Healthcare Industry Newsletter

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In this issue

SIMEKA HEALTH

member of Sanlam group

01 The impact of COVID-19 on medical schemes

When the COVID-19 pandemic reached our shores by March 2020, it soon became clear that the Council for Medical Schemes would take a firm stance to protect medical scheme members by declaring that the testing, treatment and vaccination of COVID-19 should be regarded as Prescribed Minimum Benefits (PMB). This means that, subject to certain rules, medical schemes must pay for all costs associated with the above COVID-19 claims from the scheme risk benefits. A detailed list of ICD-10 codes associated with testing, treatment and vaccination was published and this provides clear guidance in terms of COVID-19 related PMB's.

Medical schemes therefore absorb these costs for their members. While only around 16% of the total South African population are members of medical schemes, this provides welcome relief to both members and the state – who typically carry the cost of all non-medical scheme members.

During the first wave, Discovery Health Medical Scheme (Discovery) provided some insights into the costs associated to COVID-19, in a "Discoverer" distributed to brokers during the latter half of 2020.

According to Discovery, the average cost per COVID-19 hospitalisation is R98 915. This is substantially higher than the normal average cost per admission of around R30 000 as reported by the Council for Medical Schemes (CMS) Report - 2019. The average cost per COVID-19 related ICU admission is R151 756 and for a ventilated patient event, the cost is R341 936, according to Discovery.

When one expresses the COVID-19 costs as an amount per member, it can become quite scary. According to Discovery, the annual cost spread over all beneficiaries in their medium scenario, would be R2 200 per annum.

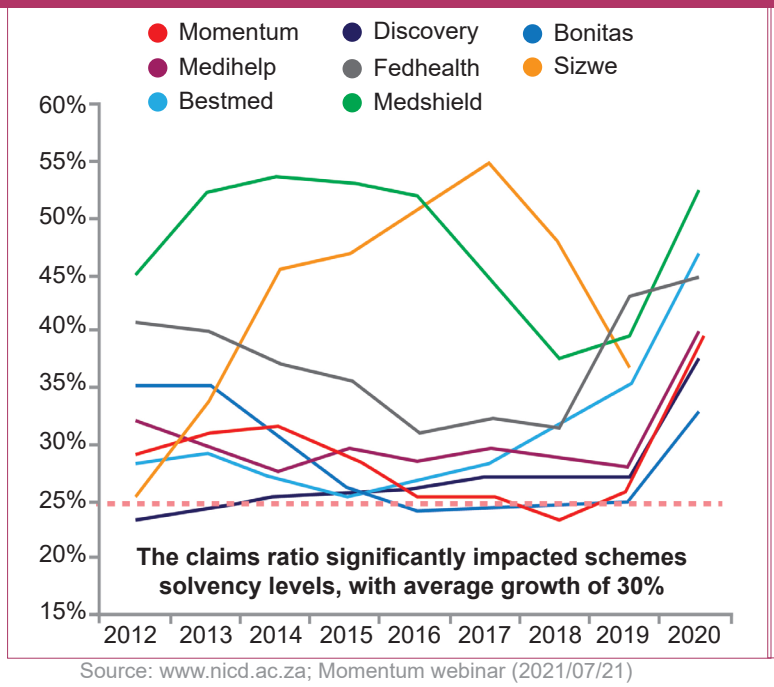
Medical schemes are required to hold reserves as protection against unexpected claims experience. When schemes calculated their contribution increases for 2020 (typically between August and September 2019), they would not have made an allowance for the impact of COVID-19.

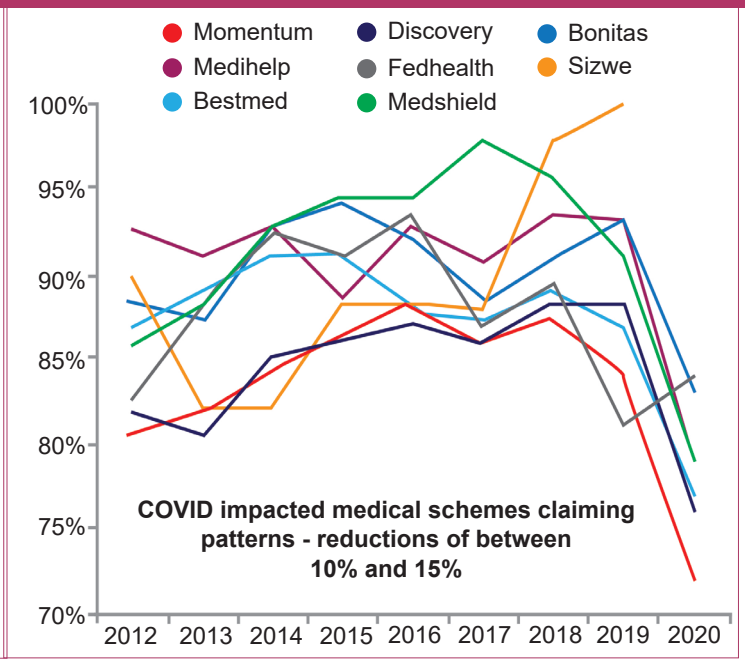
If we consider that a medical scheme must have 25% of annual contributions in reserve, then the average reserve per beneficiary should be in the region of R7 500, based upon the Council for Medical Schemes (CMS) report. Considering the earlier mentioned COVID-related annual cost of R2 200 per beneficiary, it equates to just under one- third of the value of reserves held per beneficiary. This puts the above mentioned average COVID-19 costs not budgeted for, into perspective.

