# SECTION 59 INVESTIGATION

**DATE: 2019-08-02**

**HELD IN: IMBIZO BOARDROOM,**

**COUNCIL FOR MEDICAL SCHEMES OFFICES, CENTURION**

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**ADV KERRY WILLIAMS, PANEL MEMBER**

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**MS ALTAIR RICHARDS, ENS LEGAL ADVISOR**

**MR BRUCE MOSIANE, HEALTH FUNDERS ASSOCIATION**

## CERTIFICATE OF VERACITY

I, the undersigned, hereby certify that in as far as it is audible the aforegoing is a true and correct transcript of the recording provided by you in the conversation:

**Section 59 Investigation**

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**PROCEEDINGS ON 2 AUGUST 2019**

CHAIRPERSON: Good morning, so this is day five of the public hearings of the inquiry under Section 59 of the Medical Schemes Act. We are scheduled to hear from the Health Funders Association, and later on from the Department of Health. We should probably start with introductions, I see there are five people on the front row, so can we just hear who is here?

MR MOSOMOTHANE: Morning Chair, my name is Teddy Mosomothane. I'm the chairperson of the Health Funders Association.

CHAIRPERSON: Thank you.

MS MOSIAH: Good morning Chair, I am Lerato Mosiah the chief executive officer of the Health Funders Association.

CHAIRPERSON: Thank you.

DR PHALENG: Morning Chair, Tebogo Phaleng, I'm the director on the board of directors HFA.

CHAIRPERSON: Thank you.

MS RICHARDS: Altair Richards, legal advisor to the HFA from ENS.

CHAIRPERSON: Thank you.

MR MOSIANE: Morning Chair, Bruce Mosiane, technical advisor to the HFA.

CHAIRPERSON: Alright, how are you planning to do this? Who is going to be making the submission?

MR MOSOMOTHANE: Chair I will be making the submission, I'll be taking the panel through the whole presentation. In the event that there are question that come up, I plan to call on my colleagues to assist. So it may make sense for all of us to be sworn in, but entirely up to you.

CHAIRPERSON: Okay, perhaps I should swear in everyone then. So can I start with you, is it Mr Moso?

MR MOSOMOTHANE: Mosomothane.

CHAIRPERSON: Mosomothane?

MR MOSOMOTHANE: Yes.

CHAIRPERSON: Not N, M? Thank you Mr Mosomothane. Can I start with you, are you going to take the oath?

MR MOSOMOTHANE: I'll take the oath, yes.

CHAIRPERSON: Alright, so will you say after me, I and your full names?

MR MOSOMOTHANE: I Teddy Mosomothane.

CHAIRPERSON: Swear that the evidence that I shall give.

MR MOSOMOTHANE: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MR MOSOMOTHANE: Shall be the truth.

CHAIRPERSON: The whole truth.

MR MOSOMOTHANE: The whole truth.

CHAIRPERSON: Raise your right hand and say; so help me God.

MR MOSOMOTHANE: So help me God.

CHAIRPERSON: Thank you. Ms Mosiah can we, are going to take the oath or the affirmation?

MS MOSIAH: I'll take the oath too.

CHAIRPERSON: Thank you, and will you say after me, I and your name.

MS MOSIAH: I Lerato Mosiah.

CHAIRPERSON: Swear that the evidence that I shall give.

MS MOSIAH: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

MS MOSIAH: Shall be the truth.

CHAIRPERSON: The whole truth.

MS MOSIAH: The whole truth.

CHAIRPERSON: Raise your right hand and say; so help me God.

MS MOSIAH: So help me God.

CHAIRPERSON: Thank you, Mr Phaleng.

DR PHALENG: Yes Chair.

CHAIRPERSON: Will you take the oath or the affirmation?

DR PHALENG: Yes I will.

CHAIRPERSON: Yes so will you say after me, I and your name.

DR PHALENG: I Tebogo Phaleng.

CHAIRPERSON: Swear that the evidence that I shall give.

DR PHALENG: Swear that the evidence that I shall give.

CHAIRPERSON: Shall be the truth.

DR PHALENG: Shall be the truth.

CHAIRPERSON: The whole truth.

DR PHALENG: The whole truth.

CHAIRPERSON: And raise your right hand and say; so help me God.

DR PHALENG: So help me God.

CHAIRPERSON: Now Ms Richards, did you say you're from ENS?

MS RICHARDS: Yes.

CHAIRPERSON: Alright, so I don't want to get lawyers taking oaths. What's your role, are you going to be making any submissions or?

MS RICHARDS: I will only be here to support Teddy, if he requires …[indistinct 00:03:12].

CHAIRPERSON: Alright no that's fine, then I will skip you, and then that takes me to Mr Mosiane. Will you be speaking?

MR MOSIANE: Yes, I might assist.

CHAIRPERSON: You might assist, okay. So let me take your oath. Will you then say after me, I and your name.

MR MOSIANE: I Bruce Mosiane.

CHAIRPERSON: Swear that the evidence.

MR MOSIANE: Swear that the evidence.

CHAIRPERSON: That I shall give.

MR MOSIANE: That I shall give.

CHAIRPERSON: Shall be the truth.

MR MOSIANE: Shall be the truth.

CHAIRPERSON: The whole truth.

MR MOSIANE: The whole truth.

CHAIRPERSON: And raise your right hand and say; so help me God.

MR MOSIANE: So help me God.

CHAIRPERSON: Thank you. Mr Mosomothane let's start with you, you said that you had a presentation and I see that's already up on the slides, is that the one?

MR MOSOMOTHANE: That's the one.

CHAIRPERSON: Alright, thank you very much. So you take us through and then you can decide how you want to structure it.

MR MOSOMOTHANE: Okay, thank you very much Chair. First and foremost, on behalf of the Health Funders Association, we want to express our appreciation for the opportunity that we have been given to participate in this process. It's probably fair to say that the care, the core issue that is being investigated doesn't fill one with excitement necessarily. But it demands you know attention, and we are certainly happy to oblige. I think I also have to mention Chair, having observed the discussions over the last couple of days, we observed with appreciation that given the complexity of the many issues that we deal with in the healthcare industry, there's always a temptation to, you know, to really raise a variety of issues that we are faced with over and above the core issue.

You know, that, you know, that the panel is entrusted to focus on. But be that as it may, our observation is certainly with understanding as far as that is concerned, and we are committed to make our contribution as best as we possibly can. Now in as far as HFA is concerned, HFA is made up of members in the form of entities which includes medical schemes, administrators, and managed care organisations. HFA really goes as far back as 2015, and right now in our membership base we have a total of 25 medical schemes, and this is made up of eight open schemes in particular, and 17 restricted medical schemes.

So in as far as the membership representation within HFA, we are talking 53% in as far as beneficiaries that are associated with the medical schemes in these entities, and I'll give you a sense of which entities, you know, are included in our membership base in a minute. From a number of lives perspective Chair, we are talking 4.4 million lives, and I've already indicated that there's 25 medical schemes and there's three administrators. Just to give the panel a sense of which entities are included in our membership base, I certainly intend to go through each and every one of them except to say our membership base certainly comes from a diverse, you know, industry and this is inclusive of a number of, you know, administrators that make up our membership base.

At this point Chair, I want to really proceed with telling the panel a couple of things about HFA, to introduce HFA so that there can be understanding of who we are. In as far as our role is

concerned, we see our role as focussing on facilitating and encouraging the establishment of a conducive healthcare funding industry, and this we want to pursue through active engagement with all relevant stakeholders. And it is important to know that it is our desire to have these engagements with parties both in the public, and the private sector. We also attach a lot of importance to sustainability and development of private healthcare funders, you know, in particular.

This is against the background of medical schemes not being expected to be for profit organisations, but entrusted with the responsibility of giving assurance in as far as sustainability is concerned. We are committed to participating in conversations that are aimed at influencing policy and legislation reforms going forward. You know, in the course of the conversations that are taking place in the industry Chair. It's important for us as different stakeholders to be engaged, and this is where HFA comes in to cater for a need of advocacy and lobbying. You know, creating an opportunity for us to present a united voice of the members of the association.

As far as the structure is concerned, our structure is relatively lean, and made up of a board of directors that comes from our membership base. We also make use of what we refer to as a technical advisory committee, this is where Bruce Mosiane you know comes in, and the purpose of that kind of a committee is to deal with the details in relation to you know, all aspects that require

attention and conversation, you know, in the industry that we are operating in, and feed those kinds of discussions into the board for a decision in as far as how we navigate our way forward.

