

# THE WEEKENDER

*have a good one*

## Know which medical aid will work best for you

AS MEDICAL schemes try to minimise the effect of their mostly ageing populations on scheme claims ratios, members suffering from chronic illnesses are often the first to feel the effect of restrictive managed-care initiatives.

This results from scheme administrator tools that control ballooning costs through attentive management of members suffering from conditions requiring ongoing and often expensive medical treatment.

For years schemes have grappled with the conundrum of either deriving financial benefits from denying more expensive daily treatment, but risking higher hospitalisation costs later on, or subsidising expensive drugs or sometimes even unnecessary treatment, which may have a better long-term outcome.

This is the effect of standardisation of benefits in each medical aid option, rather than schemes taking a more individualistic approach to each member.

In this complex managed-care environment, most members are unaware of their rights with regard to their chronic ailments.

Firstly, there is the question of the chronic illness for which the member is being treated.

The prevailing legislation makes provision for the “diagnosis, medical management and medication” of 27 common conditions. These include hypertension, high cholesterol, asthma, diabetes and epilepsy. All registered medical schemes have a legal responsibility to pay for consultations, treatment and medication in the management of these 27 conditions, in any setting within reasonable access to the member.

The regulations also contain a treatment algorithm per disease which translates into the minimum level of benefits to which each member is entitled, and members cannot be made to pay for such treatment from their own pockets. It is, however, incumbent on the member to comply with registration procedures in order to access these ongoing benefits.

The second consideration is for those members who suffer from chronic ailments other than these 27 conditions.

Most larger schemes cover additional diseases under their chronic illness programmes but these benefits are usually limited to the more costly and comprehensive options. Examples here would be the Extender option of Momentum Health, which covers an additional 36 diseases; the BonComprehensive option of Bonitas, which covers an additional 38 diseases; or the Comprehensive options of Discovery, which cover an additional 34 diseases.

So a person suffering from “osteoporosis” or “acne” may find that this condition is better covered by one medical aid option rather than another, and would need to prioritise this requirement when sourcing a provider and medical scheme option.

The third consideration is the prescribed drug and dosage.

Most options now list a “formulary”, or list of medications that are covered in full by the medical scheme. Some of the drugs on these formularies may not find favour with a particular doctor treating a certain patient, and in these instances members have to make a co-payment for using an alternative, usually more expensive, prescribed drug.

Members need to discuss such variations with their doctor in order to ascertain the necessity of deviating from scheme protocols, or even consider whether the prescribed medication may be available on a different medical scheme’s formulary.

The fourth consideration of chronic disease management is the choice of medication provider. Members are often required to obtain their medication from a limited number of suppliers, and on most affordable options, the choice of supplier is limited.

Taking this philosophy further, Momentum Health was the first medical aid scheme to introduce a structure in which a member’s contribution increased depending on the greater freedom of choice of supplier selected.

In most cases, there is also the option of chronic medication being delivered to a specific address . The benefit is available on even the most affordable plans, and in remote areas.

The fifth consideration concerns those diseases not covered as chronic illnesses by medical aid schemes. People suffering from these illnesses need to determine the monthly cost of their medical management in medication to quantify the day-to-day cover needed to meet these costs.

The next step is to source the appropriate medical scheme and option to provide the most appropriate cost-benefit ratio considering these “nonchronic” costs.

The sixth consideration concerns certain conditions, especially neurological conditions such as depression, delusional disorders and bipolar mood disorder, which are not clearly defined or where exact diagnosis is difficult or questionable.

In such cases, a member should find out the scheme protocols and formulary before submitting an application to their medical scheme, as in many cases an unfortunate diagnosis or prescription can lead to a medication being declined.

Lastly, even once a disease or medication has been approved, it is not uncommon that claims are processed from the incorrect benefit pool, unnecessarily depleting a member’s day-to-day benefits. In some cases the cause lies with incorrect coding of the invoice by the doctor, in others the administrator is at fault.

As with all accounts, it remains the client’s responsibility to check their statements regularly to ensure that the transactions are correctly processed .

Spending a little time studying one’s scheme benefits and processes will not only ultimately save on contribution costs and reduce benefits exhaustion, but will also improve the management of chronic diseases and lead to better health.

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