Towards the latter part of 2020, it became clear that while medical schemes had to absorb these new costs, they also saved substantial amounts on other claims during the pandemic due to non-essential procedures being postponed. Most schemes reported 2020 to be a year where they have built additional reserves, hence the lower increases being announced for 2021. While these savings have not yet officially been included in the CMS audited reports, unaudited reports have confirmed this. Discovery reported its claims ratio to have come down to 76.5% compared to previous normal ratios in the mid-eighties. This equates to additional reserves of over R7.5bn accumulated during 2020, increasing their reserves to 35.8% (unaudited).

Bonitas reported similar trends with a claims ratio of 83% for 2020 and reserves growing from 24.9% at the end of 2019 to 32.7% at the end of 2020 (unaudited).

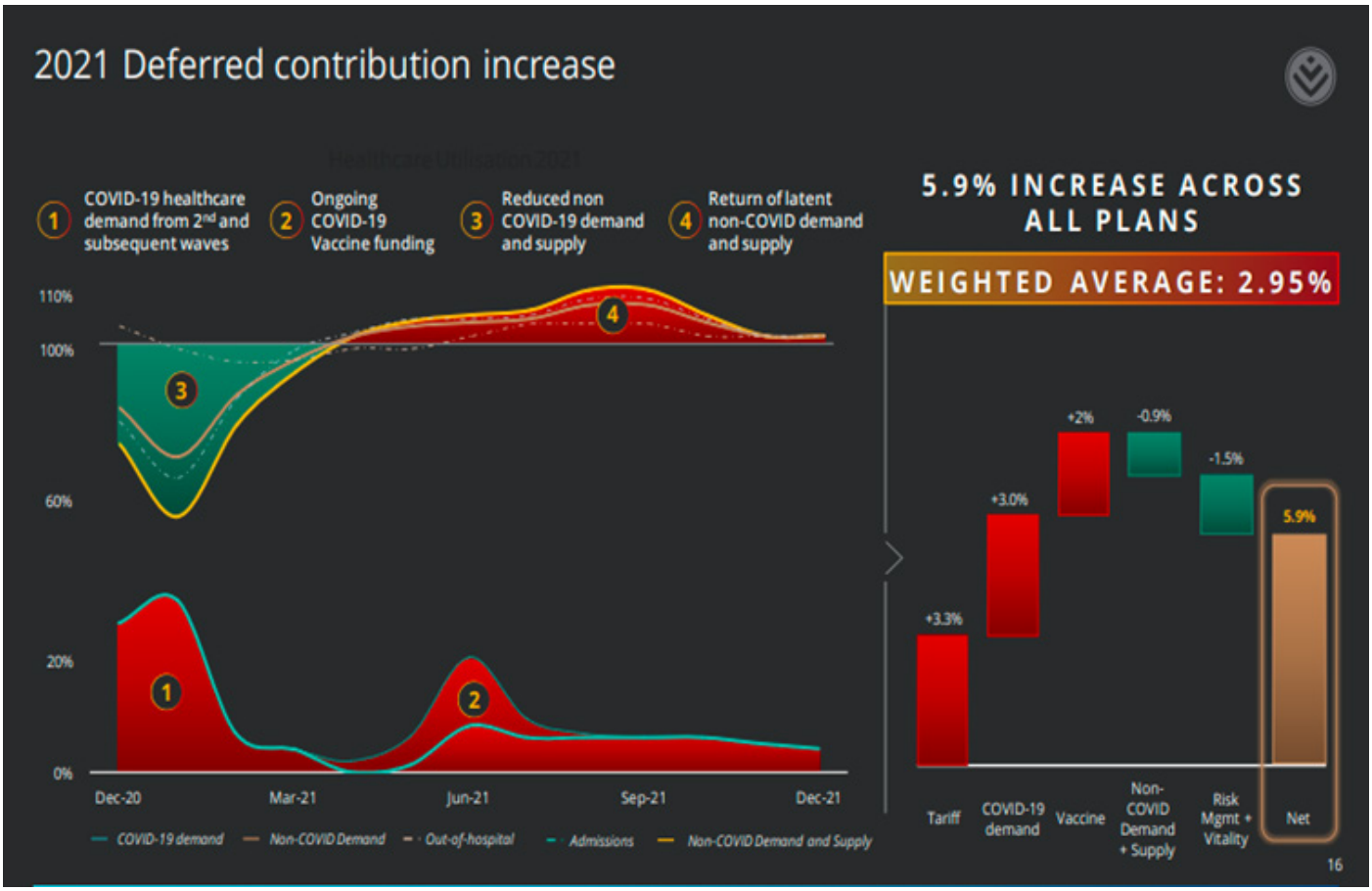
Some schemes, especially those with older membership profiles, could be harder hit by COVID, but they could also benefit from fewer non-essential operations.





