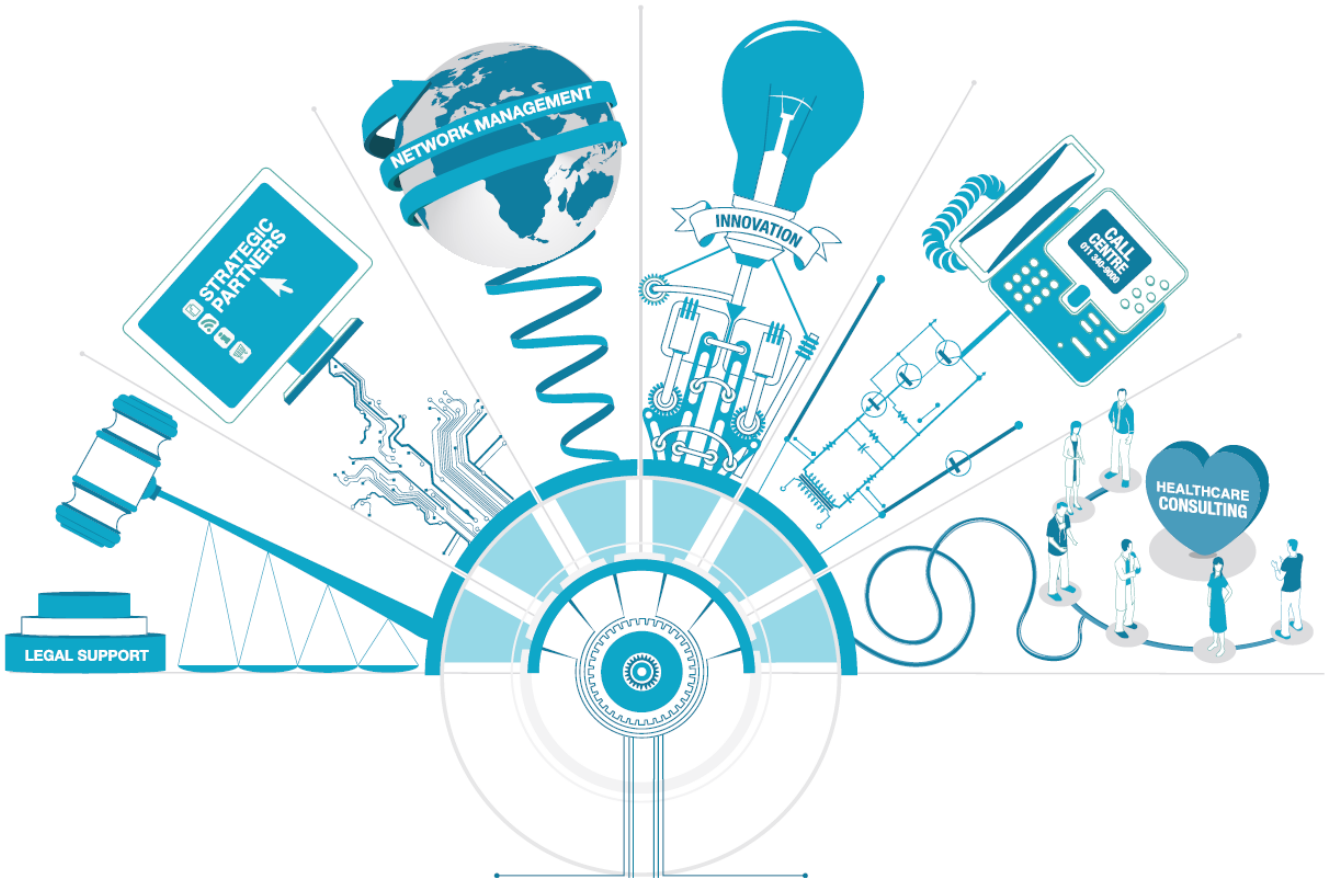
Unit 16, Northcliff Office Park, 203 Beyers Naude Drive
Northcliff, Johannesburg, 2115, South Africa
Tel: (+27)(11) 340 9000, Fax: (+27)(11) 782 0270
Email: healthman@healthman.co.za
PO Box 2127, Cresta, Johannesburg, 2118, South Africa
Registration No.: 1996/14778/07
VAT Reg.# 4190163982

New Year Newsletter 2015



Directors: Casper Venter *(BCom, CA(SA)),* Ernst Ackermann *(BCom, LLB),* Mardi Roos *(BA Hons Psychology)*

INTRODUCTION

The management and staff at HealthMan wish all our clients, their staff, and recipients of our newsletter a prosperous 2015.

This year is likely be another tough one for private practice as government, schemes and the Competition Commission cast gimlet eyes on the profession. While last year's election brought some changes to President Zuma's cabinet, the health ministry remains fundamentally the same - Aaron Motsoaledi continues to direct the department and its national policy, and as reiterated by the Department of Health (DoH) representatives at the 2014 Hospital Association of South Africa (HASA) conference, national health policy is ANC policy at the end of the day. So we cannot reasonably expect any immediate easing off on key agendas like National Health Insurance or private sector regulation.

To keep you informed, we have reviewed the pertinent legislative changes that will concern private healthcare practitioners in the immediate future: namely the Competition Commission's market inquiry which will occupy our attentions into 2016 at least, the Certificate of Need which caused great consternation when it was hastily signed into law and just as rapidly was withdrawn, and the silence surrounding the Health Professions Council of South Africa's proposal to determine new fee norms.

Regarding medical scheme news, you will find your 2015 designated payment arrangement updates outlined below for your convenience, along with scheme rate increase for the upcoming year, news of amalgamations, benefit option changes and general changes.

You'll also find updates on malpractice insurance and an important reminder regarding run-off cover about which you may hear more of in 2015.

We trust our 2015 Annual Newsletter finds you healthy, rested, and confident to meet the year with HealthMan in your corner.

