Medical Aid Schemes

What is a medical aid and what services do they pay for?

Your medical aid should be viewed as a form of insurance policy which comes into effect if any of the members require medical management or surgical treatment. Each medical procedure (for example an examination by a doctor) is identified by a specific code, which in turn has a clinical unit value attached. The medical aid may pay for some- or all of the procedures (according to the coverage schedule). As with any other insurance policy, only a certain percentage of the costs may be covered. Similar to an excess payment with normal insurance, the medical aid often requires a so-called copayment in order to cover the cost of the medical expenses. The copayment amount is directly related to (1) the rates that your medical scheme pays for the services rendered, as well as (2) the amount charged by the medical professional/implant company/hospital for their products/services.

What is the difference between medical aids and different plans?

Each medical aid offers various plans to its customers, all of which offer different benefits. What this effectively means is that, while two people may belong to the same medical aid, if they belong to different plans, they may require significantly different copayments for the same procedures or services. This is because their plan rates differ. A good example of a service which is almost never covered is cosmetic plastic surgery, which would result in a 100% copayment being required in the case of almost all medical schemes. Different medical aids may also provide different levels of cover and rates. Different plans also exclude cover for different services, such as for example joint replacements or invasive cardiac procedures, which other plans may cover partly or completely.

What is gap cover?

Gap cover is a different form of insurance which may be taken out in addition to a medical aid policy.

Gap cover provides (sometimes limited) cover for any shortfall in the rates paid by a patient’s medical scheme. It is important to note that gap cover only provides for copayment gaps in the services which your plan actually covers.
If you belong to a plan which does not cover dental work for example, gap cover will not pay for your dental work. This is in contradistinction to a situation where you belong to a plan which pays a certain amount for a service - gap cover will then pay for the difference between the amount that the service provider is charging and the amount that your medical aid is prepared to pay.

My medical aid says that my doctor should be charging a lower rate, is this correct?

Private sector medicine in South Africa functions according to a free-market business model. Doctors are able to charge highly variable rates for services rendered and patients are allowed to choose their doctor according to their personal preference.

According to a ruling by the competition commission, doctors or groups of doctors may not negotiate prices directly with the medical schemes or vice versa because this constitutes collusion, which is illegal.

A doctor will charge a certain Rand amount (clinical unit rate) per one clinical unit. Every service rendered by this doctor will have a set clinical unit value attached and the cost for the procedure is a product of the clinical unit value and the clinical unit rate. If a doctor charges R 25 as his clinical unit rate, a procedure which is worth 10 clinical units will cost the patient R 250 + VAT. The doctor is at liberty to grant the patient a discount.

There is no across-the-board medical aid rate (every medical scheme has different scheme rates, which usually vary across its various plans). Here are some of the historical developments in this regard:

The Board of Healthcare Funders (BHF) is the representative organisation for the majority of medical schemes throughout South Africa, Namibia, Zimbabwe, Botswana as well as Lesotho. Until 2004, the BHF published its own list of recommended tariffs, which was compiled by means of negotiation between the BHF and the South African Medical Association (organisation representing doctors). The BHF list was ruled as being in contravention of the Competition Act, which regulates activities between businesses and organisations that should be competitors. Therefore, the BHF no longer publishes its list of recommended medical tariffs.
The Health Professions Council of South Africa (HPCSA) is a body representing all healthcare professionals in South Africa. In December 2008 the HPCSA stopped publishing its suggested ethical rates.

The National Health Reference Price List (NHRPL) was designed by the Council for Medical Schemes (CMS) on behalf of the Department of Health, and was first published in 2004. In July 2010 the NHRPL was declared null and void by the Gauteng High Court.

Medical aids often refer to the National Reference Price List (NHRPL) and claim that all doctors’ rates should be related to this. As a rule, medical scheme rates (MSR) are based on the old NHRPL rate or percentages thereof. Their position is that any doctor who applies a higher rate than NHRPL to their services is overcharging the patient. This position has been legally tested and found to be incorrect - as a patient you have the right to shop around with respect to which doctor you choose to use. The doctor has the right to charge whatever he feels is appropriate, provided he/she informs the patient of the rates prior to performing the service.

The assumption that doctors are somehow required to adhere to medical aid regulations with respect to billing for their services is therefore incorrect - unless a doctor has signed a preferred provider agreement with a medical aid, she is under no obligation to maintain any relationship with any medical aid. Practices may submit invoices to a patient’s medical aid on their behalf at the practice’s discretion - this is again not an obligation and the onus to ensure successful and timeous claim submission rests with the patient.

