10 gaps in your medical scheme cover

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By Laura du Preez

If there was ever a time when medical scheme members believed that their schemes covered all, or virtually all, their expenses, it was a long time ago.

More recently, we, as medical scheme members, have been facing both rapidly rising contributions and increasing gaps in our cover.

Medical schemes, in turn, are facing rising costs as a result of new medicines, medical practices, technologies and research that is more complex.

In addition, we are living longer but with more illnesses that are chronic and this has resulted in schemes facing higher, and increasingly expensive, claims.

The medicines and medical practices that are used to treat us have become a lot more sophisticated and a lot more expensive, and there are better ways of diagnosing what is wrong with us. While the merits of medical schemes funding these treatments for their members collectively and individually can be debated, you may be confronted with a significant shortfall in your benefits if you want or need a therapy other than what your scheme provides.

Cost pressures typically result in one of three things: increases in your contributions, or cuts in your benefits, or both.

To make members' benefits go further, schemes have implemented a number of different measures that involve controls on the healthcare services you access or negotiations with the providers you consult. These measures can have cost implications for you, particularly if you do not follow your scheme's increasingly complex rules.

To avoid incurring medical bills that your scheme does not cover in full, you should understand how these gaps can occur and the ways in which you can minimise them within your scheme. Here are 10 common gaps and some ways you can avoid them:

1. YOUR BILLS EXCEED YOUR BENEFIT LIMITS

One of the most irritating lines on a medical scheme statement is the one that states you have exceeded your benefit limit. It means that your claim amounts to more than the benefit provided by your scheme.

Schemes have two kinds of limits: an overall limit on the benefits paid during the course of a year and annual sub-limits on different kinds of benefits.

Most schemes have sub-limits on certain benefits, and you will find yourself paying out of your own funds if you exceed these limits. The sub-limits may confine the benefits to a rand value or they may be restricted to a certain number of consultations or services, such as 12 general practitioner (GP) consultations or one pair of glasses every two years.

While some sub-limits may appear reasonable, one expensive incident can result in your exceeding the limit. For example, an annual limit of R3 000 for dentistry may seem reasonable, but the benefit would be inadequate for larger families.

2. DOCTOR’S RATE IS HIGHER THAN SCHEME’S RATE

The number of specialists who practise in South Africa has declined rapidly in recent years, while the demand for their services has increased.

The law of supply and demand has enabled specialists to charge higher fees, and medical schemes cannot meet many of these tariffs. At the same time, medical schemes have reduced the rates at which they are willing to reimburse specialists. The result has been a widening gap between what schemes pay and what specialists charge.

The shortfall between what your specialist charges (the private rate) and what your medical scheme refunds you (the medical scheme rate) is known as the tariff shortfall.

There are two ways to close the gaps in cover that result because your doctor charges more than your scheme reimburses. One way is to use a gap cover policy, e and other policies that can help you with shortfalls in your medical scheme cover.

The other way is to use doctors who charge within the scheme's rate.

3. UNPAID PMB CLAIMS

The Medical Schemes Act lists almost 300 conditions that schemes are obliged to cover as prescribed minimum benefits (PMBs). The PMBs include all medical emergencies, some 270 conditions that if left untreated would severely affect your quality of life and 27 common chronic conditions.

If your condition is a PMB, your medical scheme must cover the cost of the diagnosis, treatment and care of the condition in full, without a co-payment, and the bill may not be paid from your medical savings account.

The PMBs should ensure that you do not have gaps in essential cover.

Medical schemes are entitled to limit the services for which they pay for a PMB to those that are provided in state facilities, or to any alternative treatment as long as it is not less than that provided in state facilities. **You may therefore find that, even if you have a PMB condition, your scheme will not pay for the latest treatment, which is too expensive to be used in state facilities.**

Schemes are also entitled to control the cost of providing the PMBs by appointing designated service providers (DSPs), which you must use to access the PMBs. Schemes are entitled to apply co-payments if you choose not to use the DSP.

Schemes may also apply managed care principles to PMB services as long as these do not result in your receiving a level of treatment that is lower than that in state facilities.

Managed care for PMB conditions, such as the common chronic conditions, may involve a list of medicines or following a treatment protocol for the condition. Failure to use the listed medicines could result in a gap in your cover.

Medical schemes have agreed to abide by a code of conduct on the PMBs. The code commits schemes to reassessing a PMB claim up to three years after the scheme processed it if you later establish that the condition for which you claimed is a PMB but your scheme did not have sufficient information to identify it as such.

