

# Balance billing - It is time medical schemes accept it, it's legal!

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SADA Head Office

The South African Dental Association views the issue of balance billing seriously and highlights its stance on the matter in its latest communication to the Council of Medical Schemes.

The contents of the communication which lays out concerns and their view are laid below:

1. We wrote this to the CMS on behalf of our members who are dentists and dental specialists operating in the private sector.
2. In the present environment, one of the biggest challenges facing dentists as healthcare practitioners is balancing their professional obligations to serve the commercial demands of dental practice.

Every profession always includes elements of both altruism and self-interest, of service to others and service to self, of professionalism and commercialism. No profession ever finds an ideal balance of these elements.

3. Currently, one of the major issues that face healthcare practitioners directly is the setting and collection of fees.
4. The Health Professions Council of South Africa (HPCSA) which regulates the dental profession does permit practitioners to balance bill their patients. However, some of the bigger schemes are refusing to accept balance bills from providers of service to their members.

## Overview

1. There has been a substantial reduction in medical aid scheme pay-outs towards dentistry over the past 28 years, lack of funds to complete ideal treatment procedure, time and costs incurred in telephoning and writing motivation letters to medical aids etc.
2. The percentage changes in healthcare expenditure per average beneficiary per annum (pabpa) from 2009 to 2019 shows the amount paid in real terms on private hospitals increased by 2.76%, and for specialists increased by 4.33%.

Expenditure on GPs decreased with an annual average of 0.24% similarly expenditure on dentists decreased with an annual average of 0.57%. The bulk of medical schemes' total expenditure continues to be paid to hospitals and specialists.



3. Expenditure on primary healthcare providers, general medical practitioners and dentists continue to be overshadowed by the expenditure on specialists, hospitals and medicines dispensed.
4. The out-of-pocket payments (OOPs) being the difference between the claimed amount and the amount that was paid from the medical aid risk for dentists is 6% and for dental specialists at 2%.

The OOPs by splitting the expenditure into proportion from the medical savings account (MSA) and that paid by the member, shows for dentists 4.10% is paid from MSA and 2.19% by the member and for dental specialist 1.09% from MSA and 1.15% by the member.

5. The average number of visits to dental practitioners remained largely unchanged at about 1.8 visits per patient in both open and restricted schemes. About 99% of all dental practitioner consultations took place in out-of-hospital settings.
6. Patients in open schemes rely more on medical savings accounts than risk benefits to fund dental consultations compared with restricted schemes. In addition, the out-of-pocket payment for dental consultations was very high for beneficiaries covered by open schemes.

Beneficiaries in restricted schemes enjoyed more coverage from risk benefits and lower out-of-pocket

payments for dental procedures, which explains the higher utilisation of dentist services by restricted scheme beneficiaries. The large out-of-pocket and MSA payments are likely to disincentivise beneficiaries in open schemes from using dentist services.

7. Patients covered in both restricted and open schemes experienced a higher-than-inflation increase in out-of-pocket payments when consulting dental specialists.



#### South African economic outlook

1. The economic outlook sparked by recessions followed by the onset of the COVID-19 pandemic and the grading by credit agencies has exacerbated the country's economic distress.
2. The South African economy is already mired by the impact of a technical recession from subsequent years including many other macro-economic challenges pre-COVID-19.

Lockdown restrictions have also led to a sharp contraction of the economy. Although government interventions have, to some extent, cushioned the impact on workers and businesses, these have not offset the full impact of COVID-19.

3. The long-run macroeconomic consequences of the current COVID-19 global pandemic is likely to be dire. The COVID-19 induced economic recession is likely to be prolonged with muted demand, lower corporate earnings, higher government debt, rising unemployment rate and dwindling household earnings.
4. We believe that medical inflation, which is the costs both the supply and demand of the healthcare industry continues to track well above CPI. On the other hand, the consumer price index only measures the change in the price level of the market basket of consumer goods and services purchased by households.

We would argue that medical inflation during the last 10 to 12 years has increased by an average of 11.3% per year approximately 5.3% above the Consumer Price Index (CPI).

5. The medical scheme contributions increase rate has consistently surpassed the CPI. The average contribution increase rate of 8.2 % for 2019, as reported by the CMS was double the average CPI of 4.1%.
6. The tariff increases of schemes for the period 2012 and 2020 ranged from 6.3 to 5.1 while the CPI for the same period was 5.6 to 3.0 and the contribution increase rate was 9.7 to 8.2 in 2019.

#### Balanced billing

1. The practitioner who does not have any contract with a medical scheme as preferred provider or otherwise, thus is able to determine his or her own fees for services.

