

## **Private Healthcare: the widening gap between what you think you're covered for and what you're actually covered for**

*Sirago Underwriting Managers*

### **Why gap cover is an essential shield against financial devastation in South Africa's private healthcare system**

*"You may think that my use of the term 'devastation' is overly emotional or exaggerated. I can assure you, it is not. I have witnessed firsthand the financial devastation some medical scheme members have been subjected to due to inadequate, inappropriate and sometimes unaffordable healthcare cover." Martin Rimmer, CEO of Sirago Underwriting Managers.*

Every year, thousands of South African medical scheme members walk out of private hospitals with something they did not expect: a serious bill not covered or only partially covered by their medical scheme benefits based on their specific option, from the specialists who treated them.

In most instances, specialist doctors charge rates well above what the medical scheme benefit pays for in-hospital treatment. The result is a tariff shortfall, also referred to as the medical scheme tariff/rate, that the member must fund personally.

This is the reality of private healthcare in South Africa, and it is precisely why gap cover exists. Claims data from Sirago Underwriting Managers shows just how significant these shortfalls are and why, regardless of your medical scheme option, gap cover should be considered an indispensable part of your private healthcare funding strategy.

### **The Regulatory Framework: Why Gaps Exist at All**

South Africa's private healthcare system is governed primarily by the Medical Schemes Act, overseen by the Council for Medical Schemes (CMS). The Act requires all registered medical schemes to fund a defined basket of Prescribed Minimum Benefits (PMBs) - a set of serious conditions and emergency events, at cost, meaning the scheme must cover the full cost of treatment, regardless of what the healthcare provider charges. PMB management is incredibly complex, as the rules, while universal, are applied differently by the medical schemes.

Whether a condition qualifies as a PMB, how the scheme interprets its protocols, whether a Designated Service Provider (DSP) is involved, and whether the treating specialist has a tariff agreement with the scheme all affect the amount actually paid.

The payment rift lies in specialist tariffs. Unlike the pharmaceutical sector, where medicine prices are regulated under the Single Exit Price mechanism, there is no regulatory ceiling on what a healthcare specialist may charge in South Africa. Specialists are free to set their own fees, and in a market characterised by acute skills shortages and growing demand, many charge rates that are 200% to 500% higher than what medical schemes reimburse. There are even some outliers where the tariff rates are 800% higher than the scheme payment.

The scheme will only ever pay its contracted rate. The specialist charges their preferred rate, even if they are contracted with the schemes. The difference is the tariff shortfall, and it lands in the member's lap.

### **Medical Scheme Membership Is Not Full Cover**

There is a widely held and potentially very costly misconception that belonging to a medical scheme means your in-hospital treatment is fully covered. It is not. Most

medical scheme options reimburse in-hospital specialist fees at a fixed percentage of a reference tariff, commonly referred to as the Scheme Rate or Scheme Tariff. But these benchmarks have not kept pace with actual market charges, and a specialist billing at 500% of tariff will leave even a member on a 300% reimbursement option facing a 200% shortfall on their own account.

Beyond tariff shortfalls, medical schemes can/also impose:

- **Co-payments:** Fixed amounts a member must pay for certain procedures.
- **Sub-limits:** Annual caps on specific benefits, after which the member funds further treatment.
- **Benefit exclusions:** Certain treatments or procedures that schemes do not cover at all.
- **PMB interpretation gaps:** Where a diagnosed condition is not recognised by the scheme as a PMB under their protocols, even if it is clinically serious.

Gap cover is a short-term insurance product regulated under the Short-Term Insurance Act, specifically designed to bridge the shortfall between scheme reimbursements and actual healthcare provider charges for in-hospital events. It does not replace a medical scheme but works alongside it as supplementary cover.

### A Snapshot of Real Gap Claims

To understand just how severe these shortfalls can be, consider the following analysis of gap cover claims paid by Sirago Underwriting Managers across a representative sample of 2330 large loss claims between 2020-2025. (A large loss claim is defined as R50 000+).

Age Group	No. of Claims	% of Total	Avg large loss Gap Claimed	Highest Single Claim
0 – 29 Years	117	5%	R60,517	R164,000
30 – 49 Years	415	18%	R58,060	R173,589
50 – 65 Years	709	30%	R62,857	R201,000
66 – 75 Years	639	27%	R65,221	R204,942
76+ Years	450	19%	R64,755	R211,293
<b>TOTAL</b>	<b>2,330</b>	<b>100%</b>	<b>R62,900</b>	

23% of all large loss gap claims are from members aged 49 and under - people who statistically believe themselves to be young and healthy.

