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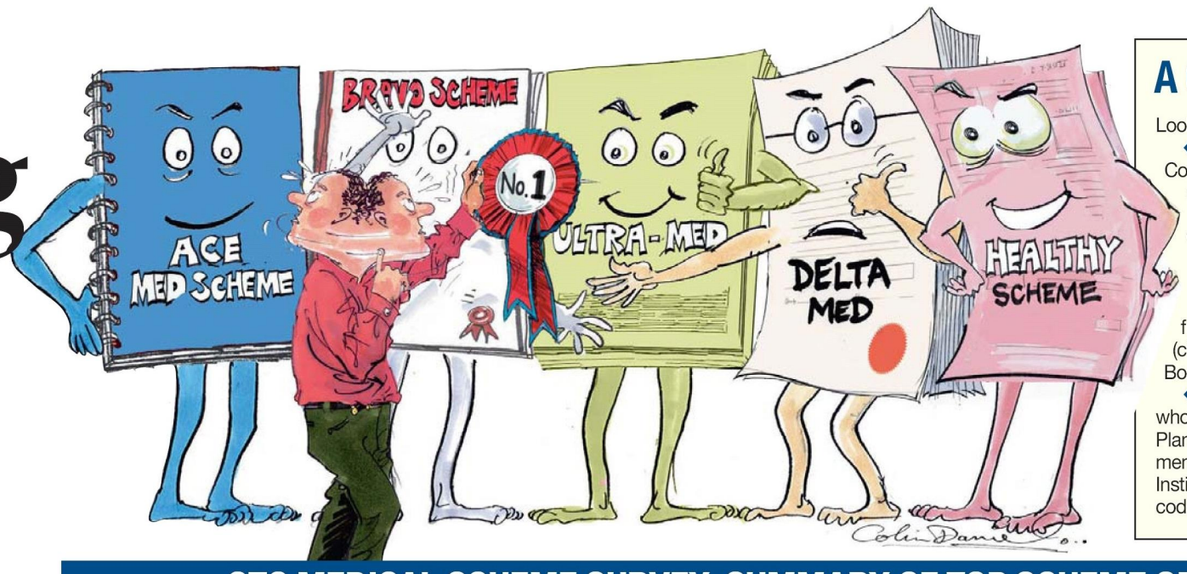
AVE: 203892.15 (ZAR)

■ A MYRIAD OF BENEFIT PERMUTATIONS

It's tricky deciding on medical cover that's best for you



The company behind a recent survey ranking scheme options is the first to admit that the survey is just a starting point, writes **Laura du Preez**.

It would be great if there was a survey that could identify the single best medical scheme for us each year.

From recent headlines in other media, you might think the GTC (previously Grant Thornton Capital) Medical Aid Survey 2016 would do just that.

But, unfortunately, it's not that easy. In fact, choosing a medical scheme is fraught with difficulties. The easy option is to find a good medical scheme broker to do the job for you. There's no extra cost to you, because the broker's commission comes out of scheme members' contributions.

The GTC survey identifies the open schemes that should be on a shortlist for GTC Health Consulting's brokers to interrogate further as suitable schemes for employer groups.

The survey does not tell you, as an individual, that if you want a hospital plan, for example, you should definitely join Bestmed Beat 1, or if you want a comprehensive option that doesn't restrict you to certain hospitals, you should definitely choose Momentum's Extender option.

Although these two options feature at the top of the survey in their respective categories, there are many ifs and buts.

STEPS TO RANKING SCHEMES

Jill Larkan, the head of healthcare consulting at GTC, is the first to admit the survey's shortcomings and to point out that it is a starting point rather than the definitive answer. The scheme that is right for you depends a lot on your healthcare and financial needs.

Comparing medical schemes and their options is a nightmare, because there are so many permutations. To make some sense of it, Larkan took the following into account when ranking schemes:

1. She grouped the options into 11 option types according to their benefits. The main ones are:

◆ Entry-level options, which typically require you to use networks and offer basic hospital and day-to-day benefits;

◆ Hospital-only plans, which offer hospital cover and prescribed minimum benefit (PMB – see "Definitions") cover only;

◆ Plans that offer hospital cover and a medical savings account for day-to-day cover; and

◆ Comprehensive plans, which offer the best hospital and day-to-day cover.

2. Within each option type, the hospital cover may differ because:

◆ There is an overall limit on the amount the scheme will pay. This mostly affects lower-cost options. To get around this problem, Larkan assumed that anyone on an option with an overall limit would buy top-up cover (see "Definitions") to bring their maximum cover up to R2 million per family per year.

◆ The rates at which schemes reimburse doctors for treating you in hospital differ from scheme to scheme. If your doctor charges more than your scheme's tariff, you are liable for the difference, unless your condition falls under the PMBs.

