2020

Section 59 Investigation Panel

27 January 2020

Bonitas

Medical Aid for South Africa

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MISSION

To ensure the sustainability of the Scheme while meeting the needs of our members

VISION

To make quality healthcare more accessible and more affordable




OUR DUTY

Section 57(6) of the Medical Schemes Act requires the Board of Trustees to:

Take all **reasonable steps** to ensure that the **interests of beneficiaries** in terms of the rules of the medical scheme and the provisions of the Medical Schemes Act are **protected at all times**

Act with due care, diligence, skill and good faith

Take all reasonable steps to avoid conflicts of interest, and act with impartiality in respect of all beneficiaries.

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- Bonitas Medical Fund is a fund established in terms of the Medical Schemes Act and operates within the ambit of this legislation.

- The Fund was established in April 1982, primarily for **Black civil servants**, and has grown to:

335 000
principal members across all South African demographics

TO DATE THE PERCENTAGE

20% White

75% Black

5% Unclassified

- It is the duty of the Board to ensure that payment of claims is only for legitimate claims and strictly in accordance with the registered rules of the Fund. Section 57(4)(c) of MSA stipulates that one of the duties of the Board is to ensure that proper control systems are employed.

Introduction - *continued*

Access to quality healthcare
remains a priority for all South Africans

It's no secret that escalating healthcare inflation and costs are key challenges currently facing the medical schemes industry.

However, with healthcare costs consistently outpacing inflation, the challenge for the industry is finding the right balance between providing a high level of value and care for members, while managing costs effectively.

The industry estimates that between **15% - 23%** of all claims paid by medical schemes constitute fraud, waste and/or abuse. This has a direct link to the high costs that the industry is facing. These costs are usually passed on to the member in the form of higher contributions year on year.

Introduction - *continued*

- The scourge of fraudulent, wasteful and abusive billing is not unique to Bonitas Medical Fund or healthcare industry in South Africa but is an international problem. This unwanted practice is always to the detriment of the collective risk pool of Scheme members.

- It is our submission that it is a minority of healthcare practitioners that do not conduct themselves according to the standards expected of them. However, the devastating impact of this is felt by the individual members who see higher contributions against an eroding benefit pool.

- It is the fiduciary duty of Bonitas to ensure that members and dependents receive access to healthcare treatment that is affordable and of high quality.

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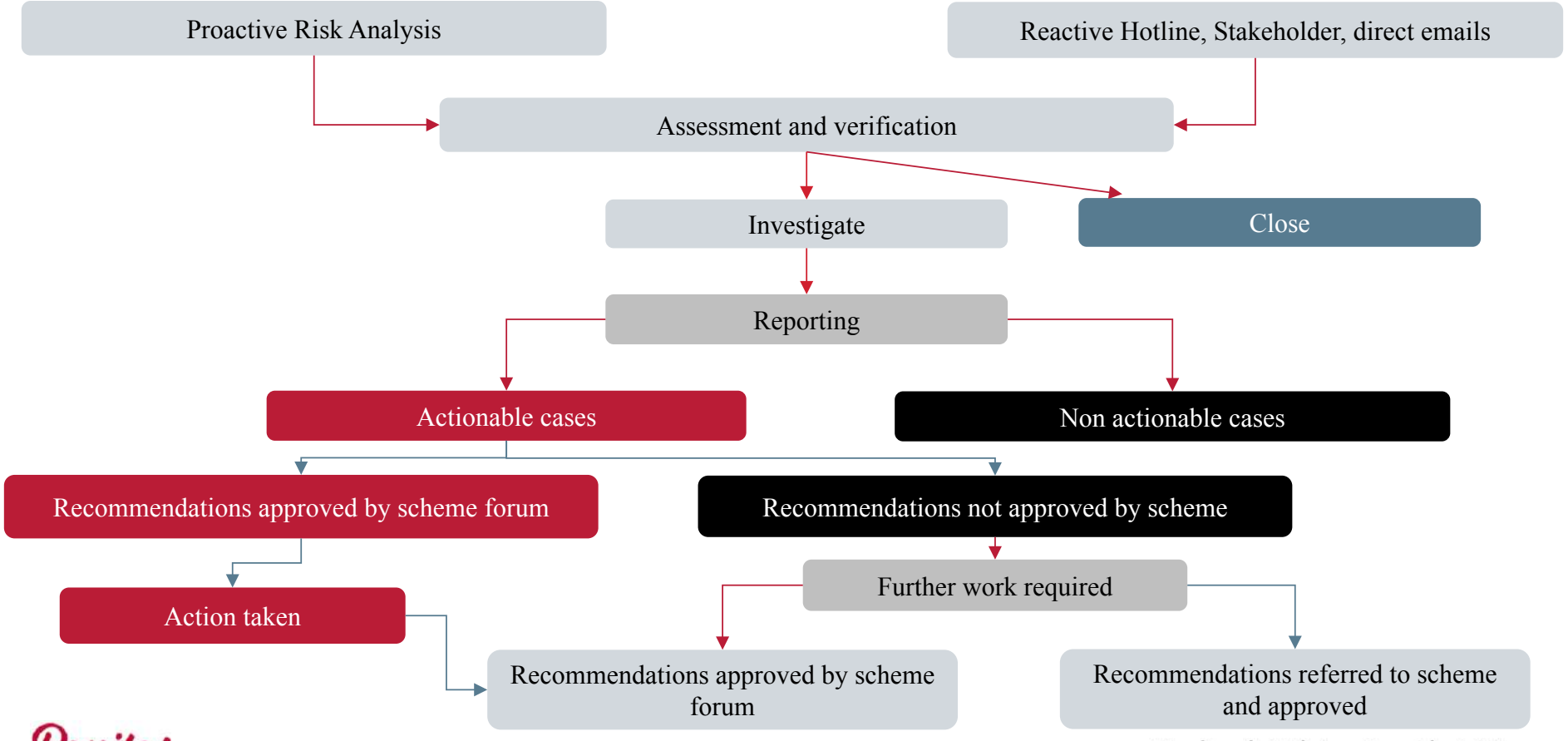
Overview

