting of standardised and comparable data on the health outcomes of provider services in South African private healthcare. This will be dealt with in Chapter 10 on Quality Measurement and Reporting. In the absence of such data it is impossible to ascertain the effects of managed health care in terms of improving quality of care through better outcomes. This has been pointed out by several stakeholders (e.g. Mediclinic and Discovery Health).

36. The HMI's practitioner survey asked doctors about the impact of Designated Service Provider (DSP) networks on the cost and quality of healthcare. DSP's are instruments in the hands of MCO's to manage costs and quality. A majority of doctors (53%) think that DSPs have a negative impact on the quality of care. An additional 27% of doctors are of the view that DSPs have no effect on the quality of care. Only 12% of doctors think that DSPs improve quality of healthcare.[24]

[23] Council for Medical Schemes (2003), Managed Health Care Policy Document, page 3.
[24] Health Market Inquiry, "Summary of results from the healthcare practitioner survey", page 6.

37. The CMS has been working on a project that aims to understand the quality of care provided by medical schemes for members who are in managed care programs. Since 2014 the CMS has published quality of care indicators (process indicators) and a few outcome indicators which are based on the thirteen Chronic Disease List (CDL) conditions. The process indicators are based on best practice for the management of chronic patients and are meant to capture minimum interventions and standards of care expected from MCOs. The CMS indicated that, over time, it will put in place processes to measure the actual cost of each managed care program.[25] The CMS recommended that it must be mandatory for MCOs to collect information on the process and outcome indicators, and make it available to the CMS. The HMI supports this assertion.

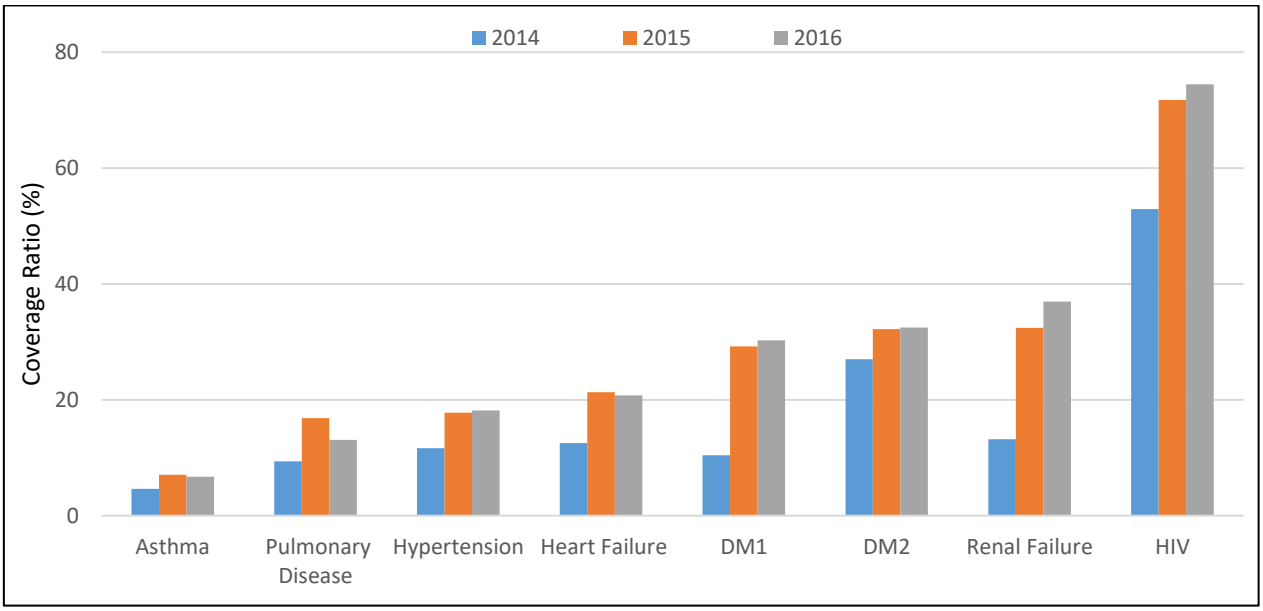
38. The CMS measured quality of MCOs using coverage ratio which it defined as the proportion of registered chronic patients receiving the appropriate care. Coverage ratios for 8 CDL conditions show an improvement in quality. The coverage ratios increased across all conditions between 2014 and 2016,[26] Figure 1. Even though there has been notable improvements in the coverage ratio across all the CDL conditions, the coverage ratio for many conditions remains low.