From a values perspective, we attach a lot of importance to collaboration and cooperation, we are passionate about adding value in our association and the partnerships that we have with our stakeholders. Driving competitiveness for prosperity is something that we attach a lot of importance to, and we also embrace you know diversity as best as we possibly can. Chair over the last couple of years, you know, going as far back as 2015, we have prioritised engagements on industry matters. We have done this through a variety of ways really aimed at ensuring that we are contributing in the conversations that are unfolding in relation to the changing healthcare landscape.

And an example of this is by way of having on-going interactions with the Council for Medical Schemes as our regulator. We think it is important to nurture really, some kind of a relationship with the regulator understanding that, you know, that kind of interaction will sometimes be accompanied by the inherent kind of tension where there are different kinds of perspectives that are expressed. In this regard we are very appreciative of, you know, the Council for Medical Schemes being very keen to have conversations with the different stakeholders, on a variety of matters. Examples in this regard include the fraud, waste and abuse summit that was hosted by the Council for Medical Schemes, which

is quite relevant to the matter that we are talking about, you know, today.

There's a range of other discussion that, you know, are underway in the industry, and the PMB review is but one other example. You know, we have deliberately decided not to list all those conversations that are taking place. Now our engagements have also included our participation in what was referred to as the presidential health summit. What became known as a compactor that came out of those conversations was signed last week, and our participation there, again was aimed at ensuring that we make a contribution to the conversations that have taken place. We, our involvement in the presidential health summit in particular Chair, was via our association with Business Unity South Africa.

Where there are other on-going engagements that are taking place there, including NHI related engagements wherein entities like Nedlac play a role. So this gives, you know, as sense of the range of activities that certainly keep, you know, keep us busy. Now Chair coming closer to the main issue that, you know, has really brought us together, you know, today. Here I am talking about the Section 59 investigation. We acknowledge the terms of reference that emerged, you know, towards what the panel is mandated to do, and I'm not going to go through them in any, you know, detail because, you know, the panel and the audience will certainly be aware of this.

What I do want to say is that HFA as an association is not directly involved with the schemes operational activities relating to

fraud, waste and abuse because we are certainly a different entity. We are an association, we interact with medical schemes and administrators, but we are not, you know, involved in the operational activities, you know, in how they respond to fraud, waste and abuse. It is also fair that we certainly condemn all forms of bullying, racial profiling, and unfair treatment that has triggered this investigation.

Now having said that, at times it's possible for one, when you say that and stop there, to come across as if you are, you know, confirming that these practices are indeed taking place in the industry. Now our interactions with the medical schemes and our administrators suggest that partly because of the fact that there is no data that is collected as far as race is concerned, and an argument is made that it would be impossible to racially profile practitioners in particular, which is what is relevant in this specific case. So we find the arguments that are being made quite plausible, but we also do not want to be dismissive of the allegations that have been raised.

And we have resolved that we are certainly going to trust the process and see what comes out of it, and participate in the process in good faith, and take appropriate action, you know, at the end of the process. Amongst [intervenes]

CHAIRPERSON: Can you just tell me, what is the explanation that you are getting from the schemes? So the one explanation is that we don't collect racially aggregated data?

MR MOSOMOTHANE: Yes.

CHAIRPERSON: So what is the other explanation, because, I mean, to say we don't collect the data doesn't mean there's no racial profiling. Because one of the problems is that we've now sat here for day number five today, we've had medical associations, doctors, practitioners across, what they show, one of the presenters showed us that the blacklisted practitioners from GEMS is almost 98% Black. Discovery says; well, we don't have the statistics. I asked the same question yesterday to another presenter, to say well, who are the doctors that are being blacklisted, who are the target of Section 59, are they Black or White, and then they say no, it, from our experience it's overwhelmingly Black. So what is your own experience?

MR MOSOMOTHANE: Chair, the reality is amongst the responses that we receive is a, you know, include the fact that we do not know, you know, why the outcome looks the way it does.

CHAIRPERSON: No, no, no, no but what does the outcome look like?

MR MOSOMOTHANE: Well based on what has been, you know, advanced in as far as these allegations are concerned, that is the outcome that I'm referring to. So the allegations are suggesting that there is racial profiling, and the response is that we don't know why that is the case. It's partly for that reason that we are committed to this process, and are trusting of it to see, you know, what will come out of it. Amongst the issues that we raised Chair, in the course of our conversations over the last couple of days, was the concept of

social solidarity. Now there's a lot has been, you know, raised, and I'm just touching on this one in particular, because we think it is important to provide a perspective from where we are sitting in as far as this amongst a number of elements that, that have been raised.

What we want to bring across is the fact that we believe the fundamentals of social solidarity. First our fundamentals that we embrace from an HFA perspective, to the extent that they are supportive of a, you know, intentions to have good quality healthcare accessible to as many citizens and beneficiaries as possible. Our observations are that the environment that we are operating in now, with reference to the Medical Schemes Act in particular, certainly includes these fundamentals relating to social solidarity, and these include open enrolment, and you know, the fact that contributions, from a contribution perspective.

Now it's important for one to make the point in this regard that contributions from a medical scheme perspective is the primary source of income if one includes, excludes investment income that you know, may be generated if the medical scheme managed to generate some savings. So there's an aspect of community rating in as far as, you know, contributions are concerned, and now community rating really entails the fact that, you know from a contribution perspective, it doesn't matter whether one is young or old, or has a different risk profile from a health perspective, you know, everybody is treated the same.

Now from, there's, income rating is allowed, and I should explain this by indicating that the act as it is now, would allow medical schemes to use income bands to cater for those with, you know, low income and while they also still have healthcare needs as everybody else would. There's also no clinical risk rating, and in addition to that Chair, there is what we refer to as prescribed minimum benefits, which are really guaranteed risk benefits, and we see all these as elements of social solidarity which are incorporated in the healthcare environment that we are operating in, and we think it's important to express this perspective so that we cannot come out of this episode with an understanding that this is something that does not exist.

It is also fair to say though, that even though these fundamentals and elements may be there, they may very well not be generating the desired outcome, or impact, and we all have work to do as far as that is concerned. But the point that I want to make, these elements relating to social solidarity, you know, are certainly there.

Now there are challenges that we find ourselves having to, to attend to in the healthcare, you know, environment and these include the deterioration in as far as the risk profile is concerned, and we would argue that there's definitely risk pooling, you know, as well, and this can sometimes be across the different benefit options that a medical scheme would offer. But you know, the optimisation of the risk pool makes it a lot more possible for us to achieve

affordability considerations to the extent that we possibly can, taking into account the healthcare needs of the individuals that belong to these medical schemes that are assisted by their administrator.

So there's another point that one wants to register, you know. Partly in relation to one of the points that was raised earlier in the course of the week, and the point that we want to get across is that there is certainly risk pooling. Now in as far as the guaranteed risk benefits are concerned, what the act allows is for medical schemes to optimise contracting, the use of networks and the use of managed care organisations to really, as far as possible manage the exposure to the fact that PMB's have to be covered at cost. So there are limited options available to medical schemes to really manage their exposure to PMB's, and this is where the designated service providers also come in Chair.

It is something that is provided for, you know, in the act and one would not argue that there is no room for improvement in how these are optimised. But they're usefulness are there for the schemes to really be able to manage their exposure, you know, in as far as PMB's are concerned, amongst other challenges that we face in the healthcare industry. So at the end of the day the point that we want to leave with the panel, with reference to this slide, is that scheme trustees are really required to manage complex risk pools in the interests of all members.

This becomes quite relevant in the context of the extent to which medical schemes are exposed to fraud, waste and abuse, which you know, presents a threat in as far as the funds and the limited resources that are available to cater for the healthcare needs that medical scheme members, you know, pay for. Chair moving on to further insights that we want to share with the panel in relation to medical scheme membership amongst other considerations. Now medical scheme membership is just under nine million lives in the country, which is only around 16% of the South African population. Now Chair, the HMI provisional report noted that this number has not been increasing as rapidly as the population over the last couple of years.

The graph that we see on the screen shows that the percentage covered varies greatly by age, with a much greater proportion of older people being on schemes, and also female coverage in child bearing years being higher. Now this in part, as is it is indicated in the submission that we have made, demonstrates the, you know, the concept of anti-selection, where people may sometimes join medical schemes at the time of need, and it does present a bit of a threat in as far as optimising the risk pool is concerned. Now what we want to stress in this regard is that it is important, you know, that trustees protect the member's funds from fraud and abuse, and make sure that they are used effectively and appropriately for paying for treatment that is needed, you know, that is of high quality as well.

