# DPA submission to Bonitas Medical Scheme regarding dental benefits and Denis Network Agreement

## 1. Introduction

A common thread that connects the annual reports of Bonitas Medical Scheme is the need to contain rising healthcare costs. Much less is said about the provision of healthcare which is of high quality, accessible and cost effective. The management of healthcare costs is indeed the prerogative and responsibility of medical schemes but it needs to be balanced with access to quality healthcare which is the primary reason that people would sacrifice all other comforts in order to make contributions towards a medical scheme.

For instance, in the Bonitas annual report for the financial year that ended 2013, it was reported that membership contributions had increased 20. 8% year on year. In the same report however, when the breakdown of claims to the scheme was analysed, the proportion of dental claims had declined from 9% to 4%. Similarly, the claims by general medical practitioners had declined from 16% to 7%. It is common cause that general practitioners and dentists are the bedrock of any healthcare system and the decline in their remuneration should therefore be alarming.

Coincidentally, the decline in the remuneration of primary healthcare practitioners has coincided with an increase in the remuneration for managed care services. The increase in the remuneration of managed care services increased by a whopping 43% between 2012 and 2013. The strategy of Bonitas to contain healthcare costs by progressively increasing managed care interventions has thus succeeded to the extent that funds have been diverted from healthcare to non-healthcare expenditure. The total expenditure for the scheme increased by 19% between 2012 and 2013. This begs the question: where are all the much vaunted savings going and, most importantly, are the patients receiving the quality healthcare for which they pay so dearly?

The question may be rhetorical, but it worth noting that with a total of 75 563 new approved members, a net membership growth of 23 495 was recorded. Put differently, more than 52 000 members left the Bonitas medical scheme between 2012 and 2013.

## 2. Bonitas Dental Benefits

All the different options that make up the Bonitas Medical Scheme have dentistry as a benefit which suggests that the scheme believes that dental benefits are important in the basket of services that members require from a medical scheme. The dental practitioners have however been experiencing a steep and consistent decline in the dental benefits available to members of Bonitas medical scheme.

Using the data contained in the Bonitas Annual Reports, the total funds allocated towards dental benefits have increased by an average 2.58% per year between 2010 and 2014. This is less than half the average rate of inflation (CPI) of 5.22%. It also pales into comparison

with the increase in member contributions over the same period which was 46. 63%. Clearly, the contribution increases are not contributing towards better dental benefits. As shown by table 1 below, the share of dental benefits as a percentage of member contributions has declined from 5. 05% (2010) to 3. 92% (2014). This is particularly significant given that Bonitas is the second largest open medical scheme in the country and any decline in benefits will have systemic effects throughout the private healthcare system.

The decline is actually more pronounced over the longer term but a five year period was used due to the readily available data sources on the Bonitas website.

Table 1: Dental benefits as a percentage of member contributions

| | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| **Dental Benefits** | 343565 | 338318 | 346569 | 339889 | 387855 |
| **Contributions Income** | 6797119 | 7077910 | 7555025 | 9080411 | 9898559 |
| | 5.05% | 4.78% | 4.59% | 3.74% | 3.92% |

Denis has been a dental managed care partner for Bonitas since at least the year 2005. Over this period, dentists have been subjected to various managed care strategies in the form of sub-limits, time rules, procedure exclusions, age related exclusions, pre-authorisations, and designated service provider contracts. This is all in addition to below inflation tariff increases. The total effects of all these manoeuvres has been the financial destruction of dentists, but more ominously, it has made access to quality dental care inaccessible to the members and beneficiaries across all the Bonitas options.

The managed care contract between Bonitas and Denis is of a capitated model whereby the total risk of dental benefits is transferred to the managed care provider in return for a premium (risk transfer premium) that is paid upfront by the scheme. In addition to the premium, the scheme also pays the managed care provider an administration fee (risk transfer arrangements). The breakdown of the transfers from the scheme (Bonitas) to the managed care provider is reflected in table 2 and figure 1 below.