39. The CMS indicated that it considers coverage ratios that are less than 60% to be reflective of unsatisfactory performance.[27] The only coverage ratio that is acceptably high is that of HIV, it was 74% in 2016. Asthma, Chronic Pulmonary Disease and Hypertension are poorly managed compared to other CDL conditions, their coverage ratio averaged across process indicators is below 20%.

40. The CMS indicated that it does not engage with medical schemes on how they can improve their coverage ratios. This is partly because the quality measurement project is still at an early stage, but also because the CMS does not have sufficient resources to do so.[28]

[25] Council for Medical Schemes. "Quality of Care in Medical Schemes for financial years 2015 and 2016", dated 06 December 2017, p 7.
[26] The coverage ratio is defined by the CMS as the proportion of registered chronic patients receiving the appropriate care.
[27] Meeting with the Council for Medical Schemes on the 18th of January 2018.
[28] Meeting with the Council for Medical Schemes on the 18th of January 2018.

Figure 1: Coverage Ratios for Chronic Disease List conditions



Source: Council for Medical Scheme.

Managed care fees

41. The CMS actively monitors managed care fees. If a MCO's fees are higher than the average, then the MCO needs to justify the increase. If the fee increase cannot be justified then the MCO is required to adjust the fee downwards.[29]

42. The CMS classifies payments made by medical schemes to MCOs based on the extent of risk transfer. Managed care fees are those payments that have no risk transfer while capitation fees have significant risk transfer. These amounts should be compared with cost savings that result from managed care intervention. This exercise is best done at a disaggregated level by looking at the actual cost of each managed care service. The CMS however has not started collecting managed care cost data at a disaggregated level.

43. Analysis on the effectiveness of managed care also requires the quantification of the impact of managed care on the overall healthcare cost. Managed care can affect overall healthcare cost through unit prices, by affecting the level of admissions, the length of stay and the level of care or intensity by which health resources are used.

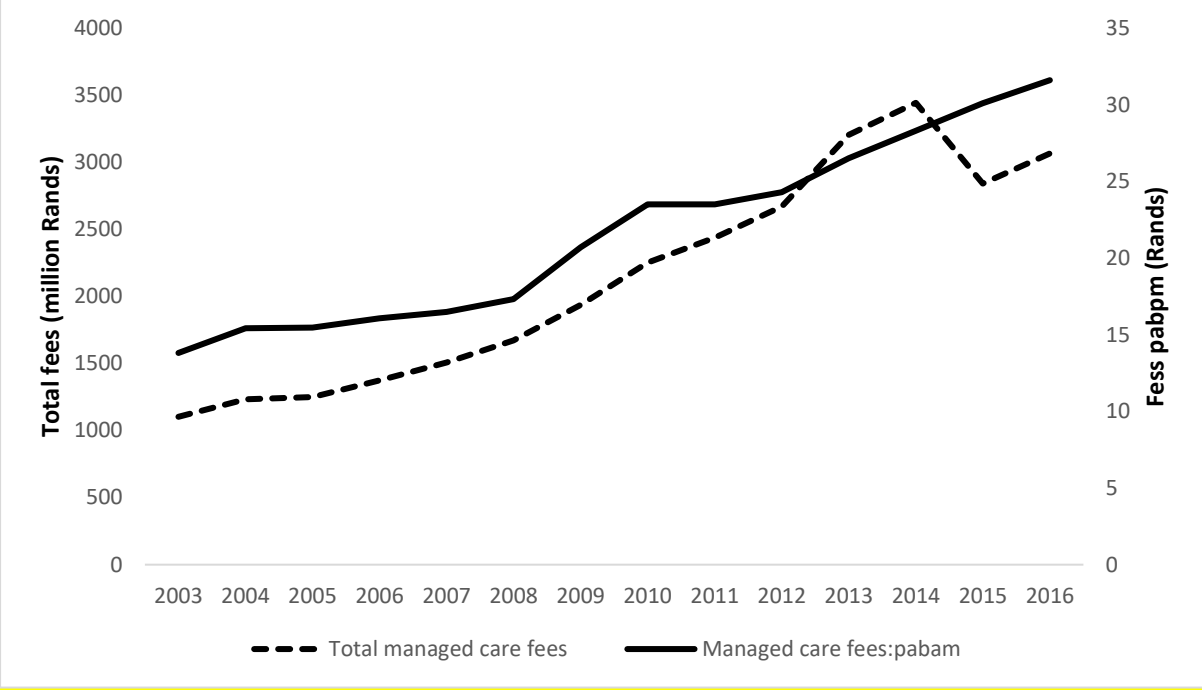
44. In the absence of disaggregated data we look at the aggregated data which provide some insights on the overall cost of managed care. The lack of managed care data at a scheme and service level makes it difficult to interpret differences in managed care