1. Regulatory News

1.1. Competition Commission Market Inquiry into Private Healthcare Costs

Deadlines have passed for final written submissions in response to the Competition Commission's (CC) Statement of Issues, which finalised the framework for its market inquiry into private sector healthcare in South Africa. The purpose of the inquiry is to establish the factors that are responsible for the pricing of health services in the private sector and to investigate reasons why the private sector costs continue to exceed CPI. There is little doubt that this commission, the biggest in South Africa's history, will have far reaching and long lasting effects on the practice of medicine in South Africa.

The South African Private Practitioners Forum (SAPPF) spent a considerable amount of time during 2014, drafting a 446 page submission to the CC. The SAPPF submission's point of departure and its fundamental thesis is that the **private sector is a South African asset** and plays an essential and indispensable role in the provision of quality healthcare services in South Africa.

The CC has an opportunity to make recommendations which can assist the State in bringing quality and affordable healthcare to all South Africans. For this to happen there must be an acceptance of the argument that **re-imbursement tariffs must be cost-based** and **professional autonomy must be enshrined**. SAPPF argued that the sustainability of, and access to, private healthcare services depends on a balance between affordability, quality and value, such that patients will be able to afford private care, medical practitioners will be able to make a reasonable living through the practice of medicine and aspirant doctors will continue to be attracted to medicine as a career.

The submission reiterated the importance of **appropriate pricing of healthcare services** and argued for a return to a central mechanism to determine guideline tariffs.

Historically such a mechanism has existed since the 1960s and SAPPF's position is to compel the CC to recommend that it be re-established, free of political interest and influence. Only a cost-plus, evidence-based benchmark can resolve whether prices are *appropriate*, and allow for the efficient processing of claims by medical schemes.

For SAPPF and its members, **professional autonomy** is critical. We believe strongly that independent doctors – independent of schemes, independent of hospitals, independent of the political apparatus - act as the patient's best advocate. Medical schemes' fiduciary responsibility to fund members as a whole, mean that they cannot assume this advocacy role. Likewise the private hospital, whose first responsibility is to its shareholders, cannot play it either. There is a pervasive view in some quarters that the employment of doctors by private hospitals and/or medical schemes would alleviate the costs of private healthcare services. SAPPF contested this in the strongest terms, arguing for protection of the public good with reference to the Ethical Rules of the Health Professions Council of South Africa (HPCSA) and arguing against the corporate employment of doctors by entities' whose first responsibility is to output-targets and shareholders.

SAPPF's submission begins by looking at the contribution that the private sector in general, and doctors specifically, make to the South African economy. **The private sector is an asset.** It is a major employer and contributor of taxes. In addition, the sector relieves the public sector of providing services to medical scheme members and their dependants who otherwise, would be compelled to rely on the State. Furthermore, at a time when the State is prioritising primary care over tertiary care the private sector provides a home to young doctors unable to find employment in state facilities and who therefore may otherwise be lost to South Africa.

SAPPF is of the view that the private sector can and must play an increasing role in expanding access to healthcare for all South Africans. It is the competitive nature of the South African private sector and its relative excellence in comparison with international benchmarks that will achieve this goal, not government intervention. All Organisation for Economic Co-operation and Development (OECD) countries that have a private sector utilise a hierarchical tariff code system that enables both providers and payers to operate in a consistent and cost-effective environment. "A technically sound price schedule is a common feature of OECD country health systems. It brings clarity for doctors, those that pay them and ultimately, the patients that these institutions serve. Today, the South African health care system lacks this clarity."

The SAPPF submission dealt comprehensively with the minutiae of Fee-for-Service coding, tariffs and central bargaining, while also touching on the promises of group-practice, new technology and alternative reimbursement mechanisms. The submission reviewed the matter of **codes and tariffs** and the historical mechanisms that have supported their development and maintenance in an attempt to prove that determining, and reviewing, codes is not an impossibly onerous task. SAPPF had to make clear that it can be largely solved by an immediate review of the Top 300 codes and procedures, and thereafter a systematic working-through of the remainder on an annual basis. Nevertheless, it also argued, medical coding is a complex area requiring skilled technicians to maintain such a system. It can only be sustained if proper specialist peer-review structures are in place, stakeholders are allowed to review and comment and the process is supported by actuarial and financial reviews. The process also needs to be independent of any regulatory interference.

Furthermore, the **pricing of and the reimbursement for professional services must be on a cost plus basis**. The submission delved into this issue in great detail, drawing on experience gained from the cost studies that were mandated by the now-abandoned National Health Reference Price List (NHRPL) system, and the final rulings of the 2010 court case that dismissed it.

SAPPF's participation last year in the **HPCSA guideline tariff determination process**, and the report commissioned at the time from consultants Genesis Analytics, put at our disposal the evidence to support our conviction that any form of **price regulation must ensure the sustainability of the service.**

To service privately insured patients *and* contracts with the public sector to deliver services at fair and reasonable rates to the broader population, the sector's sustainability must be prioritised and not undermined.

In conclusion the submission reiterated its contention that the private sector is not over-priced, but a valuable asset that should be incorporated in Government plans to improve access to quality healthcare for all South Africans. Several suggestions as to how the two sectors could be better integrated were made.

1.2. Has Government Ditched the Certificate of Need?

On April 1 last year, State President Zuma signed a proclamation bringing into force sections 36 to 40 of the National Health Act - the Certificate of Need (CoN) provisions. According to the legislation a CoN would be required for anyone "establishing, constructing, modifying or acquiring a health establishment or agency; increasing the number of beds in, or acquiring prescribed health technology at a health establishment or health agency; and, providing prescribed health services or continuing to operate a health establishment or health agency".

These provisions would have given the health authorities the power to decide where a doctor may practice or, more accurately, where a person may not practice based on demographic and/or municipal requirements. As the right to practice would accordingly have been dependent on the issuance of a CoN, it would have been deemed an offence to operate a medical establishment without it.

Conceived as a mechanism to rectify human resources and accessibility discrepancies between metropolitan and rural areas, the CoN provisions arguably infringe the right to professional autonomy. The reaction of the private sector to this muted announcement was therefore swift and vociferous.

