Govt to cut medical top-up and gap cover

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Many medical scheme members who top up their cover with gap cover policies may have to consider upgrading their medical plans after the government indicated yesterday that it wants to ban these policies.

Gap cover policies typically pay out when there is a shortfall between what your scheme pays a doctor for a procedure and what your doctor actually charges.

Top-up cover that pays out when you exhaust your medical scheme benefit or annual limits, dental insurance that provides fixed benefits for specific dental procedures, and health policies that provide top-up cover and daily preventative healthcare services could also be outlawed.

Proposals to this effect were contained in draft regulations under the Long-Term and Short-Term Insurance Acts published in the Government Gazette late yesterday.

Hospital cash plans that pay out a cash amount according to the number of days you spend in hospital will be allowed to continue but only as income protection policies, with benefits limited to 70 percent of your net daily income for each day spent in hospital.

This could mean that people who are using these policies as alternatives to medical scheme cover will have to consider joining a scheme, while those using gap or top-up policies to boost medical scheme cover may have to reconsider the option to which they belong.

Hospital cash plans are sold mostly by short-term insurers, which collect more than R1 billion a year in premiums from policies.

If you have a product that is disallowed by the regulations, your insurer will not be able to renew your policy when its term expires, the regulations say.

An explanatory memorandum published with draft regulations under the Long-Term and Short-Term Insurance Acts indicates that the government plans to amend the definition of a medical scheme to deem any policy that helps you pay for healthcare services as doing the business of a medical scheme.

The draft regulations then list a number of products with specific criteria that insurers will be allowed to issue as insurance policies.

These products include domestic and international travel insurance, policies covering emergency evacuation, dread disease cover, third-party motor insurance, third-party liability cover on homeowners or householders insurance.

In the case of policies, such as hospital cash plans, that will be permitted to continue under certain conditions, the insurer may be expected to submit details of the product to the Registrar of Short-term Insurance or the Registrar of Long-term Insurance and the Registrar of Medical Schemes within three months of the regulations becoming effective.

The registrars will then decide whether the policy undermines medical schemes and whether or not it should be allowed to continue. If not, it will be given 90 days after a date named by the registrars within which to close down.

Contracts entered into before December 15 2008, when the insurance laws were amended, may not be subject to this review.

Two policies that the draft regulations seek explicitly to allow to be sold – despite the fact that they assist you directly with the costs of medical care – are those that pay the costs of HIV-related testing and HIV and Aids treatment on an employee group basis and those that cover the costs of frail care.

A question-and-answer document released by National Treasury with the draft regulations says: "Given the current social pressures in the public and private healthcare sectors, these products have been identified as exceptions in the regulations, as there is a direct public policy imperative to allow for such products to be provided in the market.

"This is a clear example of the role that voluntary health insurance products can play in addressing some of the pressures which exist in the health sector."

The explanatory memorandum says the proposed amendment to the definition of a medical scheme will be contained in the draft Financial Services Laws General Amendment Bill 2012, which has been approved by cabinet and is expected to be released shortly.

Any financial product that does the business of a medical scheme has to be registered as a medical scheme and comply with the Medical Schemes Act. Medical schemes are obliged to admit anyone who applies for membership, to provide all members with certain minimum benefits and to charge all members on the same option the same contributions regardless of their health.

The question-and-answer document released with the regulations says the regulations seek to address concerns that certain long- and short-term health insurance products, which provide similar benefits to medical schemes, could harm medical schemes by attracting younger and generally healthier members away from schemes.

The medical scheme regulator, the Council for Medical Schemes, has also argued that schemes' risk pools are undermined when healthier members join cheaper options, which typically pay lower rates to specialists, and insure themselves against the costs of using a higher-charging specialist through a gap cover policy.

Treasury says if the practice of younger, healthier members opting out of schemes is left unchecked, it "could result in increasing costs for the older and less healthy who remain dependent on medical schemes for their cover".

"Pooling healthier and sicker individuals facilitates a form of cross-subsidisation whereby sicker people do not pay contributions according to their health status; this improves the affordability of medical schemes," Treasury says.

The draft regulations have been published for comment until April 23. Thereafter the comments will be considered and a final version published.

Insurers will be able to continue with existing products until the regulations are finalised, and thereafter products that need to be shut down will be able to continue until the contract expires. The authorities can inform insurers within three months of the effective date of the regulations, or at any time thereafter, that existing policies are deemed to be a threat to schemes.

If you are currently boosting your medical scheme cover with a gap or top-up health insurance policy, you are likely to be able to keep your cover in place until the end of the year. At that point you will be able to upgrade your medical scheme cover.

People who are using health policies as an alternative to medical scheme cover should probably consider upgrading to a medical scheme as soon as possible, as schemes tend to offer greater protection.

Treasury's document notes that the public often believe an insurance policy offers the same protection as a medical scheme, when in fact the insurance cover is "partial and conditional".

"This may result in individuals being not properly covered when serious health events occur."

It also notes that some health policies are designed to exclude cover for older people deemed high risk and that older and/or sicker people may pay more for insurance cover than younger people.

The regulations were published too late yesterday for Personal Finance to get insurers' comments.

Schemes and insurers in battle over your custom

Draft regulations under the insurance laws published yesterday are the latest move in an attempt over many years to draw a line between the business of a medical scheme and the business of a health insurance policy.

The Financial Services Board, the Council for Medical Schemes and the life assurance industry initially signed a demarcation agreement that set out the business of a medical scheme and what could be covered in a health policy in 2004.

However, the short-term insurers were not party to that agreement and continued to sell gap cover, top-up cover and other health policies.

In 2006, the Registrar of Medical Schemes attempted to have the product sold by Alexander Forbes's short-term insurance subsidiary, Guardrisk, closed down. The court case initially went in the registrar's favour, but Guardrisk took it on appeal and in 2008 won in the Appeal Court. The registrar was denied permission to take the matter to the Constitutional Court.

Since the court ruling in favour of the insurer, there has been a rapid increase in the number of gap cover products sold.

Another reason for the increasing popularity of these products is because, in recent years, there has been a widening of the gap between the rates at which schemes pay and what the doctors charge. This has been as a result of the shortage of specialists in South Africa and the dispute and subsequent striking down of the guideline tariffs for medical services, known as the Reference Price List (RPL) in 2010.

In the absence of the RPL, schemes have developed their own tariffs, and these are not always aligned to what doctors charge.

Increasingly, schemes are attempting to introduce networks of doctors who charge the rates the scheme pays, but the doctor of your choice may not always be one of these network doctors.