The medical scheme usually pays a rate that has no bearing with the actual costs of the practitioner in providing services and the unsatisfied practitioner is then forced to bill the patient to recover the difference for the services rendered to recover all the costs of services.

2. Medical schemes are deliberately narrowing their dental benefits and shifting more costs onto their members by creating limited benefits and medical savings accounts knowing patients have to pay a greater percentage of their dental bills when they consult a provider of their choice.
3. Balance billing is usually used when the dentist as a health care provider does not have a relationship or contract with the medical scheme or managed care provider and the patient requests that at least some costs up to the extent of their benefits be recovered from their medical schemes and take responsibility for payment for the balance.
4. Patients are often shocked to find that their scheme does not cover the cost of dental treatment from the very first Rand. Patients also seem to have forgotten - or never knew - that most dentists are small businessmen and women who own their own practice.
5. In the present environment, patients who are under increasing financial constraints, are purchasing low-cost medical aid plans, which provide for strict limitations, fewer benefits and restrictions.

The treatment, financial costs, and quality of professional care can be severely affected by the type of medical plan patients belong to.

6. Despite this, patients expect the same levels of benefit and quality and, in many instances still believe the general statement such as "100% cover" by medical aids which no longer correspond with the costs of all aspects of treatment patients may require.

7. The prevalence of medical debt can be partially attributed to the difficulty and confusion that befalls consumers when initially selecting their medical aid coverage. Consumers tend to believe that once they secure medical scheme cover, they will be protected against unmanageable financial outlays from either everyday medical issues or life-changing accidents and illnesses.

Unfortunately, that is not always the case. In fact, a sizeable number of consumers do not understand how medical aid plans operate, restrictions, benefits, pre-authorisation requirements etc, and still, leave it up to practitioners to determine these.

8. Patients who are members of medical schemes with limited dental benefits and financial resources are unable to agree to proposed treatment in the absence of some payment by their medical scheme up to the extent of their benefits and the balance payable by patients. This is especially the case where the dentist has no arrangement, contractual or otherwise, with the medical scheme and simply undertakes to submit accounts to their medical schemes to assist patients.

9. In addition, medical schemes are no longer providing for separate dental benefits, but rather provide for dentistry through "savings" or "day-to-day" benefits, which makes it impossible to assess whether payment for procedures will be affected, as it is never certain what other medically related costs precede the submission of the dentist's account to the scheme.

In many instances where pre-authorisation is provided, payment is withheld or reversed due to the fact that the "savings account" has been depleted subsequent to authorisation having been provided.

10. The reason that members join medical schemes is so that they get financial protection from significant financial strain that is as a result of ill-health. It is therefore a reasonable assumption that whenever scheme members are faced with dental bills they will claim.

From the member's perspective, it is the reason why they join schemes and there is no harm in claiming. The amount claimed includes in most cases includes a very limited amount of dental expenses faced by members as a result of declining dental benefits.

#### Need for schemes to accept balance billing

1. While some medical schemes do permit dental practitioners to submit their balance bill showing total costs of treatment, the medical scheme portion payable and the portion payable by the patient. In this way, the medical scheme has sight of the total cost of treatment.
2. However, some of the bigger schemes are refusing to accept balance bills from providers of service to their members. They argue that their benefit or tariffs are sufficient and do not want their members to be

out-of-pocket. The truth is that their dental tariffs are not anywhere close to the actual costs of providing services by dentists.

3. As patients' medical scheme will only cover part of the costs of treatment, patients are ready and willing to accept treatment only if part of the fees are recovered from their insurance or medical schemes and self-insure for the balance.
4. This process of balance billing is transparent and subject to an informed consent process between the practitioner and patient. The patient has full information on the self-insurance gap over and above the benefits payable by his or her scheme.
5. The Health Professions Council of South Africa (HPCSA) which regulates the dental profession does permit practitioners to balance bill their patients.
6. We would argue that practically and economically, all signs point to the need for all medical scheme to permit balance billing by dentists. If balance billing is not permitted or if the Council does not encourage or regulate medical schemes to accept balance billing across the board, dentists as providers will be forced to set and determine their own fees, disclose to patients upfront that they would be responsible for the entire bill.

Patients should have all the facts to make decisions about their treatment, and that includes full disclosure of potential financial liability. Patients will be liable to settle on completion of treatment and claim reimbursement from their medical scheme up to the level of their benefits.

7. In the light of the above, we kindly request the Council to consider issuing a directive to all medical schemes to permit balance billing by practitioners. Schemes will then pay providers on behalf of their members up to the limits of their benefits and leave the member to pay the balance.
8. Balancing the needs of all the players in South African the healthcare system is a delicate endeavour, but ultimately, medical schemes and members need to stop bankrupting practitioners to provide service at a rate lower than actual costs.