Table 2: Risk transfer arrangements as a percentage risk transfer premiums

| | 2010 | 2011 | 2012 | 2013 | 2014 |
|---|---|---|---|---|---|
| **Risk Transfer Arrangements** | 94714 | 79718 | 103872 | 91791 | 80668 |
| **Risk Transfer Premiums** | 343565 | 338313 | 346569 | 339889 | 387855 |
| | 28% | 24% | 30% | 27% | 21% |

From the above table, it is clear that the administration fees paid to Denis are on average about 26% of all the funds that the scheme pays towards dentistry, benefits and administration included. Denis thus get reimbursed at least one rand, for every three rands under its management. Given the nature of the capitated model, Denis is likely earning up to 40% of all the funds that Bonitas allocates towards dentistry. This is a plunder of scarce healthcare

resources by any definition. Instead of a risk transfer to the managed care partner, the real risk is transferred to the patient and the dentist, to the obvious detriment of both and the health system.

Figure 1: Comparison of spending on dentistry by Bonitas medical scheme.


## 3. Managed Care

The Council for Medical Schemes (CMS) defines managed healthcare, in the South African context, as a range of diverse healthcare and organisational strategies aimed at **controlling cost, improving access and assuring higher levels of quality care** provided to those covered by medical schemes[1]. The reference to "the South African context" is relevant given the fact that in South Africa, managed care organisations need not be healthcare providers or healthcare funders but may be anybody who is able to meet the minimum accreditation standards. It is also worth reiterating that managed care is not only about controlling costs but it should also result in improving access and providing high quality of care.

The CMS in one of its managed care policy documents[2] raised concern about the following issues related to managed care:

- The effects of managed healthcare in terms of improving quality healthcare outcomes may be impossible to ascertain.
- Perverse incentives may be created for healthcare providers to maximise profit through under-servicing.
- Managed healthcare may result in obstacles which decrease access to quality healthcare through: hidden limitations on benefits; unreasonable restrictions on choice of provider, or complex and bureaucratic procedural requirements.

[1] Council for Medical Schemes. Accreditation Standard for Managed Care Organisations, Version 4. November 2011.

[2] Council for Medical Schemes. Managed Healthcare Policy Document, Version 1. August 2003.

- Managed healthcare may result in increased expenditure by medical schemes through additional administrative burdens.
- Contractual arrangements may be used by stakeholders to inappropriately remove the reserves of medical schemes.

4. Limitation of benefits

The entirety of the managed care protocols of Denis are basically designed to limit benefits to members, limit access to healthcare and provide a low quality of healthcare. The interaction of the above, in addition to below inflation tariff increases gives an impression that managed care is effective in controlling cost.

Reference will be made below to some of the rules and protocols that are contained in the Bonitas benefit guide[3] to illustrate how healthcare benefits are severely limited. The Bonitas Standard Option will be used as a reference. The format for illustration is similar to the one used in the dental benefit guide.

| **Dental benefit table** | **Standard option** | **Limitation on benefits** |
|---|---|---|
| **X-rays: intra-oral** | • Benefits subject to managed care protocols. | • Benefits are limited to two (2) intra-oral x-rays per visit, to a maximum of four (4) per year. This severely limits the ability to assess and diagnose dental diseases appropriately. It follows that the treatment plans will be sub-optimal. |
| **X-rays: extra-oral** | • 1 per beneficiary in a 3 year period. | • It is a multi-year benefit limitation which is arbitrary and it imposes a financial burden on patients who may consult with multiple dentists or specialists within the period. It is disastrous in cases with post-operative complications. |
| **Oral Hygiene** | • 2 annual scaling and polishing per beneficiary. | • The managed care protocols limit this benefit to patient below the age of 12. There is no clinically valid reason for the limitation. The exclusion of oral hygiene evaluation and fluoride treatment, for patients above 16, is arbitrary and without clinical validity. |