Following many hurried stakeholder meetings, the upshot was a decision by the DoH to request the President via a Constitutional Court affidavit to rescind the proclamation. SAPPF in conjunction with almost all provider groups wrote a joint letter to the State President requesting furthermore the *permanent* abolition of the offending provisions from the NHA.

At the time of writing it is uncertain where the professions stand in regard to the CoN, what role it might still play, or whether it will be revived at all - as is, or in amended format.

1.3. Prescribed Minimum Benefits and DSP Arrangements

Precious little was said about Prescribed Minimum Benefits (PMBs) in 2013 and 2014 except for a Council for Medical Schemes (CMS) proposal late in 2013, calling for an amendment to the Medical Schemes Act to have PMBs renamed MMBs, or Mandatory Minimum Benefits, in order to emphasise their non-negotiable status.

You will recall that Judge Pretorius ruled in 2011 against the Board of Healthcare Funders (BHF) and its interpretation of the "pay in full" Regulation 8 regarding PMBs. The High Court upheld the interpretation implied in the Medical Schemes Act, and advocated by the CMS and others, that pay in full should mean at the invoiced amount (the cost of providing the service) and not at Scheme Rate.

The BHF, after two further unsuccessful appeals, announced that it was disappointed that their case was not evaluated on its merits, but was dismissed on a legal technicality – the legal standing of the applicants (BHF and SAMWUMED) to bring the matter to court.

In December 2014, news broke that Samwumed, and Genesis (a medium-sized open scheme) were again threatening court action – this time against Min. Motsoaledi if he did not amend the legislation they called "beyond-the-law, irrational and unconstitutional". The BHF publically announced too that it had evidence of overcharging, which it would present to the CC.

Meetings with medical schemes highlighted their abiding concern over regulation 8, but any decision by the DoH to prevent them from proceeding with court action would require the publication of draft amendments for public comment. Deputy DG for health regulation and compliance management Dr Anban Pillay confirmed that this was being discussed but no draft would be published before February 2015.

PMBs of course go hand-in-hand with DSPs. The consequence of cementing funders' obligation to pay PMBs at their full invoiced amount has been increased pressure on practitioners to contract into Designated Service Provider (DSP) arrangements with schemes.

GP DSPs are already in place for various schemes, including GEMS, Polmed, Discovery, Liberty, Medshield, Bankmed, Bestmed, and certain Medscheme-administered schemes. Specialist DSPs could follow the appointment of Hospital DSPs for in-hospital PMBs as is the case for Discovery Key Care option. The Discovery Direct Payment Arrangements (DPAs) now include approximately 90% of all specialists in private practice. Fedhealth, Metropolitan Health, Momentum Health, Bonitas and Bankmed have launched Specialist Payment plans very similar to that of Discovery Health.

GEMS at present defaults to the Public Sector as its DSP for non-emergency PMBs. GEMS has however rolled out a Paediatric DSP (with limited success) and has launched an Obstetric and Gynaecology network for 1st January 2015. Polmed may soon follow suit. Whilst the tariffs offered by these Specialist Payment plans are not yet at a practice cost level, it is a move in the right direction and very soon the old Medical Scheme Rates equivalent to the defunct RPL will be history.

However, take note that it can take many months to resolve PMB complaints lodged at the CMS. We will send a separate communication to practices in this regard. It is also interesting to note that the CMS now take the view that the Competition Commission Inquiry will resolve all their complaints, and they do not pursue all complaints. The serial defaulters in paying PMB's are Momentum Health, SAMWUMED, Genesis and Cape Medical Plan.

1.4. Health Professions Council of South Africa

Following an alleged spike in complaints of overcharging against practitioners in recent years and lacking an up-to-date cost based schedule of tariffs against which to adjudicate on such complaints, the Health Professions Council of South Africa (HPCSA) took it upon itself to determine unilaterally a tariff for medical practitioners in South African private practice. The Council's mandate to determine 'ethical guidelines' in terms of Section 53 of the *Health Professions Act* was interpreted to mean that the HPCSA could set, not a ceiling but a tariff schedule, which is in effect the authority of the DoH.
Nevertheless, given the HPCSA's role and the stalemate since the RPL was set aside in High Court back in 2010, all stake holders acknowledge that a new schedule of tariffs is imperative, as is an all-inclusive process.

But in September 2012, objections forced the Council to withdraw two schedules from its website. When it decided to gazette the self-same schedules some weeks later, SAPPF and others threatened legal action.

A draft process was published for public comment early in 2013, followed shortly thereafter by an announcement that Shivani Ramjee, head of actuarial science at the University of Cape Town, had been appointed to assist the Council. She proposed two options: an "administrative norm determination" process where key decisions are made by an expert committee or a "negotiated norm determination" process. The Council eventually adopted the latter, outlining it in more detail in a new process document issued in October 2013 called *Proposed Process for the determination of Fee Norms by the Medical and Dental Professional Board*. It contains echoes of the joint CMS/DoH Pricing Commission Proposal from 2010.

Ramjee apparently analysed 69 of the 80 submissions from individuals, specialist associations, funders, government and civil society to the original process, some of which are available on the HPCSA's website. No summary report of Ramjee's findings preceded or accompanies the new process.

HealthMan has it on good authority that the Minister of Health sought to cancel the fee norm determination process in mid-December 2012, but was rebuffed by Council. Council is insisting on its Section 53 mandate as an independent registering body that it will go ahead with its negotiations.

SAPPF, in its submission to the new process document reiterated many of its previous comments, notably: concerns about the independence of the various bodies and committees envisioned to conduct the fee norm determination process and challenges to the rushed and optimistic process timelines. Two processes were tabled – a truncated one for 2015 and a more comprehensive annual process for 2015 and beyond.

In its truncated schedule for 2015 Fee Norms, the tariff committee of the HPCSA was to finalise the process document in October, giving November over to affected stakeholders to prepare submissions. With the deadline for comments to the draft process document (18 November 2013) running into the 'final process timeline' and no immediate invitation for submissions or time for consultations between the Tariff Committee and stakeholders, it is unlikely that the Professional Board will meet its planned date for gazetting tariffs for public comment by the end of February 2015.