I wish to reiterate, you know Chair, that the scheme do not have the data on racial profile of members, and the health market enquiry also confirmed in their provisional report. Now CMS also does not have this information. The only source of data for the racial profile of medical scheme members that we are aware of, comes from the general household survey published by STATSA, which we have made reference to in our submission, and the latest report shows that 34% of medical scheme beneficiaries are white.

ADV WILLIAMS: Mr Mosomothane.

MR MOSOMOTHANE: Yes?

ADV WILLIAMS: I just want to ask a question about this. We hear the point that the schemes and the administrators don't collect data, or have data on race, but is that the only question that's relevant? Because thinking out aloud, it may be that their systems unintentionally draw distinctions on racial lines, do you have any information on that?

MR MOSOMOTHANE: Through the Chair, we don't. We don't have information on that, and this is why we're also quite anxious to see what will emerge from this process, because through the information that will be provided, you know, to the panel, and the investigation that will be applied we may very well learn a number of things that we can, you know, we are currently not able to draw conclusions on. So the short answer to the answer to the question, through the Chair, is that we don't know.

ADV HASSIM: Have you requested information from your members?

MR MOSOMOTHANE: No we haven't. I think in the wake of these allegations there has obviously been a number of discussions that have taken place, and the Council for Medical Schemes was quite quick off the mark as well, to call on the stakeholders and have a conversation about this, and we learnt quite early in the process that in all likelihood there would be an investigation of this nature and we believe that it's a most appropriate kind of structure to zoom into these allegations that have, you know, that have been raised.

So we haven't, we haven't asked for, you know, such information and there is also an element of whether or not it would be appropriate for us, from an HFA perspective, to ask for that, you know, information. But be that as it may, while we were considering that, we place comfort on the fact that there is this process that is underway, that is a lot more structured, that will generate, you know some insights, and the outcome of the investigation into the allegations that have been raised.

ADV WILLIAMS: And just to follow up on that, while we're on the topic. We heard allegations from the HPCSA that 99% of doctors who are contracted-in are Black, and you obviously have, or your members have some knowledge of who is contracted in and contracted out. Is that information that you have?

MR MOSOMOTHANE: No, we don't have that information, and we also observed the information that was provided by HPCSA with interest, and we noted how it was, for lack of a better word, also qualified if you like you know, in the context of the HPCSA not having collected such data before, and having started, you know, recently. So we are also looking forward to what will come out of the information that the HPCSA will provide to the panel, and what it will reveal.

ADV HASSIM: But what are you going to say about what the HPCSA has provided to the panel? So you would've seen the slide that was presented with the sources of complaints over the last two months.

MR MOSOMOTHANE: Yes.

ADV HASSIM: And the medical scheme complaints being five times higher than others, in relation to Blacks, Black practitioners.

MR MOSOMOTHANE: Now, through the Chair, one of the questions that was raised by the panel, which we really appreciated, or a request rather, was that you know, HPCSA was requested to provide information about all complaints, you know, as an example. So we are quite keen to have this process make itself comfortable about the completeness of the data from HPCSA, and the process must provide assurance about reliability. Not that we have any reasons, you know, not to trust the information, but we'll see what comes out of that, and we, you know, when we are all comfortable

based on the assurance that is given by the panel in as far as the reliability and the credibility and the insights that are revealed. We will then be in a position to give consideration to what that reveals.

ADV HASSIM: Until then you're not giving consideration to that slide?

MR MOSOMOTHANE: The reality Chair is that even from our member's perspective, being the administrators, the panel must remember that from a race perspective the administrators and medical schemes do not have that data. If questions were to be raised about what do we make of this, it would be a bit difficult for the administrators and the medical schemes to respond to it because it is the HPCSA that has indicated that very recently they started collecting data, you know, and you know on race. So in the interim we will really stay close to this process, and we also appreciate the fact that it has been confined to a short period of time.

So it won't be long before the outcome, of what will be investigated in here, will become available.

CHAIRPERSON: Thank you, would you just move on to your next slide, I think you've given us enough on this issue.

MR MOSOMOTHANE: Chair, with reference to this slide, what we wish to highlight is that the latest annual CMS report shows that in 2016 medical scheme contributions were not able to cover the costs, and the relevance of this is to, you know, really present more insight, and share more information about the dynamics that are

playing themselves out in the environment that we're operating in. In 2017 risk contributions income was about 163 billion, and claim payments were 145 billion. Now of this 49% was in respect of PMB's. Now I touched on PMB's earlier on, and I think we must really attach importance to the significance of the PMB's in the total healthcare benefits that are, you know, paid by medical schemes.

Because these are guaranteed benefits that medical schemes are required to cover at costs, and it's quite significant.

CHAIRPERSON: Sorry can I just ask you, I thought in your presentation, not your slide but your presentation you gave to us, at page five. There you dealt with the declining membership of schemes from 2010 to 2017. In 20, so that's as a proportion of the formally employed, so I thought you would probably explain what that is about. I mean, does that mean that the membership of schemes has been declining since 2010 to 2017?

MR MOSOMOTHANE: I think the point that it reveals Chair is that the pressures that we all find ourselves under, even, you know, for those individuals who may be employed. When one looks at the percentage of the number of people who are employed who belong to medical schemes has been declining, you know, in proportion. One would have expected that, you know, those who are employed would at least stay with medical schemes, what this, you know, also really should highlight is the need on the part of medical schemes, led by their trustees, to manage the affairs of the medical schemes with due consideration to the [intervenes]

CHAIRPERSON: Sorry, I'm just trying to understand first what the slide means. I mean it could mean two things. The one is that people that are already with medical aid, and are employed, are terminating their membership.

MR MOSOMOTHANE: Yes.

CHAIRPERSON: Or it could mean people that are joining the labour force, who are new, are not joining medical schemes? What does this graph actually mean?

MR MOSOMOTHANE: It's a combination of both, because there are instances where, you know, as contribution increases year on year, people who are already on medical schemes decide, look I cannot afford this anymore, and they step off medical schemes. And where there is no need for individuals who are joining the workforce to belong to medical schemes in particular, in instances where this is not necessary as a condition of employment, you know, so those individuals may also not be joining, you know, medical schemes. So it's certainly a combination of both.

CHAIRPERSON: Now my understanding is that you've got some racial statistics of membership, even if you don't have the racial statistics of doctors? Oh, you say you got this from STATSA; they're not yours I suppose?

MR MOSOMOTHANE: Yes, yes.

CHAIRPERSON: Okay.

MR MOSOMOTHANE: No, it's [intervenes]

CHAIRPERSON: So you won't really be able to help me on the demographics of the memberships to schemes?

MR MOSOMOTHANE: We won't be able to do that Chair.

ADV HASSIM: One other reason for that slide, one other explanation could be; you said that you have, the membership of schemes tends to be older, so they're more, the age aspect of the membership could mean that your members are leaving the scheme because well they're leaving this earth? It could be that your membership is dying off, is that part of the reason for the decline?

MR MOSOMOTHANE: Well Chair, I think what the graph really highlights is that we must remember that, it's fair to say that as people get older, their healthcare needs also change, and they definitely hold on to, you know, to healthcare cover to the extent that they possibly can, and it also suggests that as people get older if they can certainly get into medical schemes, you know, to access good quality healthcare, you know, they would do that. And it has an impact on the risk profile of medical schemes, and you know, to the extent that the risk profile deteriorates. It also has cost implications [intervenes]

ADV HASSIM: That's not my question. My question is whether the decline in membership has got to do with deaths of members?

MR MOSOMOTHANE: Okay, Tebogo will answer that.

CHAIRPERSON: Mr Phaleng?

DR PHALENG: Thank you Chair. Just to, maybe to just assist Mr Mosomothane. I think the broader context of this is, if you have the environment that schemes operate in now, firstly you have an open enrolment, so guaranteed participation should you choose to. So voluntary, participation is firstly voluntary, because the state does not say; if you're in the formal sector you must take up medical aid, for example. So there's, that's the first point. Then your contributions are then not rated based on your clinical profile. So the scheme does not have the ability to say, like you would for example in short term insurance, to say if you're a 24 year old with a fast BMW we're going to charge up your premiums because you represent a higher risk than a 55 year old in the same car, right so that's the second constraint.