For a number of years, there have not been any guideline tariffs at which doctors and other healthcare providers, such as pharmacies and hospitals, should bill you or your scheme, which means that each scheme has its own rates, which are roughly aligned to the now-redundant National Health Reference Price List (NHRPL) and adjusted for inflation.

The different rates at which schemes reimburse doctors make it impossible to compare scheme options, so Larkan assumed that all members would buy gap cover (see "Definitions") to ensure that doctors are paid in full. This adds to the cost of the cover.

◆ Any sub-limits applying to hospital benefits were ignored. This could be important to you if a limit applies to a condition from which you suffer.

◆ Any restrictions or treatment protocols applying to, for example, major medical benefits, such as oncology, were not taken into account. For this, you or your broker need intimate knowledge of a scheme's rules, especially if you are looking for cover for health conditions from which you or a family member suffer.

3. Medical schemes are obliged, by law, to provide the PMBs. These cover 26 common chronic conditions, but the cover for the chronic conditions differs in the following ways:

◆ Some schemes cover more than the 26 chronic conditions.

◆ Some schemes have formularies, or essential drug lists, and you must choose medication from these lists to be covered in full for your chronic condition. Some schemes' lists are more generous in terms of choice and quality than others.

◆ Some schemes insist that you obtain the medication for a chronic condition from a particular provider, known as a designated service provider (DSP). In the worst-case scenario, the DSP is a state hospital or clinic.

DEFINITIONS

Open medical schemes admit anyone as a member. **Restricted schemes** limit their membership to the employees of certain employer groups, trade unions or industries.

◆ **Top-up cover:** insurance bought in addition to your medical scheme cover to provide benefits that your scheme does not provide. For example, if your scheme has an annual overall benefit limit of R1.5 million per family per year, you can buy top-up cover of R500 000 to ensure you have R2 million of cover.

◆ **Gap cover:** insurance bought in addition to your medical scheme cover to protect you against facing a high bill from a doctor who treats you in hospital and charges more than the rate at which your medical scheme reimburses him or her.

◆ **Above-threshold benefits:** benefits provided as added protection on a medical scheme option that has a medical savings account to protect you from facing high claims for what are largely out-of-hospital claims after you deplete the savings in your account.

◆ **Self-payment gap:** if your scheme option offers a medical savings account and above-threshold benefits, the self-payment gap arises when you exhaust your savings account but have not yet reached a certain level of claims, or claim threshold. Above this threshold, your benefits are paid for by the scheme through its above-threshold benefit.

◆ **Prescribed minimum benefits:** benefits that your scheme must, by law, provide. These benefits cover all medical emergencies, 26 common chronic conditions and 270 conditions that, if left untreated, would severely affect the quality of your life.

The GTC survey shows, for example, that the best comprehensive option is the Momentum Extender (associated state) option, but on this option you must get your chronic medication from a state facility, and it is therefore probably suitable for you only if you do not have a chronic condition. If you do, you are likely to want to use a private doctor for consultations and a local pharmacy for quick access to medicines.

4. On most middle-of-the-range plans, day-to-day benefits beyond those for chronic conditions covered by the PMBs are provided through a medical savings account. Each rand you contribute to these accounts is what you get to spend on day-to-day benefits – if you contribute R500 a month, for example, you will have R6 000 for the year (R500 x 12). This means saving R500 in an ordinary bank account earmarked for medical expenses could have the same effect. The main difference is that the medical scheme typically gives you access to your annual medical savings upfront.

Larkan therefore excluded day-to-day benefits and the cost of contributing to the savings accounts from her analysis, because it doesn't assist in determining whether or not you get better value for money from your medical scheme on a rand-for-rand basis, although the discipline of savings in these accounts, the access to the credit and, if you are lucky enough to get one, a subsidy from an employer, obviously assists some members.

5. The exception to this rule is in the case of the comprehensive options. In this category, Larkan considered 16 different options that offer unlimited, above-threshold benefits (see "Definitions") once you have exhausted your medical savings account and been through what is known as the self-payment gap. Schemes have different rules about what counts towards your threshold, so to make the options comparable, Larkan assumed that all claims accumulated and were paid at 100 percent of scheme tariffs, based on the NHRPL adjusted for inflation.

She states in the survey, however, that, in reality, payments are not made in this way and "many of the costs payable are at private rates, which extend or seemingly increase the self-payment gap monthly".

When determining the best price for a comprehensive medical scheme option, Larkan used the cost of the contributions plus the cost to you of the self-payment gap, assuming your claims are incurred at 100 percent of scheme rates.

6. Most medical schemes offer preventative healthcare benefits, which are designed to ensure that, if you use them, you don't get sick in the first place or your illness is detected early. These benefits include immunisations, flu vaccinations, blood pressure and glucose tests, pap smears, dental check-ups and even scans during pregnancy. Larkan says GTC decided to exclude these benefits from the survey this year because most schemes offer them.