As was expected the HPCSA did not conclude its review process, nor did it release the Ramjee report to the public. As of December 2014 it was awaiting executive committee approval. SAPPF suspects that the contents of the report are supportive of its previous findings, if not damaging to the political agenda behind moves for private sector price regulation. SAPPF therefore compelled the CC to bring its power to subpoena the report as part of its inquiry. Meanwhile SAPPF's legal team is pursuing the HPCSA's disregard of due process.

1.5. Regulatory Reforms by DoH

National Health Amendment Act

In August 2013, President Jacob Zuma signed into law the National Health Amendment Act. A draft version of this bill was gazetted two years ago, outlining the executive and reporting structures of an independent entity called the Office of Health Standards Compliance (OHSC). This Office replaces the Inspectorate for Health Establishments, originally proposed in 2003's Health Act, but never established.

Stakeholders, including SAPPF and the National Pathology Group (NPG), made submissions on the draft bill and presented their concerns before parliament and the Portfolio Committee on Health in 2012. Major concerns were, then as now, the independence of the office from the DoH and its relations with other established standards authorities such as the South African National Accreditation System (SANAS) and the Health Professions Council of South Africa (HPCSA).

The Act establishes the Office as a juristic person and has dropped the idea of an Executive Director at its head (appointed by the Minister) in favour of a representative Board of seven to twelve publicly-nominated experts.
The Office's interaction with other standards authorities remains vague, but has been dealt with as an ancillary function. The Office may liaise with them to harmonise jurisdiction of health norms. At least proposed amendments to Certificates of Need for health establishments (about which NPG had much to say) have been dropped; no mention is made of this.

Overall, SAPPF and HealthMan welcome the Office of Health Standards Compliance as a means to ensure the quality of care. The objects of this Office are to protect and promote the health and safety of users of health services, by monitoring that all health establishments comply with, and maintain norms and standards which the Health Minister shall prescribe.

The Office will function in an advisory and enforcement capacity. It will advise the Minister on matters relevant to determining prescribed standards. It will investigate complaints of breach and monitor risk indicators to avert future breaches, it will recommend interventions to national and provincial health authorities, as well as publish information in the media relating to quality standards. We have not seen much progress in this regard during 2014 and progress reports have been limited.

National Health Insurance (NHI)

The White Paper on NHI was supposed to have been issued during July 2012. Commentators still feel that debate on national health insurance cannot proceed without the clarity promised by a white paper and accompanying Treasury Discussion Document on financing options for NHI. Government indicated that it would release more information on the funding models during February 2013. Responsibility for this belongs to the National Treasury, whose Chief Director for health and social development, Mark Blecher, acknowledged that the Treasury's discussion document was a year and a half late, but was "nearly ready." This did also not materialise during 2014.

However, in its October medium-term budget policy statement, the acronym NHI does not appear at all. Modelled on the 2011 NHI Green Paper, Treasury is about R150-bn behind on the National Development Plan for public health reform. Treasury is at loggerheads with the DoH on the question of financing and it is likely that the debate will continue to rage behind closed doors and out of the public domain for as long as Treasury maintains that a thoroughgoing reform like NHI cannot be financed with increased borrowing, nor through increased taxation, especially since it is very unlikely that economic growth will be above 3% every year until 2025, as envisioned in the Green Paper.

Our regular newsletters - HealthView and Private Practice Review - and presentations at CPD meetings will keep you up to date on all these matters. We will also from time to time be issuing Special Reports on matters of importance.

2. Medical Scheme and Coding News

2.1. Medical Doctors Coding Manual (MDCM)

The SAMA Doctors Billing Manual (DBM), last published in hard copy in 2009, was a comprehensive manual containing important information on the codes and descriptors for doctors' services, interpretation of various billing guidelines, as well as relevant legislative and ICD-10 guidelines.

Even with references to the defunct RPL expunged (which would have confused practitioners and led to Administrators and Schemes applying codes and rules that do not correctly reflect the 'Scope of Medical Practice' in South Africa), no DBM was published in 2010 to 2014. An electronic version was available from 2011 to 2014, but is a very difficult version to work with, and was incomplete in terms of rules and interpretive guidelines.

HealthMan has been informed that there is an electronic manual available for 2015 – now called the Medical Doctors Coding Manual (MDCM). Hard copies of the MDCM should be available by the end of March 2015. Please note that the MDMC includes a number of important code changes for 2015 in respect of, inter alia, gynaecology and mammography.

The rebranding of the DBM as the MDCM does away with contentious reference to 'billing' for which SAMA has previously been criticized. The CMS threatened that they will consider lodging a complaint against SAMA or any other society that publishes a Billing Manual containing Codes, Descriptors and Relative Value Units (RVUs). We do not believe that such action will be successful as all schemes still have the option to decline payment for a specific code or to change the tariff at which they reimburse a specific code, unless it relates to a PMB. No legal precedent for such an attack under Competition Law is to be found in the USA or the European Union.

A number of societies publish their own 'Coding Guidelines' and HealthMan has always contended that specialist coding belongs to its respective discipline.

SAPPF and SAMA plan to hold a joint coding meeting early in 2015 where future coding strategies and structures will be discussed.

2.2. RPL – DoH and Medical Scheme Administrators

By now it is common knowledge that on 28th July 2010 Acting Judge Piet Ebersohn declared the RPL 2007 – RPL 2009 null and void. He found the process by which the RPL and rates were determined to be unfair, unlawful, unreasonable and irrational. The Judge also said that the process resulted in tariffs that were "unreasonably low " and one of the reasons cited for the exodus of doctors from South Africa.

Nevertheless, we believe that, without exception, most Schemes and Administrators still utilise the 'illegal' RPL structures to set their benefits and tariff structures. We believe this to be unfortunate and a disregard of an order of the High Court. All scheme forensic investigations also refer to the RPL 2009 and it usually requires a HealthMan intervention to persuade the investigators otherwise.