4. MANAGED CARE LIMITS ON TREATMENT

In order to contain the costs of providing you with benefits, medical schemes may engage with healthcare providers and decide on the most cost-effective, best-practice treatment or procedure for a particular condition. These decisions are referred to as managed care protocols.

If your doctor recommends a treatment that differs from the scheme's protocols, you may find your claim for the treatment denied or only partly paid.

Schemes now use a number of measures and a range of disease management programmes may include protocols on how your disease should be managed, including stipulating the number of consultations and diagnostic tests you need and even listing the cost-effective medicines that can be used, known as a formulary.

Typically, the formulary will list cheaper generic medicines and will exclude newer, more expensive ones that have yet to be proved cost-effective for treating a particular condition.

Medical schemes' managed care protocols are usually based on what is accepted as the best practice by the association or society that represents the relevant medical discipline, and your doctor should be aware of that best practice, schemes say.

One of the best ways to determine whether or not you will have cover for the treatment is to obtain a "quote letter" from your doctor that outlines the treatment or procedure using the relevant ICD-10 codes. Then contact your scheme and ask it to check if all the services listed are covered, he says.

Before you start a course of medication, find out whether or not your scheme has a formulary. If your doctor prescribes a medicine that is not on the formulary, check with him or her whether you can use one that is.

5. CO-PAYMENTS AND DEDUCTIBLES

Besides the co-payments that schemes are entitled to apply if you do not use the scheme's DSP or formulary medication for PMBs, schemes also use co-payments or deductibles to control other costs.

By applying co-payments or deductibles to certain procedures or to medicines, schemes make you responsible for part of the bill and ensure that you and your doctor will use only those procedures and medicines that are absolutely necessary.

Procedures that typically attract co-payments are gastroscopies, laparoscopies, the removal of wisdom teeth, colonoscopies and joint replacements that schemes regard as recommended without being essential.

However, even if the procedure is absolutely necessary, you will still pay the co-payment.

Co-payments may also be applied to specialised diagnostic procedures – such as magnetic resonance imaging (MRI) and computed tomography (CT) scans – and some schemes impose a flat amount for every non-emergency hospital admission regardless of the type of procedure. These co-payments range from about R1 000 to as much as R8 000 per procedure.

6. GAPS IN CANCER BENEFITS

The treatment of cancer is developing fast, but the cost of the chemotherapy or radiotherapy involved is climbing. Specialised medicines, such as biologics, monoclonal antibodies or tyrosine kinase inhibitors, which target the cancer cells, may advance your chances of survival or prolong your life but they will increase the cost of treating you.

Medical schemes have limited their oncology benefits in the face of the rising costs of treating cancer and the increasing prevalence of the disease.

Many schemes have an annual limit on the amount that you can spend on oncology and/or exclude cover for more expensive treatments. As a result, there may be gaps in your oncology cover.

The Oncology benefit can be exhausted quickly if your treatment involves expensive chemotherapy, which can be as much as R30 000 a month, that the benefit was not intended to cover.

The treatment of some, but not all, cancers is covered by the PMBs, so your scheme is obliged to pay for your treatment beyond any scheme limits **but only to the extent that the treatment is the same you would enjoy in a state facility.**

In addition, your scheme may control the cost of treating a PMB cancer by expecting you to use the scheme's DSP, following its managed care protocols or taking medicines listed on its formulary.

But beware: the PMBs do not offer everyone the safety net of benefits that you may think they do.

Leading oncologists say the PMBs do not cover the treatment of all curable cancers and, in the case of incurable cancers, offer insufficient palliative care.

For example, the PMBs define treatable cancers of the organs as those that have not spread to other organs, whereas many cancers that have spread to other organs are in fact still curable.

Oncologists say that even when it is clear that a cancer is covered by the PMBs, medical schemes are using the vagueness of the PMB regulations to deny benefits to members, particularly for more expensive treatments. For example, in considering the level of treatment in state facilities, schemes will typically exclude treatment that is provided free of charge in state facilities by pharmaceutical companies.

This approach may result in a scheme paying only for what oncologists argue are old-fashioned therapies that are no longer appropriate, while your scheme argues that the old therapy is not out of date and is much cheaper than the new ones on offer.