[29] Meeting with the Council for Medical Schemes on the 18th of January 2018.

fees between medical schemes or between MCOs. This is further complicated by the fact that the HMI does not have data on quality of managed care services that can be linked back to managed care fees at MCO and scheme levels.

45. Figure 2 shows total managed care fees and managed care fees per beneficiary for the period 2003- 2016. Both series increased over the period with total managed care fees increasing from R1,102bn in 2003 to R3,065bn in 2016 and managed care fees per beneficiary increasing from R14 to R32.

Figure 2: Managed care fees

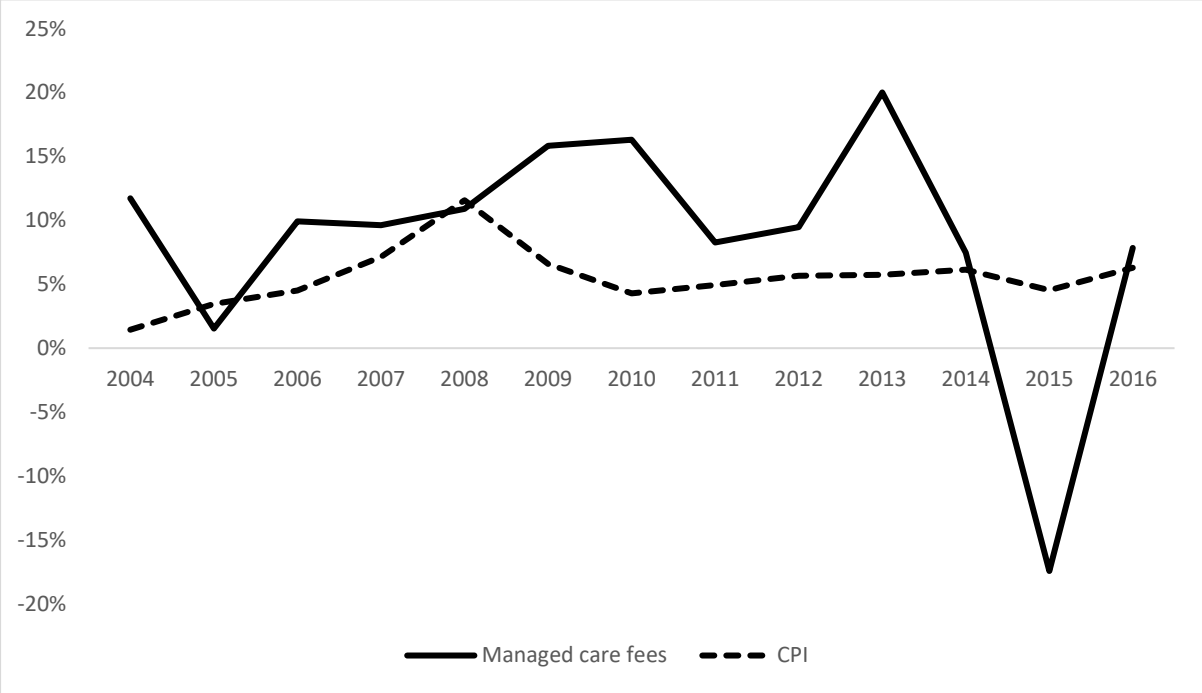


Source: CMS Annual Reports.