2.3. Scheme Rates 2015

In the absence of any guidance as to what tariffs to apply in 2015, Schemes must continue to set their tariffs independently. The reality is that Administrators are setting tariffs on behalf of the Schemes they administer. This holds true for Discovery, Medscheme and Metropolitan Health Risk Management.

If one then compares various Scheme Rates it is also obvious that Schemes do not differ much from each other. Such action by Administrators is tantamount to a unilateral determination of a national Benchmark Tariff - an administrative procedure that should be investigated by the CC.

Detailed tariff lists are available on most Scheme web sites and/or are available to all Practitioners and members on request. Problematically, however, few Schemes and Administrators have the capacity or insight into coding structures. Scheme tariffs still blindly make use of the illegal published RPL and annual tariff increases still apply to the structure inherent to the long-discredited NHRPL 2006, which does not contain all the recent changes to codes, descriptors, rules and modifiers approved by SAMA, SAPPF and other Associations for 2006 to 2014.

Medihelp is the scheme with the most up-to-date coding structure.

Inevitably, disputes between Practitioners and Schemes will increase and ultimately scheme beneficiaries will be worse off.
Increases in tariffs for 2015 vary between 3.8% (GEMS) and 10.8% (Selfmed). Details of Scheme increases are set out in Annexure A.

A summary of increases per Administrator and selected Schemes is set out below:

1. Discovery Health - 6.0%
2. Momentum Health - 5.5%
3. Bonitas – 6.0%
4. Medscheme – 6.0% to 6.6%
5. Metropolitan Health 6.0% to 6.6%
6. GEMS – 3.8%

(*Although GEMS announced a 6.0% increase for 2015, this would only apply to contracted paediatricians and gynaecologists; whereas the bulk of codes reflect an average increase of only 3.8% - calculated HealthMan*).

7. Profmed - 6.5%
8. Liberty Health Medical Scheme – 6.0%
9. Medshield - 6.0%
10. Medihelp - 6.0%
11. Bestmed - 6.6%

It is not clear to what extent Practitioners will be able to accommodate these various tariffs within their Practice Management Systems. We continue to counsel individual practices to devise an appropriate practice tariff to recover from all schemes and patients.

2.4. Balance Billing

It has been HealthMan's view for a number of years that 'Balance Billing' is an effective mechanism to promote healthy competition between various parties. It is also the only way to handle the multiple tariff structures prevalent since the RPL 2009 was set aside.

The CMS has called for a statutory provision that will enable development of a 'no-balanced billing tariff' for health services. Its joint CMS/DoH Pricing Committee would have enabled multilateral negotiations aimed at achieving such a tariff amenable to both funders and providers.

Outside of the no-balanced tariff, individual funders and providers would have been able to negotiate alternative billing arrangements as long as such negotiations are free of collusion and result in discounts off the centrally negotiated tariff.

The Minister's initial indications that he wished to expand on the possible re-introduction of centralised bargaining in 2013 came to naught. It would have required amendments to existing legislation. Incidentally, the only amendments – like that establishing the OHSC – to receive any consideration from the Minister's office are those with direct bearing on NHI implementation.

2.5. HealthMan Practice Cost Tariffs

Disciplines that contracted HealthMan to undertake practice cost studies as part of the RPL determination process unfortunately no longer have the benefit of using these for reference purposes. The HealthMan tariffs - while the closest to the reality of practice costs back in the day - now suffer along with the multiplicity of tariff schedules in the market from being outdated.

During 2015 HealthMan will test new pricing models for Paediatrics and Psychiatry. In addition, a virtual practice model is being developed jointly with Insight Actuarial Services. We trust that both projects will yield outcomes that are considerably more scientific and defensible than those previously, and currently, devised and promoted by CMS and DoH.

2.6. Discovery Health Tariffs and Payment Arrangements

For 2015, Discovery will be increasing all the Discovery Health Rates by 6%. All DPA multipliers continue to apply to these increases.

Discovery Health Rate	% of 2015 DH Rate
Premier Rate – Essential, Coastal & Classic	
Premier Rate A (In Hospital)	*137%*
Premier Rate A (Out of Hospital)	*162%*
Premier Rate B	*147%*
Classic Rate	
Essential and Coastal Plans (Can Balance Bill)	*100%*
Classic Plans (In Hospital) (No Balance Bill)	*217%*
Classic Plans (Out of Hospital) (Can Balance Bill)	*100%*
Executive Plan	*300%*

Discovery also introduced a new Day Surgery Benefit enhancement tariff in 2014. Any willing surgeon or anaesthesiologist who chooses to participate will benefit from an increase in their chosen DPA rate for all procedures performed in a day surgery facility (77 facilities) as indicated in the table below:

Surgeon rate (No Balance Billing in excess of these rates):

DPA Arrangement	Member Plan Type	Acute Hospital Rate*	Day Surgery Rate* #
Classic Direct	Classic	217%	230%
	Essential\Coastal	100%	200%
Prem A	Essential\Coastal\Classic	137%	167%
Prem B	Essential\Coastal\Classic	147%	177%
Executive	Executive	300%	

Anaesthesiologist rate :

DPA Arrangement	Member Plan Type	Acute Hospital Rate	Day Surgery Rate
Classic Direct	Classic	204%	214%
	Essential\Coastal		
Prem A	Essential\Coastal\Classic	100%	144%
Prem B	Essential\Coastal\Classic	144%	154%
Executive	Executive	300%	

This is applicable to all procedures performed in a day surgery facility, excluding ophthalmology, maxillofacial and oral surgery, dentistry and GIT endoscopies.

2.7. Momentum Health Medical Scheme Rate for 2015

Momentum Health will be increasing their 2015 scheme rate by 5.5%. This will be applicable to all providers (except for those with specific negotiated or agreed rates in place), effective from 1 January 2015.

Momentum Health Tariff Schedules and Benefit guides for 2015 are available for your reference at: www.provider.momentum.co.za.