Source: www.nicd.ac.za; Momentum webinar (2021/07/21)

The graph below, shared in May when they announced their mid-year increase, Discovery illustrated the effect of higher COVID-related costs versus the lower non-COVID costs to indicate how they derived at their mid-year increase. It demonstrates how the two factors at the top and bottom of the graph is expected to impact costs. Discovery has specifically warned against possible higher future costs into 2021, as non-essential operations will return, adding to the further cost of vaccinations. Their increase strategy clearly reflected their conservative approach.



Due to the economic hardship associated with COVID-19, we saw a number of members downgrade their options. According to a Moneyweb article published on 28 June 2021, Discovery lost 2% of its membership in 2020. This is directly related to economic factors, with a number of businesses downscaling or closing down. This is a trend with other schemes too.

Bonitas recently shared some of their statistics related to COVID-19 with the broker fraternity.

Up to the end of July 2021, Bonitas has funded over 350 000 COVID-19 tests, with just under 66 000 positive cases resulting in just under 17 000 hospitalisations. 22% of hospital events required ICU treatment and the scheme reported just over 2 700 deaths. Of their total membership, 8.5% (41 778) beneficiaries have had at least one vaccination dose.

With planning related to 2022 increases starting now with all schemes, it would be very interesting to see how the above-mentioned aspects will be factored into the expected cost of healthcare funding for the year ahead.

Trends observed - linked to COVID-19

As one of the most notable events in our lifetimes, given the global impact, COVID-19 has had a profound impact on the healthcare industry and society. Below is a short list of trends which have impacted the industry and society:

- The pandemic has placed enormous strain on healthcare resources, facilities and research
- We have seen a very high demand for COVID-19 related equipment and medicines
- We have seen lower demand for non-essential healthcare interventions
- We have seen an increased appetite for digital and home-based care
- We have seen the impact of social media in creating uncertainty regarding the severity of the pandemic, protective measures to be taken and the effectiveness of medicines and vaccines
- We have seen total disregard for lockdown measures within some communities versus overstated fear in other sectors of society
- We have seen affected businesses and vulnerable sectors of society being forced to adapt to survive

02 COVID-19 management in the workplace

With the 3rd wave of COVID-19 upon us and vaccinations beginning to gain momentum, for many employers the optimal management of the pandemic is a way to resume productivity while in the grips of the pandemic.

Various tools and measures can be implemented to minimise risks in the workplace.

Afrocentric Corporate Services, an end-to-end provider in the field of corporate wellness, can provide the full spectrum of services to manage COVID-19. Their experienced team will establish a strategic framework and specific response plan that is guided by industry and best practice guidelines as well as legislative requirements.

Vaccination

Wellness Odyssey can provide a mobile service at worksites, or employers can register their workplaces as closed temporary outreach vaccination sites and bulk upload employee data onto EVDS. The latter option allows for fast tracking of the vaccinations according to the NDOH phased approach for that population. A number of steps need to be followed to register a closed workplace vaccination site and can be completed electronically on the relevant CSIR site.

Vaccination is voluntary and will only be administered to those who are eligible in line with the NDOH phased roll out approach. From 1 September, all persons older than 18 are eligible for vaccination.

The employer- specific vaccination service allows for registered nurses who have completed the National Department of Health's online training to administer vaccines. The vaccines are obtained from contracted partner pharmacies who are responsible to store vaccines as prescribed. The registered nurses record the required information on the COVID-19 mobile application. The cost of the Johnson & Johnson and Pfizer vaccines vary, but cost around