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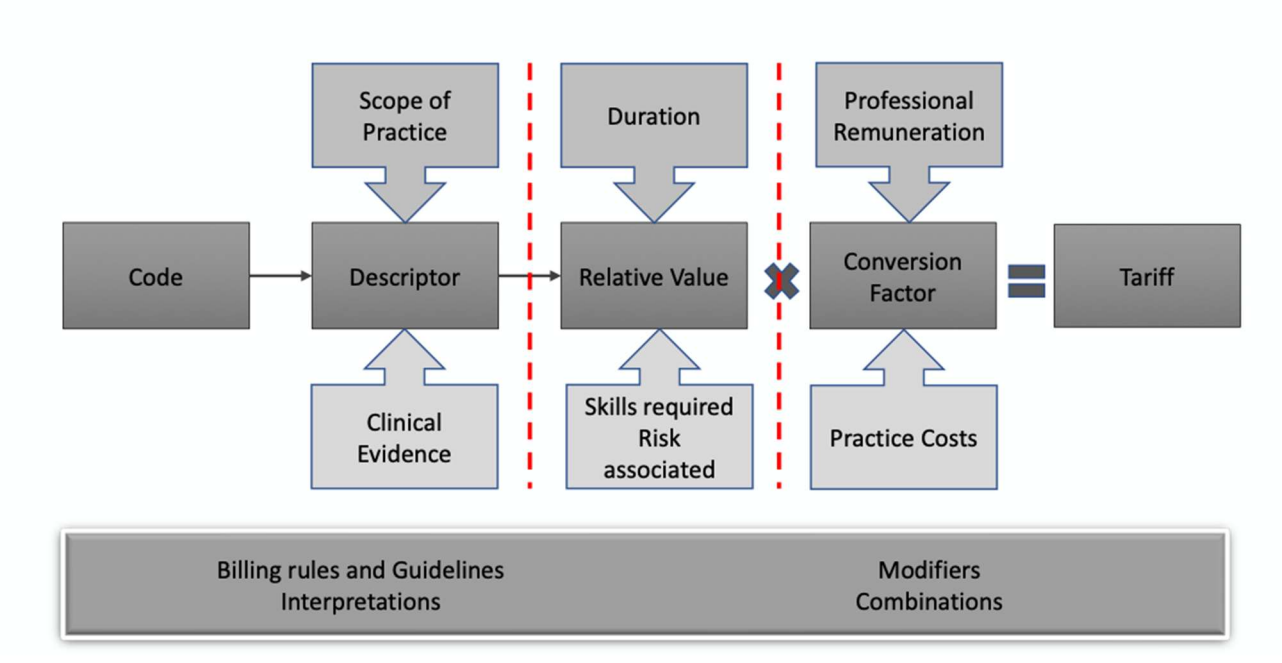
## 1. Background to Benchmark Tariffs (by Dr Sophia van Rooyen)

A benchmark tariff scientifically determined by experts and taking into account different input factors, provides a valuable reference on what can be accepted as a reasonable cost for delivering health care services. Cost calculations should include inputs for Relative Value (durations, skills required, risk associated) and Conversion Factor




(professional remuneration and practice costs).

In most countries the Codes, Descriptors, Relative values, Billing rules and Guidelines, Modifiers and sometimes Relative Units are based on internationally accepted procedure coding schedules. Examples are the American Medical Association's (AMA) world renowned CPT Codes and South African Medical Association (SAMA) Medical Doctors' Coding Manual (MDCM). Provider organisations most often have

the copyright to these resources and maintain the content by input from panels of clinical experts.

Providers associations frequently publish discipline specific coding schedules based on these accepted procedural codes. These contain refined interpretations of consensus on definitions of descriptors, billing rules and guidelines, modifiers and relative values as part of clinical governance. An example would be the Psychiatric Management Group (PsychMg), formed from members of South African Society of Psychiatrists (SASOP) that developed a very detailed Psychiatry Procedural Coding Structure.

Provider associations frequently determine benchmark tariffs for reference by their members. SASOP commissioned Healthman to determine yearly benchmark tariffs for their members. Conversion factor inputs of professional remuneration and practice costs are based on research done. Providers must decide what tariffs they claim and are held responsible for their decision by their mandated regulators.

In South Africa the Department of Health (SADH) publishes the National Health Reference Price List (NHRPL), which is frequently referenced when benefits are described. Because NHRPL is very low, the tariff is not considered reasonable, and funders pay much more than 100%. Provider organisations calculations of their benchmark tariffs based on cost, are usually considered to be around three times the NHRPL.

## 2. Background to NAMAF Benchmark Tariffs

In contrast to international practices, NAMAF unilaterally decides on benchmark tariffs, which medical aid funds (who make up NAMAF) may choose to use as a reference for benefit descriptions. At present, all registered medical aid funds in Namibia use the NAMAF coding schedule and benchmark tariffs.

Namibia Medical Care (NMC) informs their members via their website and AGM 2022 that:

*"The tariff amount is what the medical aid fund covers, which is based on the NAMAF benchmark tariffs. The Fund mostly pays according to the NAMAF tariffs. These tariffs are calculated based on what it would cost a health professional to render the service, as well as their respective expertise."*

Namibia Health Plan (NHP) states on their website:

*"The NAMAF benchmark tariff is a guideline tariff used by the medical aid fund indicating the maximum rate at which the medical aid fund is willing and able to reimburse for the services charged."*

NAMAF describes their benchmark tariff as a guideline to the reasonable cost of specified categories of medical services in Namibia.