[3] Bonitas Dental Benefit Table 2014. Availabe at: www.denis.co.za

| | | |
|---|---|---|
| **Fillings** | **Scheme exclusions:**<br>• Fillings to restore teeth damaged due to toothbrush abrasion, attrition, erosion and fluorosis. | • The exclusions defeats the purpose for fillings which is to restore teeth to original form and function. The exclusion has no clinical validity. |
| **Root canal treatment** | **Scheme exclusion:**<br>• Direct and indirect pulp capping | • Pulp capping is the first line treatment for teeth with deep caries that approximates the pulpal tissues. Successful pulp capping conserves the tooth and avoid extractions or complete root canal treatment which is more expensive. |
| **Plastic dentures and associated laboratory costs** | • 1 set of plastic denture every 4 years.<br>• No clinical benefit for repairs to denture.<br>• No laboratory fee for mouthguards.<br>**Scheme exclusion:**<br>• High impact acrylic<br>• Provisional dentures and associated laboratory fees. | • Multi-year limitation which is arbitrary. It assumes a static disease process.<br>• There is no valid reason why a clinician should not be reimbursed for this service.<br>• Patients who participate in contact sports cannot be protected from injuries to teeth and jaws.<br>• It is highly indicated in patients with traumatic occlusion and it prevents fractures to dentures.<br>• They are absolutely indicated to restore form and function and to allow for healing of sockets of recently extracted teeth. |
| **Partial metal frame dentures and associated laboratory costs** | • 1 partial frame per beneficiary per year | • Multi-year limitation that is completely arbitrary. It excludes concurrent treatment of both mandible and maxilla. |
| **Crown and bridge and associated laboratory costs** | • 1 crown per family per year | • A family benefit that effectively excludes the treatment by means of crowns and bridges from the benefit schedules of the scheme. |

| | | |
|---|---|---|
| **Implants and associated laboratory costs** | • No benefit | • Limits access to quality healthcare and new technologies. |
| **Orthodontics and associated laboratory costs** | • Benefit only granted to patients under age of 18.<br>• Benefits funded at 80% of BDT.<br><br>**Scheme exclusion:**<br>• Orthognathic surgery | • Children previously without medical cover may possibly never receive treatment.<br>• 20% co-payment increases the cost of treatment for the member and limits access.<br><br>• Limits access to quality healthcare. Severe cases of malocclusion will go untreated. |
| **Periodontics** | **Scheme exclusions:**<br>• All types of periodontal surgery, including gingivectomies. | • They are all exclusions that limit access to quality healthcare and cannot be clinical justified |
| **Maxillo-facial surgery.** | • Biopsies are only paid upon a report that confirms a diagnosis | • Biopsies are by nature special investigations which may or may not reveal a pathology. A requirement of a positive pathology diagnosis before reimbursement is unethical. |
| **Hospitalisation** | • Only children under the age of 5 can be treated under general anaesthesia | • This is the lowest threshold in the industry and it is both immoral and unethical. |

The above is only a snapshot of the totality of the exclusions and limitations of benefits. Other salient forms of exclusion and limitation of benefits include:

- Family and beneficiary limits and sub-limits which are not openly communicated.
- Non-payment for the cost of dental materials (e.g. mineral trioxide).
- Bureaucratic processes regarding pre-authorisation (crown and bridge).
- Family benefits where treatment of one member automatically excludes treatment of other beneficiaries (orthodontic treatment)
- Time limit rules (dentures).

5. Enter the Denis Network Contract

The Denis Network Contract is an unprecedented development in the healthcare system of the country. The triumvirate of the healthcare provider, medical scheme and member is being merged into one gigantic monster which will become a monopoly provider and funder of dental services.

It is already the case that Denis is providing dental managed care to the majority of medical schemes in the country. In this manner, the differentiation that exists between different schemes and options within schemes has been obliterated through the utilisation of common

and standardised rules and protocols. Schemes have gradually and completely lost the capacity to manage dental benefits and this function has been outsourced to managed care companies. The result is that Denis and a few other managed care providers would then become the de-facto providers and funders of dental benefits.

Having captured the medical schemes, the designated provider networks is the second frontier in the monopoly endeavours of Denis. Currently, the monopoly ambitions of managed care providers are being frustrated by providers who reject the managed care rules and who demand co-payments from their patients, for services rendered but that fall outside the scope of the protocols. The solution is thus to exclude from the network and reimbursements those providers who are seeking to provide a differentiated service. Differentiation is the opposite of standardisation which is the goal of managed care. Providers are thus being coerced into joining the networks with the real threats of exclusion from reimbursement. Such exclusion for many providers will automatically lead to financial destruction since most providers in private practice rely on the reimbursements from medical schemes for services rendered.