46. Increases in total managed care fees have consistently exceeded inflation, Figure 3. The annual growth rate of managed care fees and CPI was 8.2% and 5.5% respectively between the periods 2003 - 2016. This translates into a real (above inflation) increase in total managed care fees of 2.7% over the period 2004 - 2015. This is in line with the real growth of health expenditure which is has been positive.[30]

[30] Health Market Inquiry. "Analysis of claims data – initial cost attribution analysis". 08 December 2017.

Figure 3: Managed care fees and CPI



Source: CMS annual reports.

47. Despite the prevalence of managed care and the above CPI inflation increases in managed care fees, we have not seen a containment in healthcare expenditure at the aggregate level. Medical scheme claims inflation has been 4% higher than CPI on a consistent basis.[31] Half of the real increase is explained by factors that cannot be controlled by managed care. These factors are age, gender, disease profile, member movements and plan mix.

48. This leaves a 2.14% increase in the real inflation of claims that is not explained by the above factors. In order to gain a better understanding of the real inflation of claims we also have looked at the inflation of in-hospital cost. In-hospital cost claims increased by 10.84% resulting in a real increase of 5.24%. Half of the real increase is explained by factors that cannot be controlled by managed care. This leaves a 3.23% unexplained increase in in-hospital cost.[32]

49. Of the 3.23% unexplained increase in in-hospital cost, 1.19% (37% of the unexplained increase) is due to increases in admission rates that cannot be explained by explanatory factors which are age, gender, disease profile, member movements and plan mix. This is part of admission rates that managed care should be able to control.

[31] Health Market Inquiry. "Analysis of medical schemes claims data – initial cost attribution analysis". 08 December 2017, page 39.
[32] Health Market Inquiry. "Analysis of medical schemes claims data – initial cost attribution analysis". 08 December 2017, page 25.

Similarly 0.64% (20% of the unexplained increase) is due to length of stay that is unrelated to the explanatory factors and 0.15% (5% of the unexplained) is a result of unexplained increases in the level of care, Table 3.

