The GREY in the GAP

Rates in the medical field are a continued topic of hot debate in the industry, particularly given the government's stance on the matter.

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Medical aid schemes are controversial monthly insurance expenses, from the government berating that the most of South Africa's medical fraternity are ensconced in private practice and providing services to a privileged minority to the percentage that those payments consume of members' disposable income and what they receive in return.

But escalating private medical practice costs have meant that while contributions have increased, the benefits covered have diminished as specialists' rates have climbed more swiftly than the reimbursements.

Into that milieu entered the short-term gap cover insurance concept – insurance against being out of pocket when interactions with specialists become something scheme administrators are not prepared to cover in full.

Gap cover provides the difference between what medical aids pay for in-hospital procedures in line with the National Health Reference Price List (NHRPL), as maintained by the Department of Health and the Council for Medical Schemes, and what doctors actually charge. If the medical aid pays out 100 per cent of the medical aid (or NHRPL) rate and the specialist charges three times that amount, members are responsible for the difference.

Bull's Eye Financial Services Group executive Vanessa Roux says South African specialists are not regulated on the rates they can charge, meaning patients pay the shortfall from their pockets. That amount may be 500 per cent of the rate the scheme is prepared to cover. "Gap cover providers are under increased pressure from medical schemes in terms of benefit design and some service providers, who change their billing practices according to whether or not policyholders have additional insurance provisions," Martin Rimmer, CEO of Sirago Underwriting Managers, is on record for stating, effectively throwing down the gauntlet to the industry. ›

GAP COVER PROVIDERS ARE UNDER INCREASED PRESSURE FROM MEDICAL SCHEMES IN TERMS OF BENEFIT DESIGN.

SOME DOCTORS ARE CHARGING MORE THAN MEDICAL SCHEME BENEFITS BECAUSE THEY HAVE BECOME AWARE MANY PATIENTS HAVE GAP COVER AND THEY WILL BE PAID

Sebastian Zoutendyk, director at Zestlife, says that the expectation by medical aid members that their scheme will wholly cover their hospitalisation costs is seldom met. Benefits are limited to their medical scheme tariffs (MST), but medical practitioners can demand considerably more than the MST. "This charge creates a shortfall the medical scheme does not cover and the actual charges of many procedures performed by surgeons, anaesthetists and others can add up to sizeable payment gaps," he says.

Zestlife schemes include in-hospital procedures up to 500 per cent; outpatient cover for more than 50 procedures – irrespective of these being performed in-hospital or at an out-patient facility; copayments for hospital admissions; non-designated service provider (DSP) hospital copayments expressed in rands rather than as percentages as well cancer treatment, internal prosthesis, casualty, dental, accidental death, permanent disability and medical premium waivers.

Tony Singleton, CEO of Turnberry Management Risk Solutions, says members applying for gap cover are subject to waiting periods if they have not previously had these policies. Typically, a three-month general waiting period applies to all benefits with the exception of those providing cover for up to 500 per cent should the policy commencement be in line with the medical scheme's commencement date. Pregnancy and childbirth has a nine-month waiting period, while a 12-month period applies to hysterectomies – unless there is a proven malignancy, hysteroscopy and endometrial ablations, joint replacements and spinal surgery or treatment – unless sustained in an accident, tonsillectomies, grommets, adenoids, wisdom teeth and hernia treatment or surgery – unless due to emergency surgery. Pre-diagnosed cancers are covered provided the person has been in complete remission for five years.

Bryan Hirsch, director at Bryan Hirsch Colley & Associates, says that as South Africans cut their expenditure, healthcare has taken centre stage. Most medical schemes have unlimited overall benefits and members believe they are covered for major illnesses for whatever benefits they need to claim. However, Clayton Samsodien, MD of Genesis EB Solutions, says a more detailed analysis of scheme structures shows many benefits have sub-limits – only covering parts of the procedures. Sub-limits may mean a procedure will only be covered in the public sector. "Members must find a marriage between their medical aid schemes and their gap cover options," he says.

But why

The question still remains on why gap cover has become a key component of medical aid expenditure. Richard Eales, MD of Guardrisk Insurance Company, says that in 2015 the average gap cover claim rose 38 per cent to R5 800 and the number of claims Guardrisk processed increased from 0.7 per cent to 1.6 per cent – more than doubling in a single year. Driving these hikes was the reduced benefits and medical aids raising the portion schemes expect members to cover personally in a bid to contain claims for certain procedures or services.

