IN THE APPEAL COMMITTEE OF THE COUNCIL FOR MEDICAL SCHEMES

Case Numbers: CMS 16613
CMS 16500

In the matter between:

BONITAS MEDICAL FUND Appellant

and

KJ Respondent

And

BONITAS MEDICAL FUND Appellant

and

HG Respondent

RULING

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[1] These two appeals, lodged separately, raise the same issue. That issue is whether the Bonitas Medical Fund ("the scheme"), on a proper construction of regulation 8 of the Medical Schemes Act, 131 of 1998 ("the MSA"), dealing with payment for prescribed minimum benefit conditions ("PMBs"), may

validly refuse to pay accounts rendered by the respondent doctors in relation to PMBs.

[2] In both appeals, the scheme has sought to limit payment of the doctors' accounts to 100% of the National Health Regulation Price List ("NHRPL"). Both doctors have apparently charged in excess of that tariff, one of them by between 200% and 300% according to the Registrar's ruling. The scheme says 100% of NHRPL is the tariff for which its registered rules provide and that it may not pay in excess of that.

[3] There is no dispute between the parties in either appeal that the conditions in respect of which services were rendered and accounts submitted were PMBs. The only dispute is whether the accounts submitted are payable in full as presented.

[4] The starting point in my view is the Constitution of the Republic of South Africa, 1996, Act 108 of 1996 ("the Constitution"). Section 27 thereof not only provides for the right of access to healthcare (s 27(1)); it also obliges the State to take reasonable legislative measures to ensure the realisation of that right (s 27(2)). That legislative measure has come in the form of a number of Acts of Parliament, among which is the MSA.

[5] Section 29(1)(q) of the MSA obliges medical aid schemes to make provision in their rules for the payment of any benefits according to "*a scale, a tariff or*

recommended guide” or specific prescribed directives. The registered rules of a scheme are binding on, *inter alia*, the scheme (see section 32 of the MSA).

[6] Rule 7.4 of the scheme’s registered rules provides that “*for all PMBs the benefits are only available (except in an emergency)* **at 100% of the fee charged** *or agreed in state … or other designated service providers*” (emphasis supplied). There is no evidence of a rate or tariff that was agreed between the scheme and the doctors. In the result, the scheme is liable to pay “100% of the fee charged”.

[7] In lodging these appeals, the scheme says it relies on a previous ruling of this appeal committee in *Y K v Government Employees Medical Scheme*, where it was held that medical schemes are not, on a proper interpretation of regulation 8 of the MSA, legally obliged to pay accounts, as presented, for services rendered by service providers in respect of PMBs, in circumstances where the registered rules of the scheme make provision for a lower tariff. For one thing, the facts in the Y *K* ruling bear no resemblance to the facts of this case. For another, there was no question in Y*K* of the scheme contravening its own rules. In this case, the scheme’s own registered rules (which are binding on it) provide that PMB benefits must be paid for “**at 100% of the fee charged**”. It cannot now seek to cut the sails of a different yacht to fit the trim of its own yacht. Thus, far from assisting the scheme in these appeals, the Y*K* ruling presents an obstacle to the scheme on the facts here in issue.

[8] In the result, both appeals cannot succeed.

V NGALWANA for the appeal committee

Date of Hearing: *08 May 2008*
Date of Ruling: *19 May 2008*