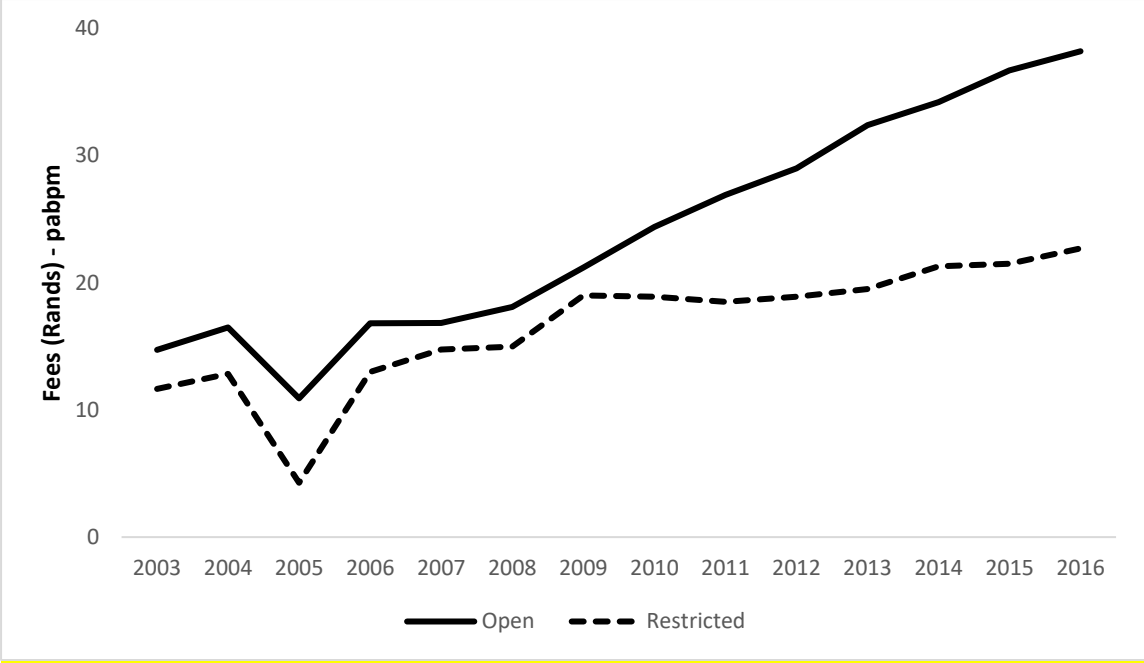
Table 3: In – hospital cost attribution

	In-hospital Cost per Life	Admission Rate	Length of Stay	Level of Care	Other
Total increase	10.84	2.17	1.48	0.60	0.63
Explanatory factors	2.01	0.99	0.84	0.45	
Unexplained factors	3.23	1.19	0.64	0.15	

Source: HMI's facilities report on analysis of medical schemes claims data, page 26, Table 19.

50. Managed care fees for open medical schemes have consistently been higher than that of restricted medical schemes, Figure 4. From 2009 an increasing differential in the managed care fees for open and restricted medical schemes is observed. In 2016 open medical schemes paid R16 (per average beneficiary per annum) more in managed care fees compared to restricted schemes. This means open medical schemes are 68% more expensive than restricted schemes for managed care services. In addition to being higher, managed care fees for open medical schemes have grown at a faster rate. The annual growth rate in managed care fees between 2003 and 2016 was 8% and 5% for open and restricted medical schemes respectively.

Figure 4: Managed care fees – open and restricted medical schemes



Source: CMS annual reports.

51. Table 4 shows the top and bottom 4 open medical schemes by managed care fees, it also shows the number of beneficiaries for each medical scheme. The correlation between medical scheme fees and the number of beneficiaries is positive but weak (+0.34). There is no systematic relationship between the amount of managed care fees and the number of beneficiaries of a medical scheme.

Table 4: Open medical schemes with highest and lowest managed care fees - 2016

Scheme	Fees PABPM	No of beneficiaries	Share of beneficiaries
Top 4			
Spectramed	45,3	27599	0,6%
DHMS	43,3	2707913	56,9%
Bonitas	42,9	676785	14,2%
Resolution Health	41,8	37546	0,8%
Bottom 4			
Medimed	21,7	14888	0,3%
Suremed Health	20,6	2772	0,1%

Bestmed	20,1	200400	4,2%
Medihelp	10,5	195858	4,1%

Source: CMS annual reports.

52. To properly evaluate the impact of membership size on managed care fees, one must match managed care fees paid to an MCO to the number of beneficiaries being managed by that MCO. We do not have the data that links managed care fees to MCOs beneficiaries. With increasing returns to scale one would expect managed care average cost to decrease as the number of beneficiaries under management increases.

53. The fact that DHMS managed care fees are among the highest suggest that medical schemes that procure MCO services from Discovery Health do not benefit (in the form of low average fees) from the larger scale of Discovery Health. Discovery Health provides the full range of managed care services to DHMS. Discovery Health is one of the largest players in the managed care market. However, medical schemes with the highest managed care fees include DHMS and Bonitas, which are the largest and second largest schemes in terms of the number of beneficiaries.

54. For restricted medical schemes the correlation between managed care fees and the number of beneficiaries is weak and negative (-0, 36). This suggest a lack of a consistent relationship between managed care fees and the number of beneficiaries under managed care. The two largest restricted medical schemes (GEMS and Profmed) are in the category of medical schemes with the lowest fees (Table 5). However this category also includes medical schemes with a small number of beneficiaries such as Alliance-Midmed and Parmed Medical Aid Scheme. Similarly the category of medical schemes with the highest managed care fees includes relatively large schemes and also small schemes.