Then in that environment you now have the statutory guaranteed risk benefit in the PMB's which you have to cover at cost. So all of that, you know, creates a pressure on the schemes to manage funds, that's a first. In terms of the decline in the profile, it's not really that, what, if you just look at CMS data. I think people in the one graph before this, actually show that your proportion in your over 40's, the proportion of the scheme population relative to the South African population, is sometimes as high as 35%, you know. We often talk about medical schemes represent 16% of the population, but it varies by age, and there's a stickiness over time, as people get older and sicker they tend to stay on the medical scheme over time.

The bigger issue, so it's not to say people don't come off. As the economy declines, asemployers change their subsidy policies as they retrench, sure people do come off the bus, and unfortunately they become the burden of the state in that case. But I think the bigger issue, the point that we're trying to make, is the voluntary participation also creates an option for younger people who are healthier, who would create a risk cross subsidy, and an income cross subsidy should they participate, are staying off. And what you'll see, there's a graph which I mean, we could share with the panel if you haven't seen, it was by Inside Actuaries, I think back in 2013.

That actually shows the South African population, and the medical scheme population by age, and what you see there is the medical scheme population has shifted to the right, which means slightly older. The actuaries will tell you that every one year shift in a population risk pool adds about 2% of cost additional. So every one year shift, so if you have two risk pools, or if you have one, a single risk pool and nobody new joins, and nobody leaves, that population a year later, they're one year, they're all one year older. Just by virtue of that one year shift, you'd need to budget an additional 2% just to be able to cover their healthcare needs.

So you know, it shows the shift to the right, and then it also shows that younger lives actually stay on their parents, so they participate, they stay on their parent's medical aid. When they become independent, there's a dip in the population, so they come

off, and they only start participating again at a point of childbearing age. So when they start having families, and they actually quantified that, that gap to say if we were to say everybody must participate who is employed, you'd probably generate another 15 to 17 billion per annum into the risk pools.

So I think the challenges, I mean as funny as it sounds, when the graph you're asking about Chair, actually simplistically means the employed population in South Africa is actually growing in numbers, faster than the medical aid population, and we all know high the unemployment rate is. That's how critical this issue is.

CHAIRPERSON: Yes I understand, but I mean if one looks at the category you're dealing with, I mean if you've got 20 employed people the graph shows that in the next five years only 15 of those would remain members of the schemes. The question I'm trying to understand is what will happen to that five? I mean, of course if people die, they're no longer employed, but those who remain in employment are also leaving the schemes. That's what I'm trying to understand.

DR PHALENG: No, I think what it's saying Chair, is that the five don't necessarily die, they just come off cover. So they basically become the burden of the state, because they have to access care somewhere. The 15 then remain, and depending on the mix, so if it's 15 older people then the risk profile shifts, it basically worsens. So that risk pool would have to provide additional funds to fund the 15. Whereas, you know, if the five who leave are younger

individuals, then what you do is lose contribution income. But if the five that leave were older, then it might actually be a positive impact. It just depends on the mix of lives that change.

CHAIRPERSON: But I mean, isn't there another explanation that the contributions are too expensive and unaffordable?

DR PHALENG: So Chair, we agree with the fact that, I mean the sustainability of contributions over time is a real challenge, and there's, I think schemes have gone on record with the HMI process, and some of the submissions there just, you know, if I try and recall, would show that some of the bigger entities are reporting CPI plus five, CPI plus six, sort of a contribution income on an annual basis. We can check the numbers there in the HMI submissions, and I think 5% above CPI is not, it's significant. What those numbers also show, that the greatest proportion of that is not pricing. It's not, it's not tariffs. Tariffs tend to contribute about half a percentage to 1% of the above CPI increase.

It's the demographic deterioration adds costs, so the one year and two year shifts that require additional funds, and the second part of it is the supply side dynamics, which deal with where schemes actually have to purchase healthcare. So the lack of regulation within, within the health facilities market for example. An environment that is predominantly fee for service based in terms of remuneration etcetera.

There are other factors, influx of new technology for example, if you have new devices that are more expensive into the market, they do cost more, and obviously another supply side factor, which we cite as fraud, wasteful care, and billing abuse. So that, you know that is a supply side contributing factor.

CHAIRPERSON: Now on that issue of the factors that are contributing to the high contributions. What do we know about fraud, waste, and abuse?

DR PHALENG: I think we were actually coming to that [intervenes]

CHAIRPERSON: …[indistinct 00:47:06] Mr Mosomothane?

DR PHALENG: Ja.

CHAIRPERSON: Alright.

MR MOSOMOTHANE: Now Chair we'll get to that point just now, you know in the next slide. If I can wrap up the point that we want to get across with reference to this one, and the figures that have been accessed from the Council for Medical Schemes, you know, report. The point that we want to highlight here is that there's a lot of pressure, you know, including financial pressure, you know, that medical schemes find themselves under. And so managing these costs becomes quite critical, and to the extent that fraud, waste, and abuse makes an unwelcome kind of contribution to those kinds of pressure. It becomes critical for all stakeholders to do their best to manage that kind of issue, in addition to any other challenges, you know that we are facing.

So I'm going to move off this slide. Now the CMS as a regulator, have certainly recognised Chair, the challenges that fraud, waste you know, and abuse is for medical schemes, and took the initiative to bring together market participants to address this challenge earlier this year, as I have indicated. Now this also followed a national initiative to address fraud and corruption in various sectors, you know, of the economy. And here we're also making reference to the National Anti-Corruption Forum, which involved the presidency.

ADV WILLIAMS: Mr Masomothane can you just, I see what your slide is dealing with.

MR MASOMOTHANE: Yes.

ADV HASSIM: But what I don't see on there is, the BHF for example, has told us that approximately R28 billion is lost to fraud, waste and abuse annually. Is that, do you have a figure like that as well?

MR MASOMOTHANE: Now as far as that figure is concerned we, from an HFA perspective given our participation in the fraud, waste and abuse summit that is led by the, you know, Council for Medical Schemes, we chose not to duplicate that estimate, so we are deferring to the numbers that have, you know, been estimated by the Council for Medical Schemes. Now we observe that earlier in the week, you know, the BHF was talking about 28 and there was a lower amount that was referred to from a CMS perspective.

So my best response to that is that we defer to the calculations that have been done by the Council for Medical Schemes in that regard. But what I do want to highlight Chair, is that there was a specific question in as far as the component of fraud in particular, and for lack of a better word, there was some confusion in as far as what that amounts to. You know, trying to isolate fraud, and we may have walked away from the discussions on the day thinking that having given an estimate of 15% of total claims as what our exposure may be, you know in relation to fraud, waste, and abuse.

We came out of the discussions with a suggestion that about three to 6% of that 15%, may be attributable to, you know, to fraud in particular. We had informal discussions with BHF after, you know, the conversation, because based on the information available to us, just from engaging other players in the industry, the three to 6% is actually relating to total claims as opposed to the 15%. So by that I'm saying three to 6% of total claims, you know, is the right estimate in as far as fraud is concerned.

But it's fair for us to say, it may be wise for the panel to just check that again, you know, with BHF because we did have an informal conversation with them about it, so that they can just confirm instead of me saying something making reference to them.

ADV HASSIM: But didn't the three to 6% come from an American survey of medical aid and fraud in the medical aid market in the US, not South Africa?

MR MOSOMOTHANE: That is correct Chair, and it happens to coincide with other sources that we have internally from big administrators who do similar kind of estimates, and it was against this background that we were raising the question with BHF and saying; look, you said three to 6% of the 15% and in that informal conversation they did indicate ja look, the right estimate is between three to 6% of the total claims. So you know, it happens to be, you know, more or less in the same range as what we are experiencing here.

DR PHALANG: Chair, if I may?

CHAIRPERSON: Yes Mr Phalang?

DR PHALANG: Thank you Chair. I think we would probably just need to double check with the BHF. What we know is this; the figure cited by the registrar of medical schemes, of 10 to 15%, my understanding is this was based on global research in advance healthcare markets, where you have health insurance etcetera. Where you have stronger data, and I think the point was we've got no reason to believe that our situation is, would be any different. I think that's the, kind of, starting position to say globally what's reported is 10 to 15%. And if it's 10 to 15% in our market then therefore it's up to 15% of, I guess R144 billion, which would make you, which would come out at about 22 billion just on, of this number.

ADV HASSIM: Yes, but you haven't got data and research in relation to the percentage of claims, to how much is lost through fraud as a percentage of claims amongst your members?

DR PHALENG: Not, not that we know of Chair. I think what we know is this estimate which has been quoted by the CMS. But again that is [intervenes]

ADV HASSIM: But that is a global study which you're trying to super impose here.

DR PHALENG: Ja.

