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M v DISCOVERY HEALTH MEDICAL SCHEME

The Complainant submitted that after being advised by the Scheme to undergo a glucose test, he followed through but the Scheme refused to authorize payment. Despite repeated follow-up, there was no response from the Scheme, leading to him covering the expenses out of pocket. Due to the failure of the Scheme to pay the claim, he decided to cease his monthly contributions and notified the Scheme of his intention to terminate his membership by the end of 2022. He indicated that the Scheme incorrectly demanded payments and proceeded to hand over his account to debt collectors.

In responding to the complaint, the Scheme explained that the Medical Savings Account (MSA) is fully allocated at the start of the year and reimbursed to the Scheme through monthly contributions. If a member exits the Scheme before year-end and the MSA expenditures exceed the contributions made, the member owes the difference. On 23 January 2023, it was noted that the Complainant's membership was terminated effective 31 October 2022 due to non-payment of premiums, as the Complainant had stopped the debit order. By the time of withdrawal, only 10 months of contributions had been allocated to the Complainant's MSA, although he had used the full annual allocation of R19,068. This overuse resulted in a cost recovery issue. Additionally, a claim from 1 December 2022 for chronic medication, was funded from the Risk benefit while the membership was active and this claim was also included in the cost recovery, as the Complainant's non-payment led to a lack of coverage for December. Furthermore, the Scheme advised that there was a system error preventing the claim dated 22 July 2022 from being processed against the applicable benefit, it thus approved funding of the claim from PMB. This payment was to offset against the cost recovery, reducing the balance.

The issue which fell for determination was whether the Scheme was correct in requesting the Complainant to payback the cost recovery.

Upon investigation, the submissions made by the Complainant and the Scheme were reviewed. Section 29(2) of the Medical Schemes Act ("Act") allows the Scheme to terminate membership on the basis of non-payment of premiums. Therefore, the Complainant was not entitled to any benefits post the non-payment of premiums. Furthermore, Section 59(3) of the Act empowers the Scheme to recoup any amount(s) paid in *bona fide* to a service provider/member, to which the latter was not entitled. In this case,

the Scheme paid the service provider in good faith based on the contractual nature between it and the Complainant at the time, however the contract was terminated due to non-payment of contributions.

It was to this end that a ruling was issued confirming that the Scheme complied with the Act and its registered rules. Furthermore, the Scheme was directed to furnish the Complainant with a detailed statement. The complaint was dismissed.