There is no change for 2015 in the rates paid directly to participating specialists under the following arrangements:

2.7.1 High Income Plan (Summit)

200% of Scheme rate for in-hospital claims and 215% for out-of-hospital claims.

2.7.2 Middle Income Plans (Custom, Incentive & Extender)

137% of Scheme rate for in-hospital claims and 154% of scheme rate for out-of-hospital claims.

2.7.3 Low-income plans (Ingwe & Access)

100% of scheme rate for all claims.

Comments:

1. Approx 85% of Momentum Health members are on the middle-income plans.
2. If you wish to participate in any of Momentum's specialist arrangements, please email: specialistpartner@momentum.co.za
3. Where coding issues are raised, please advise the HealthMan offices.

2.8. Metropolitan Health Risk Management Specialist Arrangements

In the absence of a formal price guideline in the industry, individualised scheme rates have been provided in the table below and are effective as of the 1st January 2015: The table below provides the specific detail per scheme:

Scheme Name	2015 Rate Increase
Bankmed	6.50%
BP Medical Aid Society	6.00%
Engen Medical Benefit Fund	6.00%
Fishing Industry Medical Scheme	6.50%
GEMS	6.00%
Golden Arrow Employees Medical Benefit Fund	6.50%
Imperial Medical Scheme	6.60%
Medipos Medical Scheme	6.50%
Metropolitan Medical Scheme	6.60%
Momentum Health	5.50%
Moto Healthcare	6.00%
PG Group Medical Scheme	6.50%
Pick and Pay Medical Scheme	6.00%
Polmed	6.00%
SAB Medical Aid Society	6.50%
Transmed Medical Fund	6.00%
Wooltru Healthcare Fund	6.50%

South African Breweries (SAB) Medical Aid Scheme and Bankmed have remained strong participating schemes since Metropolitan implemented its Health Specialist Portfolio in January 2012. This specialist network pays specialist claims directly to participating specialists. Metropolitan has rolled out network participation to Polmed. The rates below are applicable to the Polmed, as well as the Bankmed and SAB, network:

	Low-cost Options	Medium-cost Options	High-cost Options
Bankmed		**CoreSaver Traditional Comprehensive Plans**	**Plus Plan**
% of Scheme rate paid on in-hospital claims	100%	135%	200%
% of Scheme rate paid on out-of hospital claims	100%	150%	215%
SAB Medical Aid Scheme	**Essential**	**Comprehensive**	
% of Scheme rate paid on in-hospital claims	120%	160%	
% of Scheme rate paid on out-of hospital claims	120%	160%	
Polmed	**Lower Plan**	**Higher plan**	
% of Scheme rate paid on in-hospital claims	100%	120%	
% of scheme rate paid on out-of hospital claims	100%	135%	

If you wish to participate in any of Metropolitan's networks, please email: networks@metropolitanhrm.co.za

Where coding issues are raised, please advise the HealthMan offices.

2.9. Fedhealth Specialist Participating Scheme Rates 2015

Specialists will be reimbursed according to the following tariff structure of scheme rate:

Option Name	Percentage of scheme tariff for both in and out of hospital services
Ultimax 200	300%
Maxima Plus	210%
Maxima Exec	210%
Maxima Standard	165%
Maxima Standard Net	165%
Maxima Saver	165%
Maxima Basis	165%
Maxima Core	165%
Maxima EntrySaver	100%
Maxima EntryZone	100%
Blue Door	100%

The above tariffs are applicable to all Specialist practice types identified by the Scheme and the scheme rate has increased by 6.2% for 2015.

2.10. Bonitas Specialist Participating Scheme Rates 2015

Bonitas has increased the base remuneration rate by 6.2% for 2015 and the table below illustrates the various Bonitas plans and tariffs as a percentage of the Bonitas scheme rate for 2015.

2.10.1 The Specialist will be reimbursed according to the following tariff structure - the percentages refer to the Scheme tariff:

Option Name	In Hospital	Out of Hospital
Standard	130%	130%
Primary	130%	130%
BonSave	150%	130%
BonEssential	130%	130%
BonClassic	130%	130%

2.10.2 The above tariffs are applicable to all Specialist practice types identified by the Scheme, except, oncologists, clinical haematologists, pathologists, radiologists, anaesthetists and maxilla-facial surgeons.

2.10.3 The tariffs for BonComprehensive and BonCap will remain in place for participating and non-participating specialists in 2015, and are excluded from this agreement illustrated as a percentage of the scheme rate in the table below.

Option Name	In Hospital	Out of Hospital
BonComprehensive	300%	100%
BonCap	100%	100%

2.11. Netcare Clinical Partners

The Netcare Clinical Partners Specialist Rate is set at 150% of the Netcare scheme Rate. This rate is applicable to employees of the Netcare Group making up close to 40000 beneficiaries.

3. COMPARATIVE SPECIALIST CONSULTATION TARIFFS 2015

		GEMS Scheme Tariffs	Discovery Premier A
0190	Surgical	R 296.20	R 551.80
0190	Consulting	R 453.00	R 792.30
0191	Surgical	R 296.20	R 551.80
0191	Consulting	R 453.00	R 792.30
0192	Surgical	R 296.20	R 557.80
0192	Consulting	R 453.00	R 792.30
0161	Psychiatry Consulting	R 326.60	R 807.10
0162	Psychiatry Consulting	R 598.70	R 807.10
0163	Psychiatry Consulting	R 870.70	R 807.10
0164	Psychiatry Consulting	R 1 142.80	R 807.10

Note: As there is no RPL, we have listed GEMS and Discovery Health tariffs for comparative purposes and guidance. O&G tariffs are R17.50 higher for Scheme tariffs in the various categories (no differentiation for Discovery). Neither the GEMS nor Discovery Health differentiate between Tiered Consultations. There is also no justification for the three differential sets of tariffs between specialist groups, other than “historical accident”.

Also note that Neurosurgery consulting tariffs for GEMS and Discovery are at the consulting group levels. Both Discovery Health and GEMS apply irrational and discriminatory policies in setting consultation tariffs. This applies equally to all other Schemes and Administrators.