ADV HASSIM: I'm saying are you doing your own investigation as to how much is lost to fraud? I mean it can't be that complicated amongst your members.

DR PHALENG: It is not as easy as simply just, it's hard to dictate how much fraud is, I mean if you look at some of the figures that have been reported on recoveries. I think some, you know, two administrators were quoted by a group a day or two ago, and if you look at the total contribution income for the schemes they manage, you'll probably be coming out at about one, maybe 2% of total contributions recovered, you know? That's a different figure from saying what is their exposure? So you may, if I have R10 and I'm being robbed of R5 out of the R10, but I'm managing to recover the R1 of every R10. So, it's the two figures. I'm just simply saying that first figure we don't have hard data on but, you know, just based on global evidence, the, I think the CMS is narrative on this

was that there's no reason to be believe that, I'm, our situation would be much, much different.

CHAIRPERSON: The problem Mr Phaleng is, to just put it to you so that you can have, you know an opportunity to respond. It's not so much that we're trying to extract numbers from you. So, the big story is this. Schemes are saying in their submissions, we are losing R28 billion per annum. We are justified in invoking drastic measures of recovery. Sometimes we recover a billion if we are lucky. Sometimes one point something billion, sometimes R500 million. The doctors on the other hand are saying that these investigations techniques that they are using are unfair, disproportional and unjustified. So, BHF says to us, we think fraud accounts for 3 to 6%. Initially I thought it was 3 to 6% of the 15%. Now you are saying to us it's 3 to 6% of the total claims.

If we know for sure, what is the amount attributable to fraud, we can make an informed assessment as to the justifiability of this investigation techniques and the recovery that is used. But if we also know that a lot of it is attributable to waste and abuse, which is not necessarily the fault of the doctors but it, is a systemic problem within medical schemes themselves. That gives us a completely different picture to the justifiability of the drastic measures that are used to implement Section 59. So that's what we're trying to debate with you. And we're not trying to catch you out.

DR PHALENG: Thank you, Chair, and ja, absolutely I think we're on the same page. We're just trying to just also just

share our insights and hopefully, you know, bring the panel to an understanding. I think the analysis is not different. Is not inconsistent with what you're seeing on the recovery. So, I think what's being said is 15% is fraud, waste and abuse. Another 3 to 6% is the fraud element. So, the WA would then be 15 minus 6%. So, that's essentially what has been said. I think on, you know, I'm not a lawyer, but I think the difference mainly and if you read the definitions in the CMS fraud charter, fraud, waste and abuse charter is mainly around intend. So you know, did you intentionally kind of misrepresent a claim and commit fraud or did you bill codes that you shouldn't have, or you're practicing in a manner that is inconsistent with, you know, good clinical practice and billing accordingly.

I think the point there, Chair, is the onus I think is on the health practitioners to also bring themselves up to speed in terms of how to clinically code and bill appropriately. Sure, the industry has to play a bigger role in that so that we have a common standard and a common understanding. Right? Fraud is fraud. So I'm not even going to go there but I think from a medical scheme point of view, whether you've paid out for a fraudulent claim or whether you've paid out an incorrect amount because a practitioner billed erroneously or inappropriately. It's still money that is paid out by the scheme that should not have been paid out and I think it's in that sense, our understanding is, it's in that sense that schemes are

saying this is inappropriately paid by the scheme and therefore it needs to be recovered for the benefit of the member.

So if you pay for a consultation and you're expecting it's R400 but there's padding in terms of what's on the claim itself, fraudulent, intentionally or not. If the claim is R600 and it was meant to be R400, the scheme's, our understanding is, the schemes feel that R200 was wrongfully paid out and it needs to be recovered to the benefit of the scheme and its members. So, that's kind of our understanding.

ADV HASSIM: But what we heard is that what the schemes do, or the administrators, is not to claim back the R200. There isn't an exact quantification of what was, what is due to the medical scheme. What is appropriately and lawfully due to the medical scheme because there was a finding that it shouldn't have been paid over to the practitioner. There isn't a quantification of that amount. There is an aggregation over a period of time.

DR PHALENG: Thanks. Thanks Chair, I thought [intervenes]

CHAIRPERSON: Okay, let's go back to Mosomothane then. Are you saying you've [intervenes]

DR PHALENG: No, I was trying to [intervenes]

CHAIRPERSON: Discharge your minded.

DR PHALENG: I was trying to answer the question that I think for the HFA perspective, HFA is not that close to the scheme operations and this, these procedural aspects would differ from

scheme to scheme and administrator to administrator. I think you'll probably [indistinct - 1:00:32.4] more information from, you know, the schemes and administrators on how they actually, you know, whether or not the R200 would be recovered and how it's done. I think the HFA is not close enough to that level of operational detail.

CHAIRPERSON: No, but I mean you can give us your won perspective about whether averaging is right or not.

DR PHALENG: In what we, I think Chair, you need to find a mechanism that is fair and reasonable and I think that's the insight we're hoping, you know, some of the clarification that we hope this process will bring to the environment. CMS had been working on a codes, code of good practice. We know this. We are part of the working group and the coordinating committee. And these are some of the issues that actually came out from the summit to say we must have some form of standardised approaches to these issues. So, we welcome that and we hope at the end of this process, we will have better clarity.

CHAIRPERSON: Thank you. Let's finish your slides Mr Mosomothane. We've taken, distracted you from your [intervenes]

MR MOSOMOTHANE: No problem, Chair. I think just to move off this one, we have to a significant extent touch on all the relevant aspects, you know, one way or another, and went as far as touching on the challenges that are faced by medical schemes with reference to this up to 15% of total claims. One of the things that becomes quite relevant in this regard, Chair, are the findings that have been

raised by the health market enquiry. All be they, you know, provisional, which suggest that, you know, the HPCSA, you know, there are certainly, there are inadequacies in as far as penalties that are imposed, in as far as these acting as a deterrent to unethical conduct.

Now, I appreciate that there was a conversation that took place in as far as, you know, this is concerned with the HPCSA, and, but we find it quite relevant, you know, in as far as what the health market enquiry has raised including the fact that there is a backlog of complaints and inadequate sanctions that are imposed by the HPCSA. Now, having said all that, our understanding from interacting with the schemes and administrators, is that these inadequacies, you know, are not necessarily resulting in medical schemes and administrators doing what they believe is beyond the boundaries of, you know, laws and regulations, you know. They are really applying the recourse that is available to medical schemes and administrators to recover, you know, what has been lost, you know, to the scheme as a result of fraud, waste and abuse.

ADV WILLIAMS: Mr Mosomothane, just to pause on that point. I'm struggling with that submission because on the one hand you are saying you are not close enough to the schemes to know the detail of the information but on the other hand you are saying they comply with the regulation. So, ja, I'm struggling with how to make sense of that because I'm resisting going into the detail with

you because you say you don't know, but at the same time you are making submissions suggestion you do know.

MR MOSOMOTHANE: I think that's a very fair comment. It's very possible, you know, for us, you know, being in association that is made up of medical schemes and administrators, to find ourselves expressing views and assurances that, you know, are given in the course of the interactions with our member organisations, and I guess at the same time, you know, there is carefulness on our part not to present ourselves as knowing all the details at operational level that the medical schemes and administrators, you know, certainly do. We do have a benefit in this process. I would think of, you know, administrators and medical schemes being expected to come to these, you know, sessions and make presentations which will provide the panel with an opportunity to interrogate the nitty-gritty's of how they're carrying this out.

So, I fully understand the concern that you have in as far as at times expressing details that one would be able to do if we were close to the operations and at the same time saying look, we are not close enough.

CHAIRPERSON: Can I just ask you, I mean, maybe you are close to this one because it comes from your submission. At page 15 and 16 of your submission, there you've cited the policies of the CMS. So at the bottom of page 15 you say that, in an additional CMS document entitled Accreditation Standards for Third Party Administrators, Sections 1454 and 1455, you state the

following: “Membership is suspended/terminated in accordance with the specific rules of the medical scheme on submission of fraudulent claims.” You turn over the page. “Membership is suspended/terminated in accordance with the specific rules of a medical scheme on committing a fraudulent act and then furthermore Section 1457 states that the member is advised timeously in writing of any action contemplated above.”

What we’ve heard here is that a doctor will typically be informed after the suspension that you are now suspended and you will not be entitled to lodge claims. And yet the CMS guideline require notification of action contemplated. In other words, in advance. So, I know you will say that well, I don’t know what the schemes actually do, but assuming theoretically that someone is informed after their suspension, what would be your comment?