Late Joiner Fees and Exclusion Clauses

A medical scheme may require you to pay a Late Joiner Penalty Fee if you join the medical scheme for the first time after the age of 35. Depending on the number of years you have not been covered by a scheme, the late joiner penalty fee is calculated as a percentage of the monthly medical scheme contribution. An Exclusion Clause is a provision, which precludes new members from accessing various services such as joint replacement surgery for the first year of cover. An exclusion clause does not affect PMB conditions.
How Do Medical Aids Compare?

Medical schemes are rated by Global Credit Rating (GCR), which is an independent company which considers rates and the ability of medical schemes to pay out at their set rates. This is a statistically sound way of comparing medical schemes when you decide to join one. As mentioned previously, many medical schemes have subdivided their cover into various plans, all of which are different. You should familiarise yourself with which specific plan you are joining so that you ensure the best cover for your specific situation.

Prescribed Minimum Benefit (PMB) Conditions

What is a Prescribed Minimum Benefit?

In cases of certain chronic diseases and/or emergencies such as fractures it may be difficult for a patient to shop around. A special group of prescribed minimum benefit conditions (PMBs) have been identified by government through the medical schemes act. According to Regulation 8 of this act, any- and all medical aids are obliged to cover PMB conditions in full, irrespective of the medical scheme rate. PMB conditions are identified solely by their injury codes, which are also called ICD 10 codes. Medical schemes will often contend that a condition is not a PMB because it is not life-or limb-threatening or did not require emergency surgery - according to the legal regulations, these issues are irrelevant. Effectively, if you are suffering from a condition which qualifies as a PMB according to the ICD 10 code, all management (including non-emergency surgical procedures) required for the standard of care management of that condition as well as its potential complications should be covered in full (i.e. without copayment) by your medical scheme.

Why is my Medical Aid disputing that my case is a PMB and why do they want me to see a different surgeon?

The PMB legislation has been controversial ever since its inception, given the fact that the medical aids have consistently legally challenged it through their representative body, the Board of Healthcare Funders (BHF). The latest Appeal Court decision in this regard was handed down in 2012. The court dismissed, with costs, the BHF’s application to have the previous precedent-setting 2011 Pretoria High Court judgement set aside (In a 2011 application, which was brought by the BHF and SAMWUMed, the Pretoria High Court ruled
that the reference to "payment in full" in regulation 8 of the medical schemes act should be interpreted as meaning that medical schemes are obliged to pay the doctors’ full rate, as opposed to the medical aid’s maximum scheme rate).

The BHF has not accepted this ruling and continues to allow it’s member organisations to pay for PMB conditions according to the scheme rate, which results in copayments being required. An appeal by the BHF to the Constitutional Court has been mooted but has, as yet, not taken place. The good news with regards to PMB cases is that the Council for Medical Schemes (CMS), which is an independent regulatory supervisor of private health-care financing and which adjudicates disagreements between members and their medical aids consistently rules in favour of the patient and invokes the relevant medical aids to pay for PMB conditions in full. The precedent for this is the November 2008 ruling by the CMS’s Appeal Board, that service providers must ‘pay in full’ all invoices related to the costs of providing healthcare services for Prescribed Minimum Benefits (PMBs) - without taking the rules of the respective medical scheme into consideration. Effectively, while an appeal to the CMS might be required, with the appropriate motivating letters from the doctor, most medical aids usually adhere to the PMB legislation despite the BHF’s position.

Recently, there has been a trend for the larger medical schemes to engage legal counsel in disputes with patients, who have successfully challenged the medical scheme on a PMB issue. In response to this, the Council for Medical Schemes is now providing free legal services to patients in cases where this may be required.

