Why doesn't my medical aid pay for it?

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Medical schemes can be very confusing to consumers. If you're working in a community pharmacy, they can be just as confusing to you. It's also quite upsetting when consumers ask you why their medical scheme won't pay for something. In this article, we'll examine a few reasons why the medical scheme may not pay for goods and services.

The type of medical scheme plan

At this stage, there's no such thing as a one-size-fits-all medical scheme. Although we are moving towards Universal Health Coverage, which will be paid for by the National Health Insurance fund, at this stage people wishing to buy goods, such as medicines, and services, such as doctor's visits, in the private sector must pay for these themselves.

Many people opt to get some kind of financial protection by joining a medical scheme. They pay a monthly contribution, called a premium, in exchange for assistance in paying for healthcare services, such as doctor's visits and medicines.

There are different plans available which meet your needs at different stages of life. The lowest fee is for a hospital plan, which generally covers only in-hospital expenses. This usually suits young and healthy people. As their family grows, though, and definitely as they get older, many people choose to change the plan to one which covers other benefits, such as doctor visits and medicine.

Savings plan

Some medical schemes have a savings plan. Part of the monthly premium paid goes into a medical savings account (MSA), which is there for the member's benefit only. It does not go into a pool of money that is used to pay for everyone's claims. At the beginning of the year, the medical scheme calculates how much the member will pay over the year, and this amount is put into the MSA upfront. So it is received in advance, and not just when the monthly payments are made.

Also at the beginning of the year, the medical scheme calculates an annual threshold for the member. This is the amount that must be paid, whether from the MSA or from the member's pocket, before the medical scheme will pay for medical expenses. This will differ from member to member, depending on the number of dependents they have, as well as the ages of the dependents.

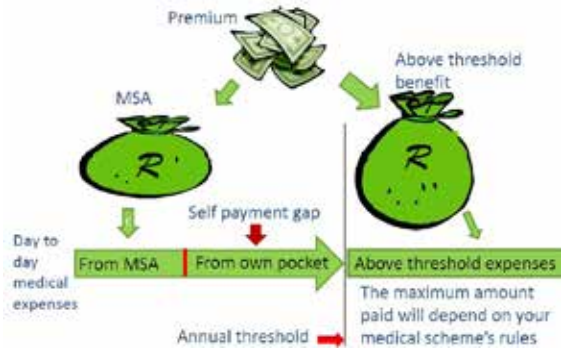
Initially during the year, the MSA is used to cover the day-to-day medical expenses. This includes doctor and dentist visits, laboratory tests and X-rays. It is also used to pay for medicines for acute use, including non-prescription medicines. Some, but not all, chronic medicines, for which you have obtained prior authorisation, are paid for from a different risk pool so they won't use up the money in your MSA.

If you have remained healthy during the year, there may still be money left in the MSA at the end of the year. This will be carried over to the next year. This, however, does not happen very often.

Self-payment gap

In most cases, the MSA runs out of money at some stage. The member then enters the self-payment gap. This means that day-to-day medical expenses must be paid out of the members own pocket, until s/he reaches the amount that was calculated to be the annual threshold. Although the medical scheme will not pay for these expenses, the member must submit the information to the medical scheme, so that it knows when the annual threshold has been reached.

The self-payment gap can occur at different stages for different people. You need to understand what this is and what the implications are for the medical scheme member, so that you can explain it to the member.



Explaining the self-payment gap

Above threshold expenses

The medical scheme will begin to pay for day-to-day expenses after the annual threshold has been reached. The member is then in the above threshold stage. Over-the-counter medicines will not be paid for by the medical scheme from the above threshold benefits. These must be paid directly by the member of the scheme.

Formularies

Medical schemes generally have formularies, i.e. a list of medicines for which they are prepared to pay for treatment of specific conditions. These are often generic medicines, and if a patient insists on buying a branded product, s/he will have to pay the difference in price between the formulary price and the selected product.

Prescribed minimum benefits

To ensure that people receive at least the minimum health services required, medical schemes are obliged to provide certain defined benefits for specific conditions and situations, namely the prescribed minimum benefits (PMB).

Medical schemes must fund these benefits, regardless of which medical scheme plan has been chosen by the member.

These benefits are:

- Medical emergencies
- A limited set of 270 serious medical conditions that may be life-threatening if not treated appropriately
- 25 chronic conditions, including asthma, diabetes, epilepsy and hypertension

The member of the medical scheme must register the chronic condition with the medical scheme. It must be remembered that the medical scheme may require the conditions to be treated with medicines from the formulary. If the doctor prescribes medication that is not on the list, the patient will be obliged to pay the co-payment.

The reason for payment for the PMB services and medicines is in order to keep the member healthy. In this way, emergency situations can often be avoided, as well as expensive and serious complications associated with the condition.

Designated service providers

Most medical schemes have designated service providers. This means the members must go to specific doctors or specific pharmacies. If they choose to go to a doctor or pharmacist who is not a designated service provider, they will usually be obliged to pay a co-payment.

Explaining the benefits and limitations

Although it is unpleasant to have to explain these concepts to patients, it is sometimes necessary to do so because nobody else has done it.