SQUIRE SANDERS

PROVISION OF HEALTHCARE – UNEASY SITUATION FOR MEDICAL FACILITIES AND PATIENTS

Imagine there is a new treatment for a seriously ill patient, but it is not covered by insurance companies. What can be done in such a situation?

The Charter of Fundamental Rights and Freedoms entitles citizens to free healthcare and medical aid based on public health insurance under the conditions of the Act on Public Health Insurance. This act guarantees payments for care provided to improve or preserve somebody's state of health or to reduce suffering, relative to the patient's state of health and according to available knowledge of medical science and the existing evidence of its effects. If it is possible to provide care while meeting these requirements, using more than just one method with identical therapeutic effect, the method which makes efficient and economic utilization of sources, the so-called basic version, will be covered. Other methods of care are covered in the amount of payment for the basic version. Nonetheless, care that can be provided using a single method only cannot be considered a less economical version.

Of course, provision of care also depends on objective conditions and the capacity of a specific medical facility. The providers receive payments for care, in principle, based on agreements with health insurance companies. Under the law, the only time when an agreement is not necessary for payment of care is in the case of emergency care.

Payment Decree

Whether the cost of healthcare is covered is dependent on the agreement between the patient's insurance company and the given medical facility. The extent of coverage stipulated in annual amendments is based on the so-called payment decree of the Ministry of Health. This decree stipulates regulatory limits for payments to various providers of healthcare based on a certain reference period (now the year 2011). The decree in many cases prescribes that medicaments will be covered at a level lower than in 2011, ignoring the fact that their price in a number of cases has increased.

The decree applies if the provider and the insurance company fail to agree otherwise, which is rare in practice, though exceptions may include cases where the insurance company and the provider are a part of a single ownership structure. Rarely, upon the express request of specific physicians in certain situations, the auditing physicians of insurance companies may approve a payment above the level agreed. Often, these are cases extensively covered by the media – for example, the recent "wheelchair case".

So how should patients proceed? Should they arrange care for themselves in a facility that does not have a contractual arrangement for coverage with the insurance company but will provide the patient with a new kind of treatment for a direct payment, or should they accept care by another contractual provider within the public health insurance system? Are we in the situation where insurance companies can actually decide which providers will provide healthcare to insured persons? Or is it the insured person who may freely choose a physician or hospital that they trust and whose treatment would be covered by the insured person's insurance?

Why Sue Insurance Companies?

Perhaps the time has already come where patients should assert their rights and sue their insurance companies for not providing due payment for healthcare as guaranteed to patients by the Charter of Fundamental Rights and Freedoms and the Act on Public Health Insurance. Patients' legal actions against health insurance companies are usual in the US and Western European countries. If a patient finds that there is a more advanced and effective method or medicaments that the medical facility can provide, the patient should apply to his/her insurance company for payment for such treatment, at least up to the amount of the so-called basic version.

What about the providers willing to go beyond the contract with the insurance company? The Czech Republic Supreme Court has issued a judgment (file no. 25 Cdo 3507/2008) in favor of providers, stating that stipulated financial limits do not apply in the case of vital and emergency care.

A ruling of the Constitutional Court (file no. I. ÚS 2785/2008) goes even further, stating that there are also other situations where the agreed level of healthcare can be surpassed, for example, an increase in the number of patients of the given insurance company and prescription of medicaments for chronically ill patients. Thus, by referring to this case law, providers of healthcare could succeed in court with requests for payments above the level of the agreed limits. Nonetheless, as the agreements between providers and insurance companies are entered into for a definite period of time, the providers might worry that the insurance companies will not enter into new agreements with them.

In March, 39 senators filed a motion with the Constitutional Court for revocation of the payment decree. It will be interesting to see what position the court takes. Directive No. 2011/24/EU on rights of patients in cross-border provision of healthcare might provide also a new impetus. Under this directive, patients are entitled to undergo treatment abroad if the waiting period in their home state is too long or the medicaments are not available, and the costs of such treatment should be paid out of public insurance – at least up to the amount of the so-called basic version. If this should work across borders, it would be a good argument why it should also be possible domestically.

Contact

Marketa Topinkova
Local Counsel
T +420 221 662 267
E marketa.topinkova@squiresanders.com

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