A *Personal Finance* survey conducted in November 2015 showed Guardrisk would raise its gap cover premiums between 7 and 34.2 per cent (average: 9.8 per cent) in 2016; KaeloXelus was implementing increases between 6 and 18 per cent (11.8 per cent); Complimed had an average 19.2 per cent increase; Turnberry a 7.6 per cent average and the Liberty Healthcare hikes were between 5.8 per cent and 25.7 per cent on its three gap cover options. Peter Hyman, director of Complimed, says if a specialist charges R350 ($24.70) for a consultation and the medical aid scheme only pays out R200 ($14.12), when the former raises their fees by 10 per cent and the scheme only hikes its benefit cover by 7 per cent, the gap cover rises by 14 per cent. The mathematics dictates the logic by which insurance companies have to raise their prices. "Some doctors are charging more than medical scheme benefits because they have become aware many patients have gap cover and they will be paid. Some doctors and hospitals are asking members to disclose whether they have gap cover and Complimed believes invoices are adjusted accordingly," Hyman says.

Victor Crouser, coastal head of health at Alexander Forbes, believes the increased awareness of gap cover products has seen medical aid scheme members claim more often against their policies. However, prescribed minimum benefit (PMB) claims have also contributed towards the spiralling cost of providing gap cover when considering PMB claims.

Legally, medical aid schemes must fully pay PMB claims, but they can appoint a designated service provider (DSP), such as a group of doctors, pharmacy chain or hospital brand, which members must use to be wholly covered – and those failing to comply are liable for the additional personal payment and thus use their gap cover policy.

Crouser adds fuel to the fire in speculating schemes are increasingly using DSPs and some doctors are charging more to treat a PMB because payment is guaranteed. *The GTC Medical Aid Survey – Benefit and Cost Comparisons 2016* report author and GTC (formerly Grant Thornton Capital) healthcare consulting head Jillian Larkan says the preceding year's report had clearly outlined the degree to which the average person lacked knowledge about healthcare cover basics. "Medical service providers are not yet regulated. This means they are able to, and many do, charge above the medical aid rate of each specific scheme unless they have a payment/network arrangement and have signed a contract to charge according to the scheme's rates," she says.

Larkan adds that since gap cover is a short-term insurance product, it is not governed by the Medical Schemes Council or the act and underwriters may impose exclusions or waiting periods at their discretion.

The nuts and bolts

A review of different gap cover insurance schemes shows the two Sanlam Gap Cover plans have a general waiting period of three months on all benefits and a 12-month period for pre-existing conditions like cancer and maternity benefits. Treatments not covered include obesity-related interventions, including bariatric surgery (stomach stapling); cosmetic surgery, unless necessitated by a trauma or as a result of oncology (breast reconstruction following a mastectomy); any copayment not defined as a rand amount but applied as a percentage; any penalty, copayment or limit applied by a medical aid scheme because the member did not comply with the benefit rules or authorisation procedures (non-authorisation of a hospital admission or where the member is covered on a network plan and uses a non-network facility) and claims older than six months. The plan also only covers specialised dentistry on its higher policy in the event of trauma, cancers and tumours.

Momentum has four options offering consumers between 400 and 500 per cent cover for in-hospital events that also carry the standard underwriting waiting periods and exceptions – three months general waiting, 12-month waiting period on pre-existing conditions, a maximum entry age of 65 years on the next birthday, 12 months on cancer, pregnancies, hysterectomies, grommets, adenoids and tonsillectomies, and the maximum annual benefit caps out at R1 million ($70 704).

South Africa's largest medical aid scheme, Discovery, has yet to offer its own gap cover policies but has indicated options are in the pipeline.

Whatever direction gap cover travels into the future and however it channels South Africa's medical industry and the related schemes and policies, there can be little doubt the controversy will continue. Doctors and specialists will steadfastly charge higher rates than medical aid schemes will cover and the schemes can't hike their contribution levels to rates that wholly cover those medical expenses, leaving consumers – expecting value-for-money from their schemes, but not always receiving it to their satisfaction – trapped in the middle.