In almost half of Sirago's large-loss gap claims in 2024, gap cover paid out more than the medical scheme did. In one case, gap cover paid R126,771 while the medical scheme paid only R27,573 - just 18% of the total treatment bill. The member's medical scheme

premium was R8,000 a month. Their gap cover premium was R450. Without that gap policy, they would have been personally liable for R126,771.

### Claims by Condition Type

The following breakdown illustrates which medical categories generate the most gap claims:

Condition Category	No. of Claims	% of Total	Avg Gap Claimed
Musculoskeletal & Connective Tissue	1,139	49%	R61,659
Neoplasms (Cancer)	214	9%	R60,830
Circulatory System	202	9%	R89,241
Injury, Poisoning & External Causes	186	8%	R58,264
Respiratory System	119	5%	R60,147
Digestive System	109	5%	R53,547
All Other Conditions	361	15%	Various

Musculoskeletal conditions dominate at 49% of gap claims. Medical schemes frequently impose co-payments and sub-limits on elective orthopaedic procedures, particularly where internal prosthetics or specialised implants are involved. Circulatory conditions, while accounting for only 9% of claims by volume, have the highest average gap of R89 000. Cancer, also at 9% of claims and an average of R61 000 per claim, and respiratory conditions at 5% and an average claim of R60 000, reflect the complexity and cost of cardiac, vascular and respiratory surgeries, as well as cancer-related surgeries, where specialist fees can be extremely high and PMB determination can be contested.

### Individual Claims: The Human Cost

For every R shown below, the medical scheme paid its portion - these amounts are what would have been the member's personal liability without gap cover:

Age Group	Condition	Gender	Gap Amount Claimed	Category
76+ yrs	Thoracoabdominal aortic aneurysm	Male	<b>R211,293</b>	Circulatory

76+ yrs	Neoplasm, meninges (growth on the brain/spinal cord lining)	Female	<b>R205,400</b>	Neoplasm
66 – 75 yrs	Acute ischaemic heart disease	Male	<b>R204,942</b>	Circulatory
76+ yrs	Spinal stenosis, cervical region	Female	<b>R197,693</b>	Musculoskeletal
76+ yrs	Malignant neoplasm, gum	Male	<b>R189,309</b>	Neoplasm
66 – 75 yrs	Spinal stenosis, lumbar region	Female	<b>R183,000</b>	Musculoskeletal
50 – 65 yrs	Spinal stenosis, thoracic region	Female	<b>R175,709</b>	Musculoskeletal
30 – 49 yrs	Acute ischaemic heart disease	Male	<b>R152,360</b>	Circulatory
0 – 29 yrs	Tetralogy of Fallot (congenital heart condition present at birth)	Female	<b>R141,441</b>	Congenital
50 – 65 yrs	Malignant neoplasm of breast	Female	<b>R70,732</b>	Neoplasm
30 – 49 yrs	Lumbar disc disorder with radiculopathy (often called sciatica)	Male	<b>R58,732</b>	Musculoskeletal
30 – 49 yrs	Scoliosis, lumbar region (age 21, Female)	Female	<b>R102,821</b>	Musculoskeletal
0 – 29 yrs	Respiratory distress syndrome, newborn (age 6 days)	Male	<b>R77,061</b>	Perinatal

Perhaps the most striking claim in this dataset is the 30-49 year age group claim of R152,360 for acute ischaemic heart disease. Equally sobering is the R102,821 gap claim from a 21-year-old female with lumbar scoliosis. It is important to remember that ill health and/or disease are not age-selective. It can strike at any time.

### **What Is Driving These Shortfalls?**

- **Unregulated Specialist Fees** - Emigration, limited training capacity, and uncertainty created by healthcare reform have reduced the pool of specialists available to serve a growing, ageing, and increasingly health-burdened population. With no price regulation binding them, fees have escalated consistently and materially above general inflation.
- **Benefit Erosion by Medical Schemes (Risk transfer)** - Faced with runaway provider costs, medical schemes have responded in two ways: increasing contributions and simultaneously restricting benefits and access. Many South African families, squeezed by economic pressure, have opted to buy down to more affordable, hospital-only plans. While these plans offer essential in-hospital cover, their tariff reimbursement levels - often 100% of the scheme rate - are wholly inadequate relative to what specialists charge. The result is that the gap grows larger precisely as the member's financial cushion shrinks.
- **The PMB Complexity** - The PMB framework, intended as a floor of protection, can be inconsistently applied. Whether a condition is classified as a PMB, how the scheme defines its clinical entry criteria, and whether the treating provider qualifies as a DSP for that condition all affect the member's financial outcome. Disputes over PMB status are very common and in the interim, while the member is recovering, the bills accumulate and the providers are demanding.