In order to track the impact of tiered consultations, we again urge all practices to charge time-based consultations appropriately, even though schemes do not pay accordingly.

4. SUMMARISED RAND CONVERSION FACTORS (RCFs) - SCHEME RATES 2015

Code		DISCOVERY 2015	GEMS 2015	PROFMED 2015	MEDIHELP 2015
10	Consultative Services	R 18.811	R 17.424	R 18.399	R18.432
11	Psychiatry	R 21.209	R 21.766	R 21.944	R21.983
12	Consultative Services *(Paediatrics & Paediatric Cardiology)*	R 18.810	R 17.424	R 18.399	R18.432
20	Clinical Procedures	R 11.012	R 11.069	R 11.394	R11.414
30	Anaesthesiologists	R 78.461	R 69.466	R 71.515	R71.643
130	GP Consultative Services (0190-0192)	R 21.933	R 19.406	R 20.627	18.432
60	Ultrasound	R 10.498	R 10.550	R 10.861	R10.881

We have not included HPCSA RCFs as they no longer exist. These RCFs do not represent the actual costs of running private practice. Discovery Health applies inconsistent RCFs to consultative services as they do not apply the correct Relative Value Units (RVU's) in all cases. The rate reflected under Code 10 is for consulting groups. For surgical groups it is R 18.90 (Discovery).

5. HPCSA & TARIFFS

The HPCSA has given no indication what tariffs they will apply in any disciplinary hearing. The current RCF used by HPCSA is of no value and for all intents and purposes can be ignored. However, we strongly advise all practitioners, where practical, to inform their patients upfront what they will be charged, and whether co-payments are likely. Please contact the HealthMan offices if you receive notification that complaints of overcharging have been made against your practice to the HPCSA.

6. MALPRACTICE INSURANCE

The malpractice insurance rate increases continue to exceed inflationary adjustments. We continue to provide Practitioners with alternative cover through our arrangements with Aon South Africa. These rates are in general well below that of MPS and can be structured in various levels of cover. This product now has in excess of 2500 members. Further group discounts are available for ENT Surgeons and other management Groups. This arrangement is not available for Obstetrics & Gynaecology or for Spinal Surgery.

For further details email Casper Venter at casperv@healthman.co.za.

7. IMPORTANT REMINDER REGARDING RUN-OFF COVER

"It is critically important that we are notified immediately of any incidents which may lead to a claim or any actual claims. It is a condition of your cover that timeous notification of such is made to Insurers and they are especially strict on this," Carol-Lee Axford of AON emphasises.

Some examples of 'possible' claims to be reported as soon as you (the Insured) become aware of them:

1. Any notification from a patient whether verbal or written indicating that they are unhappy with treatment received;
2. Receipt of correspondence from attorneys requesting copies of treatment records in respect of any of your patients;
3. Indications from any medical aid that they are investigating your accounts;
4. Allegations of any criminal conduct in the conduct of your profession, including allegations of sexual harassment etc.;
5. Complaint that is lodged against you at the HPCSA. Please do not submit your response to the HPCSA prior to consulting with us as you may unwittingly prejudice your defence."

Note that all potential matters brought to the insurer's attention during the period covered by the policy will be picked up by the Insurer, even if the policy is cancelled or even when the 3 years run-off cover period is reached. Run-off cover period allows the Insured (or in the event of the Insured's death, the Executor of the Insured's Estate) to report any claims that may come to their attention after the policy has ceased (through Retirement, Death, or the cessation of practicing as a Registered Healthcare Practitioner for reasons **other** than those enumerated below) for an additional period of thirty six (36) months (the Additional Reporting Period) to identify circumstances in connection with work performed during the currency of the Policy that may give rise to a claim for indemnity in terms of this Policy and provided that the Additional Reporting Period:

i) is not granted should the Insured's license or right to practice have been revoked, suspended or surrendered or should any prior breach of this Policy;
ii) shall not apply to circumstances that may give rise to a claim advised to Insurers after the commencement date of run-off cover period;
iii) is subject otherwise to all the terms, Exclusions and Conditions of this Policy;
iv) shall notwithstanding the stated thirty six (36) months period, terminate immediately at the commencement date thereof should insurance be obtained by the Insured replacing in whole or in part the insurance afforded by this Policy

8. IMPORTANT CHANGES AT MEDICAL SCHEMES

8.1. Schemes no longer administered by Medscheme

Wits Staff Medical Aid Fund (WITS)

WITS will be joining Discovery Health as from 1 January 2015. Medscheme will process WITS claims up until 31 December 2014. Any claims received after this service date are to be submitted to Discovery Health.

8.2. Bestmed

Bestmed has contracted OneCare Health to sign up a Specialist Network for all Bestmed Options. The tariff on offer is at Scheme Rate and is not inclusive of all current codes as used by Specialists. It also does not pay for tiered consultations.

We do not believe it is in the interests of Specialists to sign this agreement as it will undermine the current DSP and DPA arrangements that are in the market. The contract also makes certain promises that it will never be able to deliver. OneCare has no relations with Specialist Groups, and wants the cheapest possible network in order to take as much as possible of the fees for themselves. This is an easy way for Bestmed to circumvent paying PMBs at cost and is not in the interest of either Bestmed members or the doctors treating them.

9. GENERAL DISCLAIMER

The information disclosed above is based on publically-available healthcare industry information which we believe would be of assistance to you. HealthMan is not responsible for any losses incurred by a practitioner relying on the above information. Where any doubt exists regarding the eligibility of members, availability of benefits etc. we recommend that the practitioner makes direct enquiries with the relevant schemes.

