INTRODUCTION

The management and staff at HealthMan wish all our clients, their staff, and recipients of our newsletter a prosperous 2014. This year is an election year and will very likely be a tough one for private practice as government ramps up its campaign to put itself and its reforms in the best possible light. Let us review the pertinent legislative changes and ongoing projects in healthcare regulation that will concern us in the immediate future.

1. Regulatory News

1.1. Price Regulation in the Private Sector

The Competition Commission (CC) of South Africa has finalised the Terms of Reference (TOR) for its Market Inquiry into the Private Healthcare sector. These were gazetted on 29 November 2013.

The CC was also supposed to announce the members of the broadly-skilled panel who will preside over the inquiry now set to commence on 6 January 2014. This panel will make recommendations to the Commission and will essentially run the process. A technical team of researchers from KPMG and the CC will do the background work, support the panel, assist with the public hearings and draft the interim report (due by September 2014, according to acting Commissioner Tembinkosi Bonakele). The final TOR however makes reference only to the final market inquiry report, to be completed by 20 November 2015 – a deadline some commentators deem ambitious.

The South African Private Practitioner Forum (SAPPF) and Discovery both highlighted critical omissions from the draft TOR in their respective submissions. The finalised terms are more comprehensive, with the oversights regarding the medical devices and pharmaceutical industries and the integrity of the regulatory framework, acknowledged and incorporated. The final TOR's neutral tone and expanded scope are to be welcomed.

Further details regarding the administrative phases of the market inquiry, along with guidelines for participation, the TOR say, were supposed to be available on the CC's website by 6th January 2014.

The Commission's website is: www.compcom.co.za. In October it launched a dedicated portal for the market inquiry: www.healthinquiry.co.za/

Nothing has been published as yet.

Furthermore, the Netcare Group has applied for an interim interdict against KPMG – the firm appointed as technical service provider for the inquiry. KPMG was consulted to assist in Netcare's preparatory work to the market inquiry, and had access to the group's confidential information. Given the clear conflict of interest, Netcare has demanded clarity regarding the KPMG team that worked for it and the one working for the Competition Commission. It has

applied for the return of all relevant documentation as well as a halt to KPMG performing any further work for the CC until the matter has been resolved.

1.2. Risk Equalisation Fund ("REF")

Last year we suspected that the Department of Health's wholehearted focus on its pet project National Health Insurance (NHI) was delaying moves to improve sustainability measures in the medical schemes' industry - such as the mooted Risk Equalisation Fund (REF), and Prescribed Minimum Benefit (PMB) revision .

Our suspicions proved correct; the Minister of Health Dr Aaron Motsoaledi exploded in a November interview published in The Star, dismissing all these mechanisms as 'opportunistic' ("*zama-zama*"). In the Minister's own words:

> "Risk equalisation is off the table, just like the PMBs. The risk equalisation fund was a copped-out mechanism to plaster a health-care system that wasn't working. That's the bottom line. The fund, the what-what, prescribed minimum benefits, they're not working. The lower scheme what-what option, the higher scheme, they're not working. All those have never served the public. The only thing that will help is universal coverage. And private health care started working against universal coverage in 2009…
>
> This is a revolution to bring justice to the poor. And revolutions happen in a way that may not be pretty. This is war. This is for the population to see how greed is fought. It's naked, naked greed from powerful individuals who want a good life for themselves and a poor life for anybody else."

1.3. Prescribed Minimum Benefits

Precious little has been said about PMBs in 2013, besides a CMS proposal late in the year that the *Medical Schemes Act* should be amended to rename Prescribed Minimum Benefits (PMBs) MMBs, or Mandatory Minimum Benefits, 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.

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, Bankmed, Bestmed, and all 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, 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. 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.

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 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 2014 and a more comprehensive annual process for 2015 and beyond.

In its truncated schedule for 2014 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 2014.

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 welcomes 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.

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."

However, in its October medium-term budget policy statement, the acronym NHI does not appear at all. Modelled in 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. SAMA Doctors' Billing Manual (DBM)

The 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, 2011 or 2012. An electronic version was available in 2011, 2012 and 2013, but is a very difficult version to work with, and was incomplete in terms of rules and interpretive guidelines.