Table 5: Restricted medical schemes with highest and lowest managed care fees - 2016

Scheme	Fees PABPM	No of beneficiaries	Share of beneficiaries
Top 6			
Engen Medical Benefit Fund	71,1	7578	0,2%
BP Medical Aid Society	47,1	3924	0,1%
Lonmin Medical Scheme	46,7	21531	0,6%
Anglo Medical Scheme	45,5	18984	0,6%
Barloworld Medical Scheme	44,9	12527	0,4%
Naspers Medical Fund	44,8	16315	0,5%
Bottom 6			
Parmed Medical Aid Scheme	20,1	4896	0,1%
Profmed	19,8	68637	2,0%
Grintek Electronics Medical Aid Scheme	17,7	1678	0,0%
Alliance-Midmed Medical Scheme	15,8	4404	0,1%
Government Employees Medical Scheme (GEMS)	8,7	1801999	52,8%

Building & Construction Industry Medical Aid Fund	8,6	11866	0,3%

Source: CMS annual reports.

55. The lack of a consistent relationship between managed care fees and the number of beneficiaries means that differences in managed care fees cannot be explained by size. It therefore appears that beneficiaries are not benefiting from the economies of scale of large MCOs.[33]

Risk Transfer

56. The FFS method of paying providers creates incentives for over-utilisation, since providers can earn greater revenue the more services they provide.[34] Ideally a health system should have a combination of payment arrangements, including reimbursement models that are based on a degree of (financial) risk transfer from insurers to providers.

57. One of the risk transfer payment methods is capitation arrangements. Under capitation, providers receive a fixed periodic payment for each patient they enrol. If the cost of providing care exceeds the fixed payment, the provider makes a loss. The fixed payment thus creates an incentive for providers to take more efficient treatment decisions. Efficient treatment decisions are likely to result in lower cost which is the primary objective of managed care.

58. The only risk transfer arrangement that is accommodated in the MSA is capitation. The MSA defines a capitation agreement as "an arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme".[35]

59. The MSA further states that a medical scheme shall not enter into a capitation agreement unless:

    a) the agreement is in the interests of the members of the medical scheme;

[33] Differences in managed care fees could be explained also by differences in the composition of MCO services that each scheme has i.e. schemes that offer more costly MCO services would charge higher fees and those that offer less costly services would charge lower cost. The HMI is not able to test this because it does don't have data on what services each scheme procures from their respective MCOs and what price they pay for such services.

[34] H. Jiang (2009). "Medicare Hospital Stays: Comparisons Between the Fee-for-Service Plan and Alternative Plans". Agency for Health Care Policy and Research.

[35] Regulation 15 of the Medical Schemes Act No. 131 of 1998, p 12 .

b) the agreement embodies a genuine transfer of risk from the medical scheme to the managed care organisation

c) the capitated payment is reasonably commensurate with the extent of the risk transfer

60. The MSA does not explain what ought to be regarded as a genuine transfer of risk in a capitation agreement nor does it give guidance on how one should assess if a capitated payment is reasonably commensurate with the extent of the risk transfer.

61. The total amount paid by medical schemes towards capitation agreements (capitation fees) grew from R2,14bn in 2007 to R3,19bn in 2016. As a share of risk contribution income capitation fees increased from 3.3% in 2007 to 4.3% in 2016. In 2016, two thirds of total capitation fees were paid by open medical schemes and a third was paid by restricted schemes. Capitation agreements in South Africa are primarily in the primary care market and cover GP services, dental services, optometric services, ambulance services and diabetic care.[36]

62. The CMS collects data on what is termed "estimated claim recoveries" which is defined as costs which schemes would have incurred had they not used risk transfer arrangements.[37] Capitation fees are subtracted from this amount to obtain schemes gains/losses from the capitation agreements. A positive value is interpreted as a gain to the medical scheme whereas a negative value means a loss to the medical scheme.

63. Figure 5 shows income/losses from risk transfer arrangements for the period 2007-2016. The series for all medical schemes shows gains in some periods and losses in others periods with the largest loss occurring in 2012. This series is driven by the divergent experience of restricted and open medical schemes. Open medical schemes experienced losses throughout the period. In contrast, restricted schemes experienced gains throughout the period, except in 2007.