MR MOSOMOTHANE: My comment, Chair, would be I think that would be unfair and, you know, unfortunate. What we have come to know is that before these kind of, you know, suspensions are imposed, there would be ongoing or necessary, you know, interaction with the relevant parties. You know, but again, this is based on, you know, the interactions that we have with the medical schemes and administrator but, you know, what you are raising is what my comment is as far as that is concerned and my sense is, you know, if practitioners know after the fact, when they have already been suspended, that would certainly be unfair.

CHAIRPERSON: Well, I meant to say after the facts might also not put the full picture to you. I think some of the testimony we've heard is that what a scheme typically does. It will tell you that you are hereby suspended, pending the outcome of an investigation. So, at the time you learn that you are subject to an investigation, your entitlement to claim is suspended. Now, according to what you've cited under the CMS guides, you must be notified beforehand. So, that's what I'm putting to you, to say that as a practitioner getting a notice, saying you're under investigation, and you've been suspended pending the outcome of the investigation, that you would say is wrong. Sorry, Ms Mosiah?

MS MOSIAH: Yes. Thank you, thank you Chair. Coming to that point, what we've learned is that, and what we are aware of is that the perpetrator or if there is a question around that with the healthcare professional, they, there's always ongoing communication before the action is taken. So there would, the schemes do interact with the service provider prior to them being given that letter of suspension or any other punitive action taken.

ADV HASSIM: How do you know that Ms Mosiah?

MS MOSIAH: Well, we have learned that through when we interact with our schemes in terms of, and so far we have actually wanted to interact with the schemes to say, what is the process? Do they have processes? And there is proof of processes that they actually enter into to say that we will communicate with the

doctor to say, but this, because remember there could be erroneous reasons for the, for the discrepancy as well.

ADV HASSIM: So would you agree that if it were so, that a practitioner was informed at the point when he or she is being investigated, is informed that he or she is also suspended, that that would not be appropriate?

MR MOSOMOTHANE: Let me, let me answer that. I would certainly agree that's unfair and in the context of these practices not being consistent with these guidelines that we're making reference to, Chair, you know, that would certainly be an unfair, we would argue.

ADV HASSIM: And so, you set out, so speaking of compliance with what you've set out. You've set out the CMS policy and procedures. You've also set out the law, various aspects of the Medical Scheme Act and Regulations, but you don't say anything about how you understand, how you analyse that, those sections and those regulations. Can you, can you give us a bit more insight into that? You've set out the law. Do you think Regulation 6 is part of implementation of Section 59(3)?

MR MOSOMOTHANE: We certainly think it is relevant to be taken into consideration in how Section 59 is implemented. However, our reading of both the act and the regulation, is that it certainly doesn't take away, you know, the right if you like, on the part of medical schemes to, you know, to deduct monies that medical schemes believe have been paid, you know, fraudulently.

You know, even beyond the 30 days if you like. So, the interpretation that we, you know, apply to both Section 59 and Regulation, and Regulation 6 is that it doesn't take away, you know, the need on the part of the medical schemes and administrators to recover funds retrospectively.

ADV HASSIM: Okay, let's accept that. But it certainly, wouldn't you agree that Regulation 6 is, what is required is more than just taking it into consideration but actually complying with Regulation 6? In the, because Regulation 6 deals with the process. Don't you agree that, that it's incumbent upon the schemes to comply with Regulation 6?

MR MOSOMOTHANE: No, certainly and you know, in as far as what Regulation 6 and Section 59 are requires of, you know, the scheme and administrator, you know, to do, we would certainly support that, you know, all the parties need to comply. What becomes necessary however, is, you know, the parties like the Council for Medical Schemes as the regulator to bring clarity in as far as the interpretation and the application, you know, of both the act and Regulation 6, to the extent that, you know, it is exposed to interpretation.

ADV WILLIAMS: Perhaps I can just add to that question. So, can I assume you accept that a coding error made by a doctor is erroneous? Would that be correct?

MR MOSOMOTHANE: No. We cannot always assume it's erroneous because what one is not able to test, is the intention.

Because it's very possible, you know, it's a possible scenario for a doctor to do that intentionally, so it becomes difficult to say. And these are the things that tend to come out in the interaction, I would imagine, between, you know, the doctor, you know, and the scheme.

ADV WILLIAMS: So in this environment, I would have assumed you've listened to some of the proceedings. But it's pretty clear from what we've heard so far, that the coding environment is very ambiguous to say the least. There aren't, the RPL isn't enforce, the ethical tariff isn't applicable, schemes to be, schemes seem to be, sorry. Schemes are creating their own versions of the RPL which are applicable to their members. It seems that the doctors, it's very easy for the doctors to make a mistake in relation to coding. So, the difficulty I have is with that, it doesn't seem, it seems that often there is no intent on the part of the doctor, yet they may be subject to a claw back, many years later in relation to that.

MR MOSOMOTHANE: I certainly understand that, you know, in the context of what you have just outlined with, you know, with relation to coding and the lack of clearing as far, clarity as far as that is concerned. Errors are bound to happen and how this, you know, is approached, must be with due consideration to those realities, you know, in mind. But again, you know, given that, the use of coding to defraud the scheme is also possible. It's difficult to conclusively, to say, every time there's a wrong code that has been used, it's definitely an error.

CHAIRPERSON: Okay. Can I just ask about this topic of investigations? Is it your view that a suspension before the completion of an investigation is, let's put it differently, is not in accordance with the CMS guidelines. So if a scheme suspends a doctor before it finalises its investigation, that would be in breach of the CMS guidelines. Is that your submission?

MR MOSOMOTHANE: Chair, it's a difficult one because it really depends on the nature of interactions that would have taken place before that, you know, investigation is finalised. So, it is, it's very possible for the conversations to come to a point where, you know, the extent or the nature of the interaction doesn't give, you know, the medical schemes enough assurance about the claims in question not being fraudulent and, you know, at that point in time if based on the information that medical schemes may have suspect that, you know, something is amiss about those claims, I would say they would certainly be, you know, right to suspend in the course of engaging the service provider.

CHAIRPERSON: No, I accept that, but you see we're working on broad principles. Best practice. And there would be exceptions where cases are [indistinct - 1:17:04.7] or clear-cut fraud. But as a matter of best practice, bearing in mind that you are the association that represents medical schemes [intervenes]

MR MOSOMOTHANE: Yes.

CHAIRPERSON: Even though you are not a scheme. I mean would you agree that as a matter of best practice, a scheme

should not terminate membership before it finalises an investigation?

MR MOSOMOTHANE: I would agree Chair. And I think in the discussions with the Council for Medical Scheme and other stakeholders in this space in as far as how, you know, the code of conduct should spell these things out, going forward, what you've just expressed is certainly some of the inputs that we'd make in that conversation but it would certainly require all parties to commit to definitely manage fraud, you know, waste and abuse as far as possible, but my short answer to your question is, yes.

CHAIRPERSON: And then there's another, where you are not completely terminated or blocked, but where they put you on what they call, indirect payment.

MR MOSOMOTHANE: Yes.

CHAIRPERSON: Would you also accept that the indirect payment as a measure by schemes should not be resulted to, until the investigation is complete?

MR MOSOMOTHANE: Chair, as far as that is concerned, and in this specific instance I'm assuming that suspension means a member, you know, is being paid. So to the extent that this is something that, you know, the act allows for in as far as either the member or the service provider being paid. If based on the weight of the information available at the time, in the context of an intention to try to manage, you know, or mitigate against possible fraud, the administrator or the scheme is of the view that they are not

comfortable to, you know, to make the payment directly to the service provider. I think, you know, with reference to the act, it would certainly be fine if they make a payment to, you know, to the member instead of the service provider.

CHAIRPERSON: And would you say that despite the incomplete nature of an investigation, you see the difficulty with this is that one must take away the focus on the cases that are before us and then think about broad policy in order for us to be helpful to the industry. So what you have, you have a typical doctor who's been on a network or pre-authorisation, anything, for years. Five, six years. The scheme picks up something. Maybe a coding error. Maybe innocent. Maybe fraudulent, right? The question that really arises is, at what point do they block you? I think we understand that, that the blocking is a drastic measure. It must wait until the investigation is finalised. But at what point do they then put you on indirect payment and pay your patients directly? You see? From the doctors' point of view, they say it's unfair to do it before the investigation is complete, so that I have proven my innocence. You see? So, that's what I'm trying to understand. If you would agree, as a matter of best practice, that is preferable that it should only be at the time at which the investigation is completed.

MR MOSOMOTHANE: Tebogo, do you want to answer it?