HealthMan has been informed that an electronic DBM for 2014 is now available in downloadable PDF format.

A number of Societies now publish their own 'Billing Guidelines'. This is probably the right way to go. HealthMan has always contended that specialist coding belongs to its respective disciplines. SAPPF and SAMA plan to hold a joint coding meeting on 1 February 2014 where future coding strategies and structures will be discussed.

The CMS has 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 Competition Law attack is to be found in the USA or European Union.

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.

2.3. Scheme Rates 2014

In the absence of any guidance as to what tariffs to apply in 2014, Schemes must continue independently to set their tariffs. 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 unilateral determination of a national Benchmark Tariff - an administrative procedure that should be investigated by the Competition Commission.

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 illegally published RPL, and annual tariff increases still apply to the structure inherent to NHRPL 2006. This invariably does not contain all the recent changes to codes, descriptors, rules and modifiers approved by SAMA, SAPPF and other Associations for 2006 to 2013. 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 2014 vary between 6.0% (Discovery/GEMS) and 9.8% (Midmed). Details of Scheme increases are set out in Annexure A. A summary of increases per Administrator is set out below:

1. Discovery Health - 6.0%
2. Momentum Health - 5.8%
3. Bonitas – 5.8%
4. Medscheme - 5.4% to 6.0%
5. Metropolitan Health 6.0% to 8.0%
6. GEMS - 6.0%
7. Profmed - 6.0%
8. Liberty Health Medical Scheme, V Med – 7.0%
9. Medshield - 6.0%
10. Medihelp - 6.0%
11. Profmed - 6%
12. Bestmed - 5.6%

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.

Last year we initiated a process of refining the studies for consolidated "surgical" and consolidated "consulting" disciplines. This year HealthMan will test new pricing models for Paediatrics and Psychiatry. In addition, a virtual practice model is being developed jointly with Lighthouse Actuarial Consulting. 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 2014, Discovery will be increasing all the Discovery Health Rates by 6% - this is in excess of prevailing CPI at 5.5%. All DPA multipliers continue to apply to these increases.

Discovery Health Rate	% of 2014 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 will also be introducing a new Day Surgery Benefit enhancement. 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 facility) 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 2014

Momentum Health will be increasing their 2013 scheme rate by 5.8%. This will be applicable to all providers (except for those with specific negotiated or agreed rates in place), effective from 1 January 2014.

Momentum Health Tariff Schedules and Benefit guides for 2014 are available for your reference at: www.provider.momentum.co.za.

There is no change for 2014 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 Arrangement

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 2014: The table below provides the specific detail per scheme:

Scheme Name	2014 Rate Increase

Afrox Medical Aid Society	6.00%
Bankmed	6.00%
BP Medical Aid Society	7.00%
Engen Medical Benefit Fund	6.00%
Fishing Industry Medical Scheme	6.00%
GEMS	6.00%
Golden Arrow Employees Medical Benefit Fund	6.00%
Imperial Medical Scheme	6.00%
Medipos Medical Scheme	6.00%
Metropolitan Medical Scheme	6.00%
Momentum Health	6.00%
Moto Healthcare	6.00%
PG Group Medical Scheme	6.00%
Pick and Pay Medical Scheme	6.00%
Polmed	6.50%
SAB Medical Aid Society	7.00%
SAMWUMED	6.00%
Transmed Medical Fund	6.00%
Wooltru Healthcare Fund	8.00%

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 hopes to roll out network participation to more schemes in future. The following rates are applicable to Bankmed and SAB:

Bankmed	**Low-cost Options**	**Medium-cost Options**	**High-cost Options**
% 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	**Low-cost Options**	**Medium-cost Options**	
% of Scheme rate paid on in-hospital claims	120%	160%	
% of Scheme rate paid on out-of hospital claims	120%	160%	

Comments:

1. If you wish to participate in any of Metropolitan's networks, please email: networks@metropolitanhrm.co.za
2. Where coding issues are raised, please advise the HealthMan offices.