However, in practice these benefits vary widely among schemes and scheme options. Some options pay for you to have two dental check-ups a year, while others do not.

The benefits that suit you will depend on your circumstances – for example, if you are a young healthy man, you may need only dental check-ups, while a pregnant woman will value the paid-for scans.

7. The survey's option categories were also divided into those that cover healthcare providers of your choice and those that restrict you to using providers within a network. Giving up choice typically lowers your contributions, because your medical scheme negotiates a better rate with the provider by guaranteeing that its members will use that provider.

8. Within each option category, the cost of top-up cover required to provide at least R2 million of hospital benefits a year was added to each option's contribution costs. The lower the total cost to the member, the higher the score, and this determined where the scheme was ranked in the survey in terms of a micro (cost-benefit) analysis.

The survey includes certain other so-called "macro" factors that have implications for the health of the scheme (see "The bigger picture" right).

A GOOD BROKER

Look for a broker who is:

◆ Accredited with the Council for Medical Schemes (accredited brokers are listed on the council's website, www.medicalschemes.com);

◆ Licensed as a financial services provider or is a representative of a licensed financial services provider (check on the Financial Services Board's website, www.fsb.co.za).

◆ Ideally, a financial adviser who has the Certified Financial Planner accreditation and is a member of the Financial Planning Institute (FPI), bound by the FPI's code of conduct.

GTC MEDICAL SCHEME SURVEY: SUMMARY OF TOP SCHEME OPTIONS

	NETWORK			NON-NETWORK		
	P	P+A	P+A+2C	P	P+A	P+A+2C
RISK ONLY						
Entry level comprehensive (people earning R4 000 - R7 000 a month)	Compcare NetworX	Compcare NetworX	Compcare NetworX	Momentum* Ingwe (any)	Momentum Ingwe (any)	Momentum Ingwe (any)
Entry level comprehensive (students earning <R1000 a month)	Compcare NetworX	Compcare NetworX	Compcare NetworX	Momentum Ingwe (any)	Momentum Ingwe (any)	Momentum Ingwe (any)
Entry level comprehensive core (people earning R4 000 - R7 000 a month)	Discovery KeyCare Core	Discovery KeyCare Core	Discovery KeyCare Core			
Entry level comprehensive core (students earning <R1000 a month)	Discovery KeyCare Core	Discovery KeyCare Core	Discovery KeyCare Core			
Hospital only	Bestmed Beat 1	Bestmed Beat 1	Bestmed Beat 1	Genesis Private Choice	Genesis Private Choice	Genesis Private Choice
Saver	Bestmed Beat 2N	Bestmed Beat 2N	Bestmed Beat 2N	Bestmed Beat 2N	Bestmed Beat 2N	Bestmed Beat 2N
COMPLETE COSTS						
Comprehensive	Momentum Extender (associated, state)	Momentum Extender (associated, state)	Fedhealth Maxima (standard elect)	Momentum Extender (any, state)	Momentum Extender (any, state)	Discovery Essential (comprehensive)

Key: P – principal member; A – dependent adult, 2C – two dependent children; Risk only – medical savings account benefits not included; Complete costs – all costs included.
*Momentum options have any (any provider), associated (associated provider) and state (state provider) sub-categories.

THE BIGGER PICTURE

It is not good enough to find a scheme with good benefits; you also need to know if your scheme will be able to provide those benefits into the future. For this reason, it is useful to consider the financial health of a scheme.

In the GTC Medical Aid Survey 2016, Jill Larkan, GTC's head of healthcare consulting, considered four "macro" factors that can influence a scheme's financial health. The factors were:

◆ The growth in the scheme's membership;

◆ The ratio of pensioners to members under the age of 65, because pensioners typically use more medical benefits, resulting in higher contribution rates for schemes;

◆ The solvency ratio (the ratio of money a scheme has in reserve to the annual contributions it collects); and

◆ The average age of members.

Larkan weighted these four factors equally when she rated medical schemes, but you or your adviser may believe the average age of a scheme's members is more important to the future health of the scheme than its growth rate or solvency ratio.

Larkan says there are many other "macro" factors that could be taken into account. Each year, the Council for Medical Schemes publishes its annual report, which contains information about each scheme's financial status, membership, complaints laid against the scheme, how much it spends on healthcare and non-healthcare expenses, and whether each option is, as required by law, self-sustaining (the option's contribution income must meet its claims and non-healthcare costs).

Larkan says that, for example, while the Compcare NetworX option scored highly in the survey as an entry-level option, it made an operating loss last year and this may be a concern. Because schemes must ensure that options are self-sustaining, if an option makes a loss, the scheme must cut benefits, increase contributions or both.

Financial services company Alexander Forbes publishes an annual medical scheme sustainability index that indicates how sustainable schemes are, in its annual *Diagnosis* publication.