7. INADEQUATE MEDICAL SAVINGS ACCOUNTS

If you are on a traditional medical scheme – one that does not use a medical savings account – your day-to-day benefits are usually limited per benefit category. These limits could, for example, be R2 000 a year for optical benefits or R3 000 a year for dentistry.

Once the limits on your day-to-day benefits are exhausted, you have to pay future accounts out-of-pocket unless you have a medical savings account to top up the limited benefits.

Many medical schemes expect you to fund your day-to-day benefits exclusively from your medical savings account.

If the amount that you will contribute to your medical savings account during the year is inadequate for your usual annual medical needs, or if you have a particularly bad year health-wise, you may find that the balance in your savings account is depleted and you may then incur high out-of-hospital costs.

When paying your day-to-day medical expenses out of a medical savings account, you may also face a gap in your cover if your scheme reimburses providers at the scheme rate only.

Watch out for options that appear cheaper because they set contributions to a medical savings account at much less than 25 percent of contributions, unless the savings account is intended only to top up the day-to-day benefits provided by the scheme.

Once you have an idea of your average day-to-day medical costs, assess whether the level at which you are contributing to your savings account is sufficient.

Remember that you should also have room in your savings account or in your budget for some out-of-the-ordinary medical expenses that you may have to cover – for example, complications after the flu, such as a lung infection that requires X-rays (about R200) and visits to a specialist (about R650 to R800).

Also, check whether radiology benefits for MRI and CT scans, wheelchairs and artificial limbs, which can cost thousands of rands, must be paid from your savings account.

If you join an option with insufficient cover for your day-to-day needs because the medical savings account contributions are too low, you must accept that you will have to pay for some of your medical expenses yourself..

You can, at additional cost, minimise the risk of running out of funds in your medical savings account by choosing an option with above-threshold or safety benefits. These insured benefits ensure that if you exhaust your savings account, you are not left without essential cover.

You should be aware that the scheme determines whether you have reached the threshold by adding up your claims as if they had been paid at the scheme rate, rather than the rate charged by the service provider, so you may have to spend a lot more than the threshold to get out of the self-payment gap.

In addition, the scheme may have rules that specify that only certain claims contribute to the amount you need before you reach the threshold.

For example, the scheme may allow you to pay for over-the-counter medicines from your savings account, but these claims may not be included for the purposes of determining whether you have reached the threshold.

Similarly, for the purposes of determining the threshold, there may be a limit on what you can spend on spectacles.

Buy an option with an above-threshold benefit only if you have ongoing health problems and are likely to access these benefits, otherwise the difficulty in reaching the threshold typically does not justify the cost of the above-threshold benefit.

8. LIMITS ON BODY PARTS AND APPLIANCES

There is a huge variation in the cost of artificial body parts, such as an artificial arm or eye, or an internal prosthesis, such as the rods and screws used in back operations and the stents in cardiac operations, and hip, knee or shoulder replacements.

Similarly, external appliances and devices, such as wheelchairs, walking frames, hearing aids and crutches, are available from the most basic to the top of the range. Medical schemes tend to limit their benefits for these items to the cost of the functional necessities, and your and your doctor's desire to fit you with the deluxe model may come at cost.

While some schemes will entertain good reasons in a clinical motivation for cover for artificial body parts that exceed the limits set by the scheme, your doctor's motivation may not be enough to sway your scheme's clinical team.

9. EXCLUSIONS ON COVER

Most medical schemes have exclusions on cosmetic surgery, healthcare services related to infertility and injuries sustained from wilful violations of the law or during wilful participation in a war or participation in high-risk activities or professional sport.

When joining a scheme, you may also face exclusions from cover if either of the waiting periods (**a three-month general waiting period** on all benefits or **a 12-month waiting period on benefits for a pre-existing condition**) are imposed. Be aware of these exclusions, because they could result in gaps in your cover.

Other exclusions may be less obvious**. Some schemes offer PMB cover for costly procedures in public hospitals only**. Cover for these procedures in a private hospital is excluded. Should you require one of these transplants and wish to have the operation performed in a private hospital, you should be aware of the costs you could incur.

10. LONG-TERM REHABILITATION

Good medical schemes offer rehabilitation benefits if you are temporarily disabled as a result of injury – for example, after being involved in a car accident – or after surgery or a stroke. These benefits are intended to cover your needs after "acute events" for a short period of time, such as three weeks. But you may need treatment for many months or even years, and so your scheme's rehabilitation benefit may be insufficient.