### Gap Cover: What It Does and Does Not Do

Gap cover is a short-term insurance product, not a medical scheme. It does not replace your medical scheme membership and it does not fund day-to-day outpatient expenses such as pathology or medication. What it does do, is address the specific financial exposure that arises from in-hospital events where your scheme's benefit pays less than what specialists actually charge for treatment.

A comprehensive gap cover policy will typically cover:

- **Tariff shortfalls:** The difference between what a specialist charges and what your scheme pays, for in-hospital procedures.
- **Co-payments and deductibles:** Fixed amounts your scheme requires you to contribute toward a hospital admission or procedure.
- **Sub-limit top-ups:** Coverage once a specific scheme benefit (e.g., internal prosthetics, MRI, oncology) has been exhausted within the benefit year.
- **Initial cancer diagnosis benefits:** Lump-sum payments to fund the diagnostic costs of an initial cancer diagnosis, such as PET scans, MRIs.
- **Cancer co-payment cover:** Coverage of ongoing treatment co-payments once the scheme's cancer benefit sub-limit has been reached.

A comprehensive gap cover product such as Sirago's Ultimate Gap provides up to R223,000 per beneficiary per annum in gap cover protection, for a family premium of around R780 per month (2026 rates). Based on Sirago's average large-loss gap claim of R63,000, a single claim would be equivalent to nearly seven years of premium payments.

### The Five-Year Trajectory: An Accelerating Crisis

Sirago's large-loss gap claims data over five years (2020–2025) reveals a picture that demands attention. Mega claims - those exceeding R50,000 - have increased by 512% in volume and 437% in value over this period. In 2020, 89 such claims totalled R6.2

million. By 2024, 549 claims totalled R34 million. Claims exceeding R60,000, once exceptional, are now daily occurrences.

Cancer-related gap claims have surged in parallel. Initial cancer diagnosis claims increased by 263% between 2020 and 2024, reflecting both the delayed-diagnosis effects of the COVID-19 pandemic on preventative healthcare and a structural increase in cancer prevalence across the covered population. Cancer co-payment claims covering ongoing treatment shortfalls once scheme sub-limits are reached, increased by 130% in 2024 compared with 2022, when this benefit was first introduced.

These claims represent a fundamental and accelerating shift in the financial exposure of medical scheme members, across all income levels and all age groups.

### **What You Should Do**

- 1. Don't assume your scheme option is adequate:** Review your current scheme option's tariff reimbursement level. If your scheme pays at 100% or 200% of tariff, you are likely significantly exposed to shortfalls for any specialist-heavy in-hospital event.
- 2. Add gap cover - regardless of your scheme option:** Even comprehensive scheme options leave members exposed to tariff shortfalls.
- 3. Understand your PMBs - and their limits:** Know which conditions qualify as PMBs under your scheme and understand your scheme's DSP (designated service provider) arrangements.
- 4. Get a quote before a planned procedure:** For elective surgery, request a formal quote from every treating specialist, not just the surgeon, but the anaesthetist, and any other providers involved. Ask what they charge relative to your scheme's tariff. Where there is a significant shortfall, engage your gap cover provider to confirm benefit availability. Gap Cover providers DO NOT provide pre-authorisation and/or confirmation of exact costs.
- 5. Do not disclose your gap cover to healthcare providers:** There is growing evidence in the sector that some providers adjust their billing upward upon learning that a patient holds gap cover. You are under no obligation to disclose your gap insurance to your healthcare provider. Your scheme membership details, required for pre-authorisation, are sufficient.
- 6. Work with an accredited healthcare financial advisor:** Healthcare funding is complex, and the interaction between medical scheme benefits, gap cover, critical illness insurance, and disability cover requires coordinated planning. An independent, accredited broker can help you develop a healthcare financial strategy tailored to your specific health profile, life stage and budget.

### **The Cost of Being Unprotected**

A medical scheme membership card is not a guarantee of complete cover for a health crisis. It is an agreement that your scheme will fund your healthcare up to certain limits, at certain rates, for certain conditions. Beyond those limits, beyond those rates, and in the grey areas between PMB classification and providers charges, members are on their own - unless they have gap cover.

Sirago's claims data is a window into the financial realities that real South Africans face in private hospitals every day. Gap cover is a financial solution necessity for any South African who relies on private healthcare as a medical scheme member in the country.