BV

National Treasury

26th April 2012

RE: Draft Regulations on the demarcation between health insurance policies and medical schemes.

Dear Dr Sheoraj,

I write to you as a current medical scheme member and gap policy holder, in the hope you will reconsider the draft regulations in their current form, with particular regard to 'gap' policies.

What do I mean by a gap policy?

Before I begin, I think it is important that I clarify what I mean when I write about gap policies. The draft regulations seem to paint all health-related policies with the same brush and, in doing so, have blurred the distinctions between the all the types of policies available in this space. For the purposes of the discussion below, when I refer to gap policies, I mean a policy that:

- Pays the difference between the fees charged by treating doctors and the amount reimbursed by the medical scheme
- Only pays this difference for treatments obtained in hospital or a specified list of outpatient procedures (i.e. Gap cover does not pay tariff differences for day-to-day expenses)
- Requires medical scheme membership

Do gap policies undermine medical schemes?

The various press releases regarding the draft regulations have detailed concerns that these types of policies undermine the medical scheme system in the following ways:

- Potential members do not join medical aids and opt to take out these policies instead
- Members "do not pay contributions according to their health status" (National Treasury Media Statement, 2 March 2012)

It should be clear from my clarification of gap policies that they cannot be guilty of the former – medical scheme membership is a requirement in order to take out and claim on the policy. Every gap policy holder is also a medical scheme contributor.

As for the latter, it is completely correct. Members do not pay contributions according to their health status: *they pay contributions according to what they can afford*. Very few South Africans are in a position to be able to afford the top options available – and they are even less likely to be able to do so if they are in poor health. Even the lower end medical scheme options are well out of reach for the majority of South Africans and are a massive financial burden to many of those who can. The assumption that if gap cover was no longer available that all policy holders would simply 'upgrade' their options is exactly that: an assumption. Has any research been conducted to ascertain that this is the case? I know that, in my own circumstances, there is no way I would be able to afford to upgrade my medical scheme option. I would simply be left with enormous financial risk and no way to protect myself against it.

This idea also assumes that such an 'upgrade' is even possible. Numerous medical schemes have dropped their in-hospital reimbursement rates on higher options significantly over the past number of years (a process which began long before gap policies became popular and I believe was the cause, not the result, of gap cover's popularity). Some no longer have options which have higher in hospital rates at all. Even if members of these schemes could afford to upgrade – there is nothing available for them to upgrade to.

Are PMBs enough?

In an attempt to protect patients the government introduced the PMBs and, while the protection they afford is welcome and necessary, they introduced a number of new problems. The rapid deployment of PMB related legislation has resulted in a massive open-ended risk for medical schemes. With medical practitioners reluctant to join scheme networks, and a growing problem of provider profiteering, schemes are being forced to funnel increasing portions of scheme contributions away from traditional benefits to fund PMBs.

Unfortunately for patients, PMBs are far from exhaustive. Here are just a few things not covered by PMBs:

- A large percentage (49%, according the Council for Medical Schemes) of hospital admissions are for non-PMB cases.
- Exploratory, diagnostic and screening procedures where the cause is found to be non-PMB
- Newer and more expensive treatments which are not available in state facilities
- Countless ordinary medical conditions which, while normally not life threatening, can become so and can severely affect quality of life.

All of these cases are increasingly subject to tariff shortfalls as schemes drop reimbursement rates in order to fund PMB treatments.

How administrative problems create financial risks for patients

PMB administration also puts patients in significant financial risk. While I have been very impressed by the Council for Medical Scheme's complaints procedures, these complaints can take a very, very long time to resolve – easily long enough for patient to suffer significant financial hardship (in the form of debt, financial judgements or insolvency). Significant confusion still exists at scheme and patient level as to what should be covered under PMBs in terms of specific treatments. A particular problem is the question of when a condition constitutes an emergency – a distinction patients are rarely able to make in the moment.

Designated service providers are another significant problem. DSPs are often scarce or unavailable, and although a member should be able to claim at any provider in those circumstances, in reality this can involve

months of disputes and motivations before the claim is paid. There are also very vague guidelines as to what constitutes 'available'. How far from a patient's home can they be? Must they be able to speak the patient's language? Is a doctor still 'available' if he can only grant an appointment in 8 weeks? Problems can also arise when the DSP surgeon doesn't work out of the DSP hospital, or if he does, there is no DSP anaesthetist at that hospital.

Why I need Gap Cover:

Gap cover protects me by:

- Covering shortfalls for a wide variety of treatment which are not covered by PMBs
- Covering shortfalls for newer, more advanced treatments for PMB conditions
- Protecting my freedom to choose who I entrust my medical care to
- Protecting me from financial difficulty during dispute processes
- Giving me peace of mind in knowing that I can go for diagnostic procedures and the account will still be paid, in full, even if it doesn't turn out to be a PMB condition
- Giving me peace of mind that if a medical condition arises suddenly I can seek treatment and the bill will be paid, in full, even if the condition doesn't meet someone else's definition of an 'emergency'
- Enabling me to treat a condition immediately, rather than having to wait until my life is on the line and it becomes a PMB condition. (example: If I had a hernia, I would have to wait for it to develop gangrene or an obstruction before I could get full cover under PMBs – rather than preventing complications, PMBs can sometimes require them)

Medical schemes are under a great deal of strain under the current environment and simply cannot provide all the coverage and protection listed above (even on the most expensive options). My medical aid does a great deal for me, but its resources are not infinite and a gap exists. Gap cover simply enhances what my medical aid provides and affords me options.

And finally ...

Gap cover is not a replacement for medical aid, nor does it influence my medical scheme option choice. Until the cost of medical care is addressed – *at the source* - consumers need protection against the financial risks involved. Removing gap cover simply reduces even further the value-for-money proposition of medical scheme cover and makes reliance on the state and self-insurance a more attractive option. Medical schemes provide the basic medical protections all South Africans need, gap cover acts in concert with schemes to enhance the attractiveness of medical scheme membership.

I urge you to please reconsider these draft regulations and introduce distinctions between types of health-related insurance so that gap cover can continue to enhance medical scheme benefits and members can protect themselves from potentially devastating out of pocket expenses.

Yours sincerely,