Historically, NAMAF used the SAMA coding schedule and Board of Healthcare Funders (BHF) tariffs as the basis for their initial compilation of NAMAF benchmark tariffs. However, it remains unclear how NAMAF obtained copyright permissions from SAMA. Additionally, the BHF/NHRPL tariffs were set so inappropriately low that NAMAF significantly increased consultation tariffs around 2006. Consequently, medical aid funds decided to cover in-hospital procedures at NAMAF plus 125% to reduce member out-of-pocket payments and correct the tariff lag behind South Africa.

In their 2018 Annual Report, NAMAF declared that they had never conducted any costing analysis. They reported conducting a survey of billing behaviours in 2009, just after the tariff increases, and found that most healthcare providers were charging NAMAF benchmark tariffs. As a result, NAMAF concluded that:

*"The benchmark tariffs were reasonable at that stage, and a strategy was adapted to maintain those levels adjusted for inflation."*

Namibia is among the few countries -if not the only one- where private health care funders not only determine benchmark tariffs and monetary conversion factors at their discretion but also exercise exclusive control over procedure codes, descriptor

interpretations, and billing rules/guidelines—functions that, in most international systems, are handled through collaborative or professional regulatory frameworks.

NAMAF **explicitly states** that it **does not engage in negotiations** when setting benchmark tariffs. Furthermore, billing rules and guidelines are also not open for negotiation.

Since 2018, NAMAF **has restricted access** to **coding schedules, descriptors, billing rules and guidelines, relative units, monetary conversion factors, and benchmark tariffs.** These documents are **no longer publicly accessible**, nor are they **available to fund members or patients**. Healthcare providers can only access their own discipline's coding schedule.

**3. Forced Implementation of ICD-10 as a Precondition for Payment**

In addition to its monopolistic control over tariff setting, NAMAF mandates the continued use of the outdated ICD-10 coding system as a precondition for medical aid claims processing and payment, despite the availability of ICD-11. This requirement is imposed through fund rules, even though the MAF Act and its regulations do not explicitly grant medical aid funds the authority to determine coding schedules. The latter should fall within a standardized and collaborative regulatory framework.

NAMAF's forced introduction of ICD-10 lacks a legal basis and is enforced purely through coercion, amounting to regulatory overreach and abuse of public power. As highlighted in previous legal opinions, including that of Adv. Tötemeyer (SC), NAMAF's setting of benchmark tariffs has already been deemed unconstitutional. By extension, NAMAF's unilateral imposition of ICD-10—without lawful authority—mirrors this unconstitutional conduct.

NAMAF's narrative that it is *"mandated to manage the affairs of medical aid funds"* is particularly alarming. NAMAF is not mandated to *manage* medical aid funds but to *regulate* them. This persistent misrepresentation underscores NAMAF's disregard for the legislative intent behind its establishment and its failure—since 1995—to implement and enforce the necessary rules to regulate medical aid funds effectively.

## 4. Summary of the Namibian Benchmark Tariff Debate

The debate surrounding NAMAF's benchmark tariffs (BTs) requires careful differentiation between the legitimacy of producing BTs and NAMAF's unconstitutional overreach in controlling the entire medical billing process. A benchmark is a reference standard, while a tariff is a monetary fee for a service. Producing a BT, in itself, is not unconstitutional. Any entity—including independent healthcare practitioners—could theoretically produce a BT that others may choose to reference.

However, NAMAF does not merely produce a BT; it claims exclusive control over:

- The designation of its tariffs as the **Namibian Benchmark Tariffs (NBT),** misleadingly implying national standardization.
- The selection and inclusion of procedure codes for each discipline.
- The sole interpretation of descriptors, billing rules, guidelines, and modifiers.
- The assignment of Relative Unit Values (RUVs) and conversion factors, without a transparent, scientific basis.

NAMAF dictates these processes without negotiation, transparency, or provider input, rendering the system unaccountable and arbitrary. This monopolization of BTs by the funding sector is inconsistent with international conventions, where coding structures are determined through collaborative frameworks.

## 5. Conclusion

NAMAF's approach starkly contrasts with international best practices observed in countries where medical associations such as the AMA and SAMA facilitate open negotiations on coding, tariffs, and reimbursement structures. In these jurisdictions, standardized coding systems like CPT and ICD-11 are used transparently, with healthcare professionals actively participating in tariff-setting discussions. However, global coding experts following these approaches argue that tariff-setting should go beyond mere participation—healthcare professionals must lead the process, as coding structures define the scope of practice for a profession.

NAMAF's assertion that it is *"mandated to manage the affairs of medical aid funds"* is an unequivocal misrepresentation of its statutory role. The legislator never granted NAMAF the authority to control fund management decisions or dictate professional billing structures. Since its inception, NAMAF has refused to implement the regulatory rules required to govern medical aid funds. This failure has enabled NAMAF to position itself as an unaccountable authority, making arbitrary decisions without oversight.

The medical professions are authorized to determine the scope of practice (**see the table under point 1**) and therefore globally retain authority over coding interpretations, ensuring that tariffs are set in alignment with best practice procedures and in consultation with all relevant stakeholders rather than being dictated by funders. Just as healthcare professionals have no jurisdiction to design medical aid benefits, funders have no legal authority to determine professional billing structures.

NAMAF's ongoing overreach of regulatory power not only exceeds the authority provided under the MAF Act but also disrupts the balance between professional autonomy and funding mechanisms. This deviation has resulted in an obscure and unaccountable system that prioritizes cost containment over equitable reimbursement for healthcare services, ultimately disadvantaging both healthcare providers and patients in Namibia.