DR PHALENG: So, Chair as a matter of best practice and I think as part of the commitment that would be made by all stakeholders to really collaborate, you know, in this and work

together, I think what you are suggesting would certainly, you know, be fair in as far as going forward is concerned. I think it will also be important, you know, for this process hopefully to come out with recommendations that will not necessarily diminish any recourse available to medical schemes and administrator in their attempts to contain fraud as far as, you know, as much as they possibly can. At the same time the element of fairness must definitely be introduced and strengthen in that kind of process. So, from a policy perspective the way you've articulated and, you know, going forward, it would be a fair expectation to express.

CHAIRPERSON: I think my colleague has a question.

ADV HASSIM: Just one question, very quickly. Just a clarification. At page 15 of your submission where you cite the CMS policies and procedures, at 1.4.5.5 the policy states that membership is suspended or terminated in accordance with the specific rules of the medical scheme and so on. Is membership there meaning membership, membership of who, whose membership? The beneficiaries of the scheme or are you, or is that the service providers, the doctors?

MR MOSOMOTHANE: Chair, it can only mean the member, the beneficiary, because a service provider would not be a member in this context.

ADV HASSIM: Right. Okay. So it would be the beneficiaries who have to be notified in advance?

MR MOSOMOTHANE: Correct.

CHAIRPERSON: Yes. But I mean I just hope you understand my question relates to service providers and not to members. The policy question we were debating.

MR MOSOMOTHANE: Yes, I understood that, ja.

CHAIRPERSON: Thank you. Ms Mosiah?

MS MOSIAH: Thank you. And what I'd like to say is precisely what Teddy has already said, Mr Mosomothane, has already articulated, is that this process precisely, we are, we're finding ourselves in this situation because yes, we need to get to a point where there can be some kind of fairness in the system that we can start using for service providers when, you know, when they get blocked. But what I, the point that I wanted to just say now, is that we also do, it's both parties are responsible. So in the process, I'm urging that, when we do come up with the recommendations, do look at the other end of the process, on the supplier's side because if, you know, we do need a lot of cooperation as well from the suppliers' side of this transaction to say that if, for example, information is required, it does get, you know, provided at the time that it should be and therefore then I guess it will reduce the delay that does eventually come out of the process. So, that's just the plea that I wanted to put forward.

CHAIRPERSON: Can I put something else to your association as well. So, one of the complaints beyond the stage at which a doctor is taken out of direct payment, is, the way that the investigation is conducted, doctors are required by non-medical

people to submit confidential information, and somebody made the example, I don't know want to diminish the status of the forensic investigators, but someone made the example of ex-policemen descending upon your practice and demanding access to clinical notes. What is your view on that because I don't see it addressed in your submission?

MR MOSOMOTHANE: Chair, our view on this, you know, we would prefer to really defer this to the, you know, administrators and the medical schemes who will be here, to really provide context, you know, around circumstances where these kind of measures apply. I'm also aware that, you know, where questions have come up in this regard, the responses have included, you know, legal opinions that, you know, administrators in particular have made reference to, in as far as, you know, what is possible or what is allowed or what is within the boundaries of law and what is not. I think it will be a more complete kind of response when, you know, the medical schemes and administrators provide a full response in relation to those kind of practices.

CHAIRPERSON: No, I accept that. We will ask them for the specific detail, but I still want to get just a broad principle understanding. The complaint is, under the act and in terms of our codes that are subscribing to under the Health Council, we are not required to submit confidential patient information, right? As a matter of policy, I mean what would you say to that? And especially not to people who are not medical practitioners themselves.

MR MOSOMOTHANE: I would say, the expectation is that we must comply with the law, you know, in our practices there. It's also important perhaps to mention that invariably the clinical information that would emerge out of a consultation transaction, the medical scheme would have it, you know, anyway. So, it's partly this context that I think medical schemes and administrator will be able to provide and the point that I want to get across, Chair, is that the clinical information the medical schemes would already have and the questions that, you know, will probably have to deal with at a later stage, is, what exactly is the nature of the information that may be required as part of the investigation. Because the medical schemes would invariably have the confidential and clinical information already.

ADV WILLIAMS: A further question on a similar point. We've heard allegation from doctors, that medical schemes and administrators interrogate the amount of time spent with the patient and practices will be flagged on that basis. The concern here is that the amount of time spent with the patient seems to be inherently a clinical decision of the doctor, and there is a concern about the interference by medical schemes and their administrators on this part. Can you give your comment on that?

MR MOSOMOTHANE: Chair, I think context becomes, you know, important here, because if any specific, you know, consultation with reference to that specific case, suggest that this is definitely an outlier, you know, if you like. Our understanding that it's

based on that, that questions would be triggered. Just to get absolute assurance that there's definitely no fraud, waste or abuse in as far as that transaction is concerned. So I suppose the way that interaction takes place, is something that needs to be visited, revisited and influenced by whatever code of conduct will emerge from the conversations currently underway.

So, my response is that context is important, but my understanding is that those questions would arise on the part of medical schemes and administrator to make themselves comfortable that what they are paying for, or what they've already paid for, is certainly genuine and, you know, and passes the reasonability test.

CHAIRPERSON: Right. Fine. Sorry, you want to add something?

DR PHALENG: Just to add to that Chair, thank you. I think when we engage with the HFA member organisations, what they seem to be saying is the schemes are simply seeking to understand, so there's a claim for a service and was that service actually rendered. And we must remember, Chair, I think on the point of context, how these investigations are trigged, are not just through analytics, it's also through tip-offs. So, if someone, if a member, a patient says I was, I did, you know, I've just been billed for this and I never went to see this doctor, or I was there for 30 minutes and I see I've been billed for two hours, right? The scheme in that case is looking for some kind of verification. They already

have information on the claim to say this was the diagnosis, this was the treatment, da-da-da.

But I think what they're trying to do is saying okay, given this suspicion, how do you then, can you please verify that this service was actually rendered in the same manner as it was claimed for. So, I think it's, you know, it's hard to kind of respond to these are the broad principle level, but I think it's quite clear here that both parties have a responsibility to kind of operate with trust and in a truthful manner. And our understanding is that most claims are actually paid, the vast majority of claims are actually paid in good faith within, well within the 30 day required period because it's not only about service to the member and the doctor, it's also about if you delay payment, you're potentially, you know, delaying access to benefits in a way because that benefit would not, until day 30 have been paid for. I think it's hard to respond to the specifics until we kind of have the schemes and administrators' response. But I hope, you know, my answer kind of at a principal level just provides the position from HFA's point of view.

ADV WILLIAMS: Just to clarify that then. Would you say in principle, it is not fair to have a practitioner questioned by someone who isn't at least equivalently qualified?

DR PHALENG: Not necessarily, I don't think I would necessarily agree with that. I think if you're simply saying, can we have verification that you actually saw the patients, you're not saying, you're not asking a claim [intervenes]

ADV WILLIAMS: In the context of the question I have previously asked. Sorry for my lack of clarity. But in relation to, for example, time spent with the patient over servicing, etcetera. Those decisions that are inherently clinical.

DR PHALENG: Okay, thanks for that clarification. I would say it depends on, I think in a world where everything is fair, the practitioner is engaging openly and willing to, you know, to assist in the process, it's probably not going to be a, you know, a very confrontational conversation. I think the worst kind of scenario, worst case scenario, is practitioners who have perhaps wilfully submitted a claim, or claimed inappropriately, try and use patient confidentiality as an instrument to kind of not disclose or provide verification information. So, I think you know, it's, I'm sorry if I'm not giving you a generic answer, because I think there are times where it's simply inappropriate, we think, from a healthcare provider to say, well the only source of this information is, you know, very confidential information and I cannot provide for that.

What schemes are also saying is that the patient, the members, in their application forms and I'm not sure whether this is true for all schemes, we'll have to establish that, have already in upfront given permission for, you know, information relating to their care. They have given the scheme consent for these kind of purposes to source this information. So, it's not ideal, I mean I think that's what [indistinct - 1:33:23.5] says, it's not ideal for, to ask for information that is not relevant to the problem you are trying to

solve, and that's not, we certainly, I would agree with you there in principle. But at the bare minimum, the information provided should be sufficient to validate, verify the claim.

If I may give an example, you know, if the healthcare professional could have a system where they simply say, upfront I'll have a patient name, time-in, time-out and patient signs on their way out. That would be good enough to, you know, if the healthcare practitioner provided that kind of information to say here, I have a schedule in my practice. Patient X came in here 10 o'clock, left at 10:30 and I billed for 30 minutes and the patient signed for it. You know. Then, you know, you don't, if you had that as a tool, then you don't need to actually go into discussions around, you know, show me from clinical case notes. So, the information required is not really that it's, it's not clinical information. It's really just to verify that the service has actually been given.