64. The average loss for open medical schemes over the period 2007- 2016 is R136bn and the cumulative loss is R1,4tn. On realising that it is making losses on the capitation agreement, one would expect a medical scheme to renegotiate the capitation fee down so as to limit the losses. It is also not clear why open medical

[36] Submission to the Private Health Market Inquiry by the South African Private Practitioner Forum, dated November 2014, p 150.

[37] Council for Medical Schemes 2016/2017 Annual Report, p 184.

schemes have consistently incurred losses while restricted medical schemes have gained from risk transfer arrangements.[38]

Figure 5: Gains/losses from capitation arrangements

Source: Council for Medical Schemes.

65. Optimal risk transfer arrangements should operate by transferring some of the claims risk to providers. Very few provider payment arrangements in the South African healthcare are proper risk transfer arrangements. Over the period 2010 – 2014 ARMs accounted for 4%-5% of hospital admissions.[39] ARMs include capitation arrangements and other forms of reimbursing providers.[40]

66. The risk transfer agreements in place, although specified as managed care, appear to take the form of reinsurance agreements, as the risk-transfer to providers appears negligible. If a medical scheme enters into an agreement with an intermediary which involves a monthly premium in respect of each beneficiary and the intermediary

[38] The CMS is investigating the issues of gains/losses from risk transfer arrangements. At the time of their meeting with the HMI (January 2018) it was not able to provide an explanation for the observed trends in gains/losses from risk transfer arrangements.
[39] Health Market Inquiry "Report on Analysis of Medical Schemes Claims Data – a focus on facilities", dated 15 December 2017, p 74.
[40] Capitation arrangements would be classified as ARMs if the reimbursement of providers under capitation is not on a fee for service basis.

undertakes to pay the actual expenses claimed by service providers on a fee-for-service basis that agreement is effectively a reinsurance agreement because no risks have been transferred to healthcare providers.

67. The intermediary (or managed care company) is therefore the sole *insurer* of the scheme liability and merely offers financial-risk-protection to risk pools. Healthcare providers have no incentives to manage patients more efficiently which is the primary purpose of managed care agreements.

68. The failure of funders to enter into genuine risk transfer arrangements can be explained partly by provider market power i.e. providers with sufficient market power are able to prevent the implementation of contracts that would result in greater provider competition.[41]

8. Conclusion

69. The inquiry found no barriers to entry for the MCO market. There may be economies of scope for those who offer more than one service. Discovery Health, Medscheme and Metropolitan who jointly account for 80% of the administration market are also active in managed care. There is a need to separate managed care services fees and administration fees to allow independent MCOs to compete with administrators that also offer managed care services. This will also allow medical schemes to evaluate competing managed care services with greater ease.

70. The rate of increase in managed care fees has consistently been higher than CPI inflation. However, this above inflation increase in managed care fees has not resulted in the containment of overall healthcare costs. In spite of the prevalence of managed care, the industry has experienced real health expenditure that cannot be explained by explanatory factors such as age, gender, disease profile, member movements and plan mix.

71. The development of quality indicators that are linked to managed care is still at an early stage. Where scant information is available - largely some structure and process information of quality of service supplied - results suggest that the quality of healthcare services under managed care is still unsatisfactory. Medical schemes should ensure that more energy and measures are in place to improve the quality of services that are under managed care and should insist on the registration and use of meaningful indicators of the quality of care provided.

[41] Chapter 3 of the HMI's Provisional Findings and Recommendations Report.

72. Open medical schemes have incurred significant losses from capitation arrangements over a long period of at least 10 years. These sustained losses point to poor governance of open medical schemes. In contrast restricted medical schemes have not incurred losses on capitation arrangement. This suggest that restricted medical schemes, in particular those employers who pay a subsidy towards employee contribution are better at managing capitation arrangements.

73. The CMS has started collecting data on quality indicators and is in the process of collecting associated cost. The collection and dissemination of this data should be prioritised because without it, it is difficult to assess whether or not beneficiaries are deriving good value from managed care. It is of utmost importance that outcome measures will become available in order to improve the effectiveness of risk sharing arrangement and monitor and assess contracts.