- The Fund functions as a wholly outsourced model, Amongst the other services outsourced is the fraud, waste and abuse management services.
- The FWA services are conducted by Medscheme, who uses specialized software to analyze claiming patterns of HCPs on behalf of their clients including the Fund.
- Bonitas also uses an independent service provider for whistle-blower services where members of the Fund may call anonymously to report incidents of FWA.
- Where there is a prima facie indication of fraud in the desktop investigation and/or a more intense investigation is necessary, the Fund instructs Qhubeka Forensic Services to undertake such investigation.

Overview - *continued*



Overview - *continued*

- The Fund has Fraud Waste and Abuse framework, policy on the process to be followed when FWA is identified and a policy on the actions which may be implemented where FWA is confirmed.

- The main purpose of the policies is to ensure that a consolidated approach is followed in dealing with FWA whilst simultaneously protecting the Fund's reputation as we are dealing with our own stakeholders, namely members, HCPs and other external parties.

- Upon finalization of the investigations conducted by our contracted service providers, the findings are discussed with the Fund through a formal FWA Forum chaired by the Fund.

Governance structure

Governing legislation and regulation

The Act and regulations (including proposed Amendment Bill) – all medical schemes in South Africa are governed by the Act.

Scheme Rules – developed and maintained in accordance with the Act and approved by the CMS.

Corporate governance principles – although voluntary for medical schemes, Bonitas is committed to subscribing to King IV™ for additional governance guidance and leading practice on good governance.

Common law – relevant common law principles such as Fit and Proper, Public Funds, Position of Trust, etc.

Board

- Scheme governed by an independent Board
- Trustees duly elected by members of the scheme for a five-year term, as stipulated in the Scheme Rules
- Fit and Proper
- Accountable to Bonitas members.

Sub-committees

- Board supported by four sub-committees to effectively fulfil its duties and responsibilities
- Consist of both Trustees and independent members
- Mandated through defined terms of reference/charters.

Principal Officer

- Board appointed
- Accountable for implementing strategy and any other decisions made by the Board
- Responsible for the day-to-day management of Bonitas
- Fit and Proper
- Supported by an Executive Management team.

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The health care provider renders an account to the member for service(s) provided. The account must reflect the particulars stipulated in regulation 5 ("Reg 5 Particulars") [section 59(1)] It is to be noted that this is merely administrative compliance, and does not take any fraud investigation into account.

