Submission to Health Market Inquiry – Competition Commission SA

The healthcare financing regulatory framework and the impact it has on competition in the South African private healthcare sector.

Annexure C

Late addition of annexure in relation to the following paragraph, as this article was published two days after submission deadlines, but substantiates a very important part of the submission:

From page 9:

"It is exactly this complexity that do not allow administrators to evaluate data for trends, patterns and links that could point to fraud perpetrated by both providers and members alike, the administrative burden is immense. In the nineties we ran tapes at night to extract data to analyse, and found unnecessary claims (whether due to fraud or ignorance on behalf of the members) in some cases as high as 30% of payments – setting up a data warehouse and dealing with these issues based on cost, volume and priority ensured major savings. There is no mention anywhere in the submissions regarding these issues. Notifying administrators of suspected fraudulent activity is mired in red tape, forms and scheme rules. In this digital age there is no reason not to be able to set up checks and balances to not only highlight trends but to prevent them."

It is astounding that twenty years after we started running basic reports, looking at actual trends, rather than just what was paid, payors are still running retro-active 'complicated algorithms' to detect unusual claim patterns, and do not set up pro-active prevention of fraudulent claims for the majority of cases - because the technology we have available today is so much more advanced.

Most claims processing systems from first world countries have this built in, and have done so since the early nineties. The system we adapted for the global project covering seven hundred clinics, had a finance management component added, to prevent claims from being generated that would likely be rejected (i.e. to produce a clean claim). We built in functionality (into an old Delphi based system) that would allow unlimited entries of benefit options and plans; the proforma invoice was run through this mechanism, to produce an invoice for each type of payor, be it prepaid, health plans, or what the patient would have to pay as it was not covered under other payor types. Some visits created three or four invoices (especially for Japanese healthcare, which was paid by episode not visit).

Examples given in the attached report, published on Sunday 21 January 2018, are a classic example of items that should not have been paid by the administrators:

"In 2016, the administrator uncovered that a particular pharmacy was found to have dispensed multiple high-cost items to individual families during the year.

- One family claimed 19 thermometer units, while another family claimed 14. These cost approximately R3 200 each;
- A family claimed four swivel bath chairs, costing approximately R2 000 each. Two of these were claimed on the same day, with another two within a day of one another; and
- Another family claimed for 11 nebulisers."[i]

In addition, this is only what was uncovered - Discovery Health CEO Dr Jonathan Broomberg said: "Although we have secured large recoveries as a result of our fraud avoidance efforts, we believe

that this is only part of the story and fraud and billing abuse most likely costs medical aid schemes several billion rand per year. These precious funds could be used to pay for the critical healthcare needs of our medical aid members."

"Discovery Health uses a specialised team of over 100 analysts and professional investigators to uncover fraud. It uses its own forensic software system that relies on sophisticated algorithms to analyse claims data and identify any unusual claim patterns."

Fraud creates a huge administrative burden, as testified above, and the MSA holds Principal Officers responsible for paying fraudulent claims, or claims that does not comply with the scheme rules, as they pay from trust funds.

If the situation is getting worse after twenty years of efforts to prevent fraud, I would submit that benefits and scheme rules need to be much more specific, and audits need to be done to ensure that claims systems comply with registered benefits and scheme rules. Rules without consequences for breaches seems to be a very common occurrence throughout the health care sector in South Africa, in both the public and private sectors.

If administration costs are paid on outcomes for paying correct claims, systems may be adapted to prevent such rampant fraud from continuing.

Discovery uncovers more than R500m in

[i] Sunday Times; Times Live. 21 January 2018) Katharine Child. Discovery uncovers more than R500m in fraud.