2.9. Fedhealth Specialist Participating Scheme Rates 2014

2.9.1 Fedhealth has launched 2 new options to its range namely the Maxima Saver and Maxima EntrySaver. The Ultima 300 option has been discontinued and these

members have moved to the Maxima Plus option, which means that the accounts will still be paid at the same rate and illustrated in the table below.

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

Option Name	Percentage of scheme tariff for both in and out of hospital services
Ultima 200	165%
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%

2.9.3 The above tariffs are applicable to all Specialist practice types identified by the Scheme, except anaesthetists.

2.10. Bonitas Specialist Participating Scheme Rates 2014

Bonitas has increased the base remuneration rate by 5.8% for 2014 and the table below illustrates the various Bonitas plans and tariffs as a percentage of the Bonitas scheme rate for 2014.

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 2014, 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%

3. COMPARATIVE SPECIALIST CONSULTATION TARIFFS 2014

		GEMS Scheme Tariffs	Discovery Premier A
0190	Surgical	R 285.40	R 520.50
0190	Consulting	R 436.40	R 747.50
0191	Surgical	R 285.40	R 520.50
0191	Consulting	R 436.40	R 747.50
0192	Surgical	R 285.40	R 520.50
0192	Consulting	R 436.40	R 747.50
0161	Psychiatry Consulting	R 308.10	R 761.40
0162	Psychiatry Consulting	R 564.80	R 761.40
0163	Psychiatry Consulting	R 821.40	R 761.40
0164	Psychiatry Consulting	R 1 078.10	R 761.40

Note: As there is no RPL, we have listed GEMS and Discovery Health tariffs for comparative purposes and guidance. O&G tariffs are R16.24 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 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. The Bonitas pilot in this regard is a positive step and can be supported.

4. SUMMARISED RAND CONVERSION FACTORS (RCFs) - SCHEME RATES 2014

Code		DISCOVERY 2014	GEMS 2014	PROFMED 2014	MEDIHELP 2014
10	Consultative Services	R 17.746	R 16.788	R 17.276	R17.291
11	Psychiatry	R 20.009	R 20.535	R 20.604	R20.622
12	Consultative Services *(Paediatrics & Paediatric Cardiology)*	R 17.746	R 16.788	R 17.276	R17.291
20	Clinical Procedures	R 10.389	R 10.664	R 10.699	R10.707
30	Anaesthesiologists	R 78.461	R 66.933	R 67.150	R67.207
130	GP Consultative Services (0190-0192)	R 23.00	R 18.693	R 19.369	
60	Ultrasound	R 9.904	R 10.164	R 10.198	R10.207

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. 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 intent 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 a substantial number of members. Further group discounts are available for ENT Surgeons. This arrangement is not available for Obstetrics & Gynaecology nor 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

Massmart

Massmart will be joining Universal Healthcare as from 1 January 2014. Medscheme will process Massmart claims up until 20 December 2013. Any claims received after this date are to be submitted to Universal Healthcare, regardless of the date of service on the claim.

Benefit option changes include MASSMART HEALTH PLAN being renamed Choice Option, and a new option called Network becoming available as of 1 January 2014.

BMW

BMW will be joining Discovery Health as from 1 January 2014. All claims for date of service in 2013 will be processed by Medscheme and claims from 1 January 2014 are to be submitted to Discovery Health.

8.2 BMW Employees Medical Aid Society joins Discovery

As from 1 January 2014, the BMW Employees Medical Aid Society (BEMAS) will be administered by Discovery Holdings. In order to ensure a smooth transition, please take note of the following:

Claims payments and queries (including hospital claims):

- All BEMAS member treatment date claims and transactions dated before 1 January 2014 will be dealt with, processed and serviced by Medscheme until 30 April 2014.
- If you have any claims queries, please call 0860 002 107 or send an email to: bmw@medscheme.co.za.

BEMAS Networks:

- The current Networks will be valid until 31 December 2013. All claims and transactions updated for 2013 will be dealt with, processed and serviced by Medscheme up until 30 April 2014.
- No additional healthcare professionals will be contracted to join the BEMAS Networks after 30 November 2013.