CHAIRPERSON: Ja. I mean I presume you agree in principle. I don't know if you do. I don't want to put words, that if it's clinical related, there should be an equivalently qualified person assessing it?

DR PHALENG: I'm not sure on the practicalities of that. So, if it's a cardiologist, are we saying, just I'm not being cheeky Chair, I'm just trying to get clarity. Would that question mean on a like for like basis, the scheme now is required to source a cardiologist to interview that? I think it's just the practicalities of doing things that way would be difficult. I think, a possible remedy to

these sort of issues could be that you have, you know, some clinically qualified person, either employed in the administrator or independent who is present to kind of assist with these sort of processes. That might be, you know, kind of reasonable remedy just for some of these tricky situations.

CHAIRPERSON: But I mean I don't think the question from Ms Williams was that a cardiologist must go and conduct the work of forensics, but the point was that it should reasonable when you submit information that the person receiving it must at least be capable of interpreting it.

DR PHALENG: Absolutely.

ADV WILLIAMS: The question comes from the place where we squarely had an allegation that an obstetrician was questioned by a, sorry an obstetrician was questioned by a GP, if I recall correctly and there is something, for me certainly inherently odd about that because the speciality is the speciality and well the professions are different [indistinct - 1:36:25.0].

DR PHALENG: I'm not sure that GP's are trained in obstetrics and gynaecology. So, they have GP's in this country are fairly well versed on all the disciplines and they have a fair enough understanding on issues and I think if you had a GP asking these questions it's, I wouldn't think that's unreasonable. I think what seems unreasonable is to expect each and every medical scheme to now have a panel of ENT's and cardiologists to deal with case specific requests. Just the practicalities of that is [intervenes]

ADV WILLIAMS: No, it could be managed by a central body. I didn't, it's not necessarily a burden on the scheme, you know. But it's just a matter of principle. Forget the pragmatics. But as a matter of principle it strikes me as odd to have a non-qualified person asking any professional interrogating, clinical related decisions and even, let's say, GP questioning a specialist.

DR PHALENG: Ja, so I think in terms of just basic verification of a service, I don't think you need a clinically qualified person to say, did a visit actually happen. Did a consult, so I think that's, that we've dealt with to the extent that a clinical conversation is necessary. I wouldn't think that's an unfair dispensation to look at.

CHAIRPERSON: Thank you. How far are we now with our PowerPoint? Alright, let's finish the two slides.

MR MOSOMOTHANE: Now as far as forensic services are concerned, the only point that we want to highlight here, I am going to take advantage of the panel having seen some examples of, you know, the fraud that we, our schemes and administrators find themselves having to deal with, which include you're charging for services not rendered, modifying billing codes, you know, what, we have referred to as ATM and card farming and the point that we want to get across here is, that it's important for trustees in particular, it is their fudiciary duty to make sure that to the extent that they can have risk management practices that, you know, manage our exposure to these activities, they must certainly do though.

Fraudulent practices that are identified are also reported to the relevant authorities, including SAPS and HPCSA and it's, it becomes important for trustees in particular to have a handle on what is happening in this regard. In conclusion, Chair, now the medical scheme industry embraces the social solidarity principles enshrined in the Medical Scheme Act as I indicated very much earlier on. Medical schemes are experiencing significant cost escalations driven by a multiplicity of factors including demand-side and supply-side factors. So, scheme trustees, Chair, have a duty to maintain a sustainable balance between accessibility of benefits and affordability of members. This includes ensuring members are adequately protected against fraud, waste and abuse.

Based on the numbers that we have touched on, we think fraud, waste and abuse does present itself as a significant contributor to medical inflation. Now, if I can quickly share with you some of the key themes that came out of the fraud, waste and abuse summit that was hosted by the Council for Medical Schemes. Which will be fed into ongoing conversations going forward on this matter, include a common framework for forensic processes, emphasis on fairness and transparency. And this takes into account some of the things that, you know, the panel has highlighted here and we certainly embrace these suggestions. Industry standards for coding and billing will be important. Peer review and/or support to be incorporated into interventions.

Now, Chair, CMS Section 59 investigation, HFA's of the view that the schemes and administrators, based on what we have come to know, are interpreting Section 59 of the Medical Schemes Act accurately but I have to qualify that by saying, we are certainly trusting this process. What will come out of this as recommendations, will be given due consideration. We have not been made aware of any conclusive evidence of racial profiling, you know, in particular. And I also observed in the course of the week, a conversation that was suggesting that, look, maybe it may not be by design but the implication of our practices may affect a certain, you know, population group. Now, we as HFA are not aware of unlawful application of forensic procedures within its membership base and HFA code of conduct on fraud, waste and abuse is being developed. It will support and align with the CMS code of practice which is currently in draft format. And Chair, that's it.

CHAIRPERSON: Thank you. Could I just ask you something about what is in page 17 of your submission? Because this is an issue that was raised by the Competition Commission. See, under conclusion way forward, the second sentence, you say that: It is important to recognise that the funds recovered from identifying and prevailing fraudulent practices, directly benefit medical scheme members through their availability for paying benefits as well as reducing contribution increases. Now, there are two complaints here. The one is that there is no transparency with what happens to the funds that have been recovered through, under

the umbrella of preventing fraud, waste and abuse. The second is that in reality they don't benefit members because contributions are not going down and contributions have been going up for the past 10 years.

So, what do we know about what happens to the monies that are recovered under the umbrella of FWA?

MR MOSOMOTHANE: Chair, our understanding is that they certainly go back to the schemes and the reality is if those funds were not recovered, the contribution increases would possibly be a lot higher than they have been. So, essentially given that they are high as they are, and sustainability is a bit of a challenge, it makes it even more important for us to pay attention to a variety of cost drivers including fraud, waste and abuse. So, in short the funds certainly go back to the scheme and, you know, if they didn't go back to scheme, based on the actuarial work that is done leading up to annual contribution increases they could potentially, contribution increases that is, be a lot higher than, you know, is the case, had we not recovered those funds from fraud, waste and abuse.

CHAIRPERSON: Well, yesterday we heard evidence that the forensic investigators are charging extortionate amounts to the tune of 36, 37% of what they recover.

MR MOSOMOTHANE: Chair, we have no knowledge, you know, of that and what we would be aware of is any support that is provided by administrators to their medical schemes in as far as

fraud risk management, and we have no knowledge or information about what any other parties may charge in this regard.

CHAIRPERSON: How much do the administrators get out of this?

MR MOSOMOTHANE: It will vary from scheme to scheme. We have no indication of any additional layer of cost that is attributable specifically to fraud, waste and, you know, and abuse. And I know there would be administrators who really see this as part of their bundle of services in support to the medical schemes that they administer. But a short answer to your question, we have no figure that we're aware of that is specifically charged by administrators, you know, for fraud, waste and abuse.

CHAIRPERSON: Thank you. Unless there are any other, oh yes, Ms Mosiah.

MS MOSIAH: Just to add on to the topic that we've been on, is to remind the panel also that some of those, the recoveries would also be based on erroneous transactions that were made, either, you know, that is, that was, that would be non-intentional, erroneous claims. So that should be justified that it would come back to the scheme. So this is now in response to the notion that, you know, not the money actually belongs back to the member. It must be reimbursed to the member, which is what we've over the past few days. So, just to make a point there that there are those erroneous transactions where the monies have to come back to the scheme for.

CHAIRPERSON: Thank you very much. Well, unless there are further submissions on your side, it just remains of me then to thank Mr Mosomothane and his team for being present, making submissions and having submitted written submissions to us at the time this process was closed. We'll obviously be coming back to you with request for further information, further data and the conversation will continue. The schemes are only scheduled to appear in September. So, perhaps before the schemes appear we may be sending further letters and correspondence and request for information. So thank you for your co-operation and your participation.

MR MOSOMOTHANE: Thank you.

CHAIRPERSON: We are going to take a short adjournment. We are going to take a short adjournment. It's 10 to 12. So, we should probably come back at quarter past 12. We were scheduled to take the Department of Health at 11:30 but we are running a little bit behind schedule. So, I hope they are already here. Somebody knows them. So, let's adjourn for 20 minutes. We will come back at quarter past. Thank you.

**PROCEEDINGS ADJOURN**

**END OF AUDIO**