The account does not reflect all the Reg 5 Particulars or does not reflect it correctly

The account reflects all the Reg 5 Particulars correctly and must be paid by the Scheme within 30 days from submission thereof [section 59(2)]

The Scheme informs both the member and the health care provider within 30 days after receipt of the account that it is erroneous or unacceptable for payment. Reasons include non-compliance with Reg 5 Particulars or lack of benefits and states the reasons therefor. The Scheme affords the member and health care provider 60 days to correct and re-submit the account (where possible)

The Scheme fails to inform both the member and the health care provider within 30 days after receipt of the account that it is erroneous or unacceptable for payment or does not reflect it correctly, or fails to provide an opportunity for correction and resubmission thereof. In the event of any dispute regarding the account under these circumstances, the Scheme shall bear the onus of proving that such account is in fact erroneous or unacceptable for payment

The account is corrected and re-submitted and if compliant, and the Scheme must pay the account within 30 days of re-submission

The Scheme may deduct any amount which has been paid bone fide by the Scheme to a health care provider in terms of section 59(2) but to which the member or health care provider is not entitled to, or any loss which has been suffered by the Scheme through theft, fraud, negligence or any misconduct which comes to the notice of the Scheme, from any benefit payable to the member or health care provider [section 59(3)]

Overview - *continued*

- The above-mentioned policies have been adopted by Bonitas to ensure that we act without fear, favour or prejudice and rely solely on facts when deciding on FWA matter. We strive to act fairly, transparently and within the boundaries of the law at all times.

- Both our internal and external auditors help us to monitor that the policies are interpreted and applied consistently. Any deviation is reported and dealt with in accordance with the applicable Charter.

- As stated in the sanctions document, Bonitas reports aberrant healthcare practitioners to the regulatory bodies and to the law enforcement agencies;

- From beginning 2016, Bonitas has reported 62 cases to the Health Professions Council of South Africa and 19 cases to the South African Pharmacy Council;

- Of the 62 HPCSA reported matters only 11 cases have been finalised with various outcomes. Cases reported to SAPC have not been adjudicated on.

- We reported over 44 cases to the South African Police Service and 7 healthcare practitioners have been found guilty of fraud by the various courts around the country. The sentences imposed vary from prison terms, fine and suspended sentences.

Terms of reference - continued

- The Fund adequately responded to 23 concerns that were referred to us by the Secretariat and will not deliberate on each in this presentation.

- Further, we summarised the general allegations against medical schemes and respond as follows:

- **Medical schemes conduct profiles based on racial terms and only Black and Indian doctors are audited.**
  - Bonitas refutes that it engages in any form of racial profiling for purposes of identifying possible incidences of FWA. We distance the Fund from any allegations of racial profiling and as the Fund we condemn any entity that practices such.

- **Medical schemes demand patient confidential records of their members when verifying claims.**
  - The Fund respects the confidentiality of the patient's information disclosed with the treating doctor. When claims are submitted, it is done with the ICD-10 code detailing the diagnosis and the treatment plan to be employed. Motivation for pre-authorisation contains very detailed clinical information about the surgery and/or treatment of the member.

  - In order for the Scheme to process claims (as contemplated in Reg 5) or to assess whether a member is entitled to benefits sought, implicitly, the Scheme must have access to reasonable clinical information.

Terms of reference - continued

- **Medical schemes do not report healthcare providers to the regulatory bodies and law enforcement agencies.**
  - Bonitas has a zero-tolerance approach on FWA matters and has reported the errant practitioners to both SAPS and other regulatory bodies as stipulated in this submission above;
  - The Fund also has a programme through our managed care that is aimed at rehabilitating HCPs identified as outliers in the clinical protocols where such rehabilitation is warranted.

- **Medical schemes unlawfully bully healthcare practitioners to sign Acknowledgement of Debts ("AODs") without any legal basis.**
  - No person is coerced or bullied into signing AODs
  - HCPs are invited to the meetings and advised to bring legal or any other representation to such a meeting

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Conclusion

Bonitas has an escalation process where any person who feels aggrieved by our service providers while conducting investigation on fraud, waste and/ abuse, can escalate the matter to the Fund for intervention;

We further wish to submit to the Panel that we remain committed in working with the stakeholders to rid the industry of fraud, waste and abuse to the benefit of our members and all South Africans;

Bonitas remains committed to the Constitution and other laws of this country. We reject any form of racial discrimination.

THANK YOU