Hospital pre-authorisations:

- All BEMAS member pre-authorisations and admissions with a discharge date before 1 January 2014 will be dealt with and updated by Medscheme until 30 April 2014.
- For hospital pre-authorisations and queries contact the BEMAS call centre on 0860002107 or send a fax to (021)4661913 or send an email to: bmw.authorisations@medscheme.co.za.

Note: If a BEMAS member is still in hospital at 23:59 on 31 December 2013, please request a new authorisation for that member with Discovery Holdings.

Oncology network

- All existing pre-authorisations for Oncology treatment of BEMAS members for 2013 claims and transactions will be dealt with, processed and serviced by Medscheme up until 30 April 2014.

Paper claims dated for 2013 only

- Please post these to Medscheme, Claims Department, PO Box 74, Vereeniging, 1930.

8.3 Topmed and Pharos merger

Topmed Medical Scheme and Pharos Medical Plan will merge with effect 1 January 2014.

8.4 Medshield Benefit Option changes

From 31 December 2013, Medshield Medical Scheme discontinued its ESSENTIAL plan. With effect from 1 January 2014, however, a new benefit option – MEDIPHILA – becomes available.

8.5 Liberty Health Benefit Options renamed

With effect from 1 January 2014, the approved name changes to Liberty Health Medical Scheme's various benefit options are as follows:

- Prestige has been renamed TRADITIONAL ULTIMATE
- Gold Focus and Gold Focus Select have been renamed, respectively HOSPITAL STANDARD and HOSPITAL SELECT
- Gold Saver and Gold Saver Select have been renamed, respectively, SAVER STANDARD and SAVER SELECT
- Platinum Complete has been renamed COMPLETE PLUS
- Platinum Focus has been renamed HOSPITAL PLUS
- Platinum Saver has been renamed SAVER PLUS
- Bona Plus has been renamed TRADITIONAL STANDARD
- Titan and Titan Select have been renamed, respectively, COMPLETE STANDARD and COMPLETE SELECT

- Gateway has been renamed TRADITIONAL BASIC

8.6 Fedhealth Benefit Option changes

Fedhealth has launched two new options, namely the *Maxima Saver* and *Maxima Entry Saver*. The *Ultima 300* option has been discontinued and most of these members have moved to the Maxima Plus option.

8.7 Profmed drops option

Profmed's *Pro Secure Plus* and *Pro Active Plus* plans will no longer reimburse specialists at 300% of scheme rate. The maximum reimbursement is now 200%, reflecting a 33% decrease in benefits.

8.8 Sizwe Medical Scheme new curator

Following investigations into irregularities in the management of Sizwe Medical Fund, the CMS appointed a curator. After months of dispute with the medical scheme's administrator, Sechaba Medical Solutions, Dr Marshall Gobinca agreed to resign as curator of Sizwe and in September 2013 the North Gauteng High Court appointed a new curator - Johannes M. Seloane.

The financial position of the scheme is nevertheless sound and it continues to honour claims. The scheme has additionally proposed a new benefit option – Sizwe Basic Care – from 1 February 2014. CMS approval is pending.

8.9 Goldfields becomes Sisonke

Goldfields Medical Scheme has changed its name, effective 1 January 2014, to Sisonke Health Medical Scheme.

8.10 Xstrata becomes Glencore

Xstrata Alloys Medical Aid Scheme has changed their name to Glencore Medical Scheme effective 1 January 2014. All the other details, including plan option numbers and the electronic routing of claims, remain the same.

8.11 Medical Scheme Amalgamations for 2013/2014

- ALTRON MEDICAL AID SCHEME amalgamates with Discovery Health Medical Scheme, with effect from 1 January 2014;
- IBM (SA) MEDICAL SCHEME amalgamated with Discovery Health Medical Scheme on 1 July 2013;
- NAMPAK (SA) MEDICAL SCHEME amalgamated with Discovery Health Medical Scheme on 1 March 2013;
- MINEMED MEDICAL SCHEME amalgamated with Bestmed on 1 September 2013;
- SAPPI MEDICAL AID SCHEME amalgamated with Bestmed on 1 April 2013;
- SPECTRAMED's amalgamation with Liberty Health medical Scheme is pending.