However, even those providers who would have joined the Denis Network will very quickly realise that they have entered into a deal that takes away their professional independence and puts their decision making and future into the hands of an entity, whose primary motive is not the provision of healthcare but the maximisation of profits to institutional investors. Being a member of the network the provider gives up the right to set his or her own treatment standards and protocols, and cannot negotiate payment with patients. It is obvious that their financial destruction is certain but will be postponed until the benefits and tariffs fall below a particular threshold.

It is already the case that access to quality healthcare of members is already compromised but the quality will decline rapidly under the designated provider model. Patients will lose confidence in their providers and medical schemes and will vote with their feet or downgrade to lower options which offer basically the same level of standardised benefits as higher priced options, for a fraction of the premium. There is a real risk therefore that the private medical system will collapse with adverse consequences for the entire health system.

6. Whereto for the DPA

The DPA has taken a principled decision to reject all the network contracts, including the Denis Network Agreement. The organisation obviously does not have the power to prevent individual members from joining the networks but it only requires a fraction of the members to decline participation before the scheme collapses. It will collapse due to members showing displeasure with their schemes and thus cancelling their memberships. We are equally conscious to the pain that our members will endure in the process.

The designated provider networks are not unique to dentistry and they exist across all areas of healthcare. A real opportunity thus exists to forge alliances with other professional organisations that have similar concerns and collective action across the industry will thus become a real possibility.

However, it is clear that there are systemic risks that are in existence which require a multi-pronged intervention at a political and regulatory level. In the short term, we shall take our case to the CMS to focus its mind on the risks to the medical scheme industry and to request specific scrutiny of the contacts between the medical schemes and managed care companies. The Competition Commission is the other regulatory that we shall approach to

investigate the anti-competitive practices of medical schemes and managed care companies. Finally, fundamental changes can only occur at the political level and engagement at that level is already underway.

7. Whereto for Bonitas

The relationship between the membership of DPA and members of Bonitas is a dynamic one that is both historical and continuous. The members of Bonitas are predominantly the Black middle class that is employed by the government or parastatals. They live in township areas and they depend largely on the Black dentists and general practitioners for their healthcare needs. The relationship has been cemented by the relationship of trust that providers will be properly reimbursed by the medical scheme, into which the members pay monthly contributions. Managed healthcare has unfortunately done a lot to damage the relationship and providers are no longer able to provide the best possible healthcare to the members of the scheme given the severe restrictions and limitation of benefits.

We urge the management of Bonitas to immediately do the following:

a) Assess the impact of its managed care relationship with Denis on access to quality of dental healthcare for their members.
b) Analyse the value of the managed care contract with Denis given its costs and the limitation of access to dental healthcare for its members.
c) Set aside the application of the Denis Network Contract and designated provider networks across all the Bonitas options.
d) In the medium-term, review the allocation of dental benefits within the basket of healthcare benefits, including managed care arrangements that the scheme offers to its members.

8. Conclusion

The submission has attempted to highlight the deterioration of dental benefits over a period of time to a point whereby the members have had access to dental healthcare severely curtailed and the financial situation of dentists has deteriorated as a direct result. It is our contention that the decline in the remuneration of dentists and limitation of benefits is directly related to the profit motives of Denis, the dental managed care provider of the scheme. The sheer costs of the managed care contract and the disproportionate benefit from the scheme expenditure cannot be justified and it amounts to a plunder of scarce healthcare resources.

The Denis Network Contract and its designated provider networks is an audacious attempt to wrestle control of the funding and supply of dental benefits in South Africa. The capacity to manage benefits is being eroded from medical schemes and providers are being coerced into low benefit contracts. Those who resist will be ruined financially through financial exclusion. This will result in monopoly pricing for services by the managed care companies from the funders and the providers. The result will be the transfer of profits from the providers and the reserves from the schemes to the managed care company. Ultimately, the entire private health system will experience financial strain and it will collapse, to the detriment of all.

The interaction with the management of Bonitas should thus be seen as an effort to mitigate the real risks that are facing the dental professionals in particular, and the healthcare industry in general. It is our hope that the scheme will respond responsibly to manage the

risks due to its leadership position in the intermediation of healthcare funding, in the interest of its members and the healthcare system.