Regards

Casper Venter
Director HealthMan

Ernst Ackermann
Director HealthMan

Mardi Roos
Director HealthMan

6 January 2015

ANNEXURE A - Medical Scheme Rates - 2015

SCHEMES ADMINISTERED BY MEDSCHEME

Scheme Name	2015 Rate Increase
AECI Medical Aid Society	6.00%
Barloworld Medical Aid	6.20%
Bonitas Medical Fund	6.20%
Fedhealth	6.20%
Glencore Medical Scheme (previously Xstrata Alloys Medical Aid Scheme)	6.00%
Horizon Medical Scheme	6.50%
MBMed Medical Aid Fund	6.20%
Nedgroup Medical Aid Scheme	6.60%
Old Mutual Staff Medical Aid Fund	6.00%
Parmed Medical Aid Scheme	6.20%
SABC Medical Scheme	6.20%
Sasolmed Medical Aid Scheme	6.20%

CLOSED SCHEMES ADMINISTERED BY DISCOVERY, PARTICIPATING IN DPAs FOR 2015

Scheme Name	Premier Rate Payment Arrangement	Classic Direct Payment Arrangement	Custom Direct Payment Arrangement	KeyCare Specialist Arrangement
Anglo Medical Scheme	No	No	No	No
Anglovaal Group Medical Scheme	Yes	No	No	No
BMW Employees Medical Aid Society	Yes	No	No	No
LA Active LA Comprehensive LA Core LA Focus LA KeyPlus	Yes Yes Yes Yes No	No No No No No	No No No No No	No No No No Yes
Lonmin Medical Scheme	No	No	No	No
Malcore Medical Aid: - Plan A - Plan B - Plan C	 Yes Yes Yes	 No No No	 No No No	 No No No
MMED Option of the Naspers Medical Fund	Yes	No	No	No
Naspers Medical Fund N Option Plus Naspers Medical Fund N Option Basic	Yes No	No No	No Yes	No No
Quantum Essential Comprehensive Quantum Essential Saver Quantum KeyPlus	 Yes Yes No	 No No No	 No No No	 No No Yes
Remedi Comprehensive Option Remedi Classic Option Remedi Standard Option	Yes Yes No	Yes Yes No	No No No	No No Yes
Retail Essential Retail Essential Comprehensive Retail Essential Plus	Yes Yes Yes	No No No	No No No	No No No

Scheme Name	Premier Rate Payment Arrangement	Classic Direct Payment Arrangement	Custom Direct Payment Arrangement	KeyCare Specialist Arrangement
TFG Medical Aid Scheme Plan A	Yes	No	No	No
TFG Medical Aid Scheme Plan B	Yes	No	No	No
Tsogo Classic Comprehensive	Yes	No	No	No
Tsogo Classic Saver	Yes	No	No	No
UKZN Medical Scheme	Yes	No	No	No
Wits Medical Scheme	Yes	No	No	No

- *Consultation codes limited to 0190 – 0192 and 0161 – 0164*

Scheme Name	Reimbursement Rate for 2015						
	Premier Rate A (IH)	Premier Rate A (OH)	Premier Rate B (IN & OH)	Classic Direct (IH)	Classic Direct (OH)	Custom Direct (IH & OH)	KeyCare Specialist (IH & OH)
Anglovaal Group Medical Scheme	137%	162%	147%				
BMW Employees Medical Aid Society	137%	162%	147%				
LA Active	137%	162%	147%				
LA Comprehensive	137%	162%	147%				
LA Core	137%	162%	147%				
LA Focus	137%	162%	147%				
LA KeyPlus							110%
Lonmin Medical Scheme							
Malcore Medical Aid							
- Plan A	137%	162%	147%				
- Plan B	137%	162%	147%				
- Plan C	137%	162%	147%				
MMED Option of the Naspers Medical Fund	137%	162%	147%				
Naspers Medical Fund N Option Plus	137%	162%	147%				
Naspers Medical Fund N Option Basic						130%	
Quantum Essential Comprehensive	137%	162%	147%				
Quantum Essential Saver	137%	162%	147%				
Quantum KeyPlus							110%
Remedi Comprehensive Option	137%	162%	147%	217%	100%		
Remedi Classic Option	137%	162%	147%	217%	100%		
Remedi Standard Option							110%
Retail Essential	137%	162%	147%				
Retail Essential Comprehensive	137%	162%	147%				
Retail Essential Plus	137%	162%	147%				
TFG Medical Aid Scheme Plan A	137%	162%	147%				
TFG Medical Aid Scheme Plan B	137%	162%	147%				
Tsogo Classic Comprehensive	137%	162%	147%				
Tsogo Classic Saver	137%	162%	147%				
UKZN Medical Scheme	137%	162%	147%				

OTHER SCHEMES

Scheme Name	2015 Rate increase
AECI	6.00%
Affinity Health Insurance	6.00%
Bankmed	6.50%
BARLOWORLD	6.20%
BCIMA	6.00%
BONITAS	6.20%
Camaf	6.00%
BPSA	6.00%
Camaf	6.00%
Cape Medical Plan	8.00%
Compcare	6.00%
De Beers	6.00%
Engen	6.00%
Eternity	6.00%
Fedhealth	6.20%
Fishmed	6.50%
GEMS	3.80%
Glencore	6.00%
Golden Arrow	6.50%
Grintek	6.00%
Horizon	6.50%
Hosmed	6.00%
Keyhealth	7.00%
Libcare	6.50%
Liberty Health	6.00%
MB MED	6.20%
Medipos	6.50%
Medshield	6.00%

Scheme Name	2015 Rate increase
Midmed	6.00%
Momentum (MMSA)	5.50%
Moto Healthcare	6.00%
NBCRFLI Wellness Fund	6.00%
Nedgroup	6.60%
Netcare	6.00%
Old Mutual Staff	6.00%
Parmed	6.20%
Pick n Pay	6.00%
Polmed	6.00%
Primecure	6.00%
Profmed	6.50%
SA Breweries	6.50%
SABC	6.20%
Sabmas	5.50%
Samwumed	6.00%
Sasolmed	6.20%
Selfmed	10.8%
Sizwe	7.00%
Status	6.00%
Thebemed	6.00%
Tiger Brands	6.00%
Topmed	6.00%
Transmed	6.00%
Umvuzo Health	7.50%
WCMAS	6.00%
Wooltru	6.50%
Worker Plan	6.00%