8.12 Medihelp Specialist DSP

Medihelp has published its DSP list for PMB conditions on its web site. The list of practitioners published is purely based on the tariff of the treating doctor, anaesthetists tariffs, and the cost of the relevant hospital. There is no recognition of health outcomes or quality, which Medihelp says they will start to review in the current year. The list of DSP doctors is also deficient in many other respects and in most instances Medihelp patients may not even have access to a suitably experienced specialist in his/her area. We are in the process of engaging with Medihelp to extend the list, making it more inclusive of members of the various specialties.

8.13 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

6 January 2014

ANNEXURE A - Medical Scheme Rates - 2014

SCHEMES ADMINISTERED BY MEDSCHEME

Scheme Name	2014 Rate Increase
AECI Medical Aid Society	6.00%
Barloworld Medical Aid	5.80%
Bonitas Medical Fund	5.80%
Fedhealth	5.40%
Glencore Medical Scheme (previously Xstrata Alloys Medical Aid Scheme)	5.50%
Horizon Medical Scheme	6.00%
MBMed Medical Aid Fund	6.00%
Nedgroup Medical Aid Scheme	6.00%
Old Mutual Staff Medical Aid Fund	5.80%
Parmed Medical Aid Scheme	5.90%
SABC Medical Scheme	5.80%
Sasolmed Medical Aid Scheme	5.80%
University of the Witwatersrand,	5.80%

CLOSED SCHEMES ADMINISTERED BY DISCOVERY, PARTICIPATING IN DPAs FOR 2014

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	Yes	No	No	No
LA Comprehensive	Yes	No	No	No
LA Core	Yes	No	No	No
LA Focus	Yes	No	No	No
LA KeyPlus	No	No	No	Yes
Lonmin Medical Scheme	No	No	No	No
MMED Option of the Naspers Medical Fund	Yes	No	No	No
Naspers Medical Fund N Option Plus	Yes	No	No	No
Naspers Medical Fund N Option Basic	No	No	Yes	No
Quantum Essential Comprehensive	Yes	No	No	No
Quantum Essential Saver	Yes	No	No	No

Quantum KeyPlus	No	No	No	Yes
Remedi Comprehensive Option	Yes	Yes	No	No
Remedi Classic Option	Yes	Yes	No	No
Remedi Standard Option	No	No	No	Yes
Retail Essential	Yes	No	No	No
Retail Essential Comprehensive	Yes	No	No	No
Retail Essential Plus	Yes	No	No	No
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

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

Scheme Name	Reimbursement Rate for 2014						
	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							
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	2014 Rate increase
AECI	6.00%
BARLOWORLD	5.80%
BCIMA	6.00%
Bestmed	5.60%
BMW	7.50%
BONITAS	5.80%
Camaf	6.00%
Cape Medical Plan	8.00%
Carecross	
Commed	6.00%
Compcare	6.00%
De Beers	6.00%
Eternity	6.00%
Fedhealth	5.40%
Furnmed	6.00%
Genesis	7.00%
Grintek	6.00%
Horizon	6.00%
Hosmed	6.00%
Keyhealth	7.00%
Keyhealth Optom	7.00%
Libcare	7.00%
Liberty Health	7.00%
Malcor	6.00%
MASSMART	6.00%
MB MED	6.00%
Medihelp	6.00%
Medshield	6.00%
Midmed	9.80%
MMSA	5.80%
Nedgroup	6.00%
Netcare	6.00%
OCSA	5.50%
Old Mutual Staff	5.80%
Opmed	5.50%
Parmed	5.90%
Pg Bison	5.50%
Platinum	5.50%
Primecure	6.00%

Profmed	6.00%
Providence	6.00%
Resolution	5.50%
Resolution Health	6.00%
SABC	5.80%
Sabmas	5.50%
Sasolmed	5.80%
Selfmed	8.00%
Sizwe	6.00%
Spectramed	6.50%
Spes Bona	6.00%
Status	6.00%
Thebemed	6.00%
Tiger Brands	6.00%
Topmed	6.00%
Umvuzo Health	7.00%
WITS	5.80%
XSTRATA (now Glencore)	5.50%
Yebomed	5.50%