Often, you may be suffering from a PMB condition, for example a broken arm, which has been stabilised and a plaster slab and does not require immediate surgical management. Another common scenario is a patient with a fracture of the extremities, which may require initial elevation and splintage in order to allow the swelling to decrease, which in turn decreases the chance of developing an infection of the surgical wound. In these cases, the medical scheme is within its rights to advise you to have your condition further managed by a designated service provider (DSP). While they are legally obliged to pay the treating clinician for the initial consultation and management according to the PMB legislation, they may refuse to pay the rate of a non-DSP in full for any medical or surgical services rendered after 24 hours post injury. Patients are excluded from this if they are required to remain in hospital and cannot safely or reasonably be transferred to a DSP, or if there is no DSP locally available.
Medical aids are notoriously reluctant to provide doctors with lists of their designated service providers. It is therefore unrealistic to expect- and indeed often impossible for your initial contact surgeon to organise referral to a designated service provider. This must take place through consultation between the patient and/or their representative or broker and the relevant medical scheme. Your initial contact surgeon is, however, obliged to provide you with a quotation for the planned services/procedures and he is further obliged to encourage you to contact your medical scheme so that you may obtain clarity regarding potential referral to a DSP. In cases where DSP referral is impossible (see above), your treating surgeon should provide you with a written motivation in this regard, which can be forwarded to the medical scheme.

What is a Designated Service Provider?

As mentioned above, designated service providers (DSPs) are doctors who have specific payment arrangements with some medical schemes. Some of them may only provide services for certain plans in a medical scheme and not others. The medical scheme negotiates discounted rates with these doctors and in return provides them with business in the form of exclusive referral of their PMB patients.

An advantage of being managed by a DSP is that no co-payment will be required.

Possible disadvantages of being managed by a DSP include that your choice of doctor is limited. Given the super-specialised nature of orthopaedic trauma management, this may exclude you from management by some of the better qualified surgeons. Many of the more experienced specialists either pull out of their DSP arrangements or do not sign up in the first place.

When contacting a medical aid telephonically, the initial contact person is usually a call centre operator, who works off a database, governed by a set computer algorithm. If your case is escalated, you may be placed in contact with a medical adviser. It is important to be aware that neither of these are medically trained and they are therefore unable to make any decisions regarding the management imperatives of your medical condition.
Each patient’s condition is different and may require slightly different management. If a doctor makes a diagnosis or gives a prognosis, this is done based on years of training and experience. Even more importantly, medical professionals are both ethically and professionally policed by the Health Professions Council (HPCSA) - if doctors are found to be negligent, they may be stopped from practicing medicine and they can be held legally responsible.

The call centre operators and medical advisers operate under no such restrictions (i.e. if they tell you that your management can wait or refer you to an inappropriate specialist, there is no legal recourse available to you). These workers are simply there to align your level of cover with the medical management that you may require. They may, for example, be able to advise you regarding designated service providers (DSP) in your area and they should be able to advise you what copayment will be required if you choose to be managed by a non-DSP. It is imperative that reference numbers are obtained when contacting your medical aid so that previous records of your claim may be accessed if required. Ideally, all communication should be in writing or by e-mail.

This also allows a forensic audit of your claim, should you later have a complaint against your medical scheme with the CMS. Another good idea is to record telephone conversations with your medical aid for later reference. You are not legally obliged to advise the person on the other end of the line that you are recording the conversation.

Important aspects to remember when booking surgery or admission to a hospital the following:

Obtain authorisation for the admission and the specific procedure. Your doctor’s secretarial staff should provide you with appropriate codes as well as a quotation for the proposed surgical procedure.

You should familiarise yourself with your level of cover. What this means is that you should be absolutely clear as to whether your medical aid allows you to have surgery in the hospital where your surgeon operates as well as what percentage of the hospital costs, surgical costs, anaesthetic costs and implant costs are covered by your medical aid. The difference between the quoted amounts and your medical aid cover, amounts to the copayment, for which you will be responsible. Should you wish to negotiate a discount with any other involved parties, this should be initiated a reasonable period prior to admission for your procedure.
If you are advised that you are suffering from a PMB condition, this should be brought to the attention of the medical scheme at the first contact and you should insist on your case being run as a PMB. In the case of our practice, you will be given a letter in this regard together with your quotation and consent form. If you fail to inform your medical scheme accordingly, your case will automatically be run as a non-PMB and revision of this issue can only take place on a monthly basis, when the medical scheme’s review board sits and is by no means guaranteed. This results in at least a temporary copayment being required for your procedure.

Obtain clarity regarding your medical scheme’s DSP network (ask them for a list of local surgeons and their contact details) so that you may request referral to the appropriate DSP if you choose to be managed further by them, in preference to your first contact surgeon. Please inform the practice timeously of your decision to change surgeons, if this information is received less than 24 hours prior to the planned surgical procedure, you may be charged for a consultation by the anaesthetist, who may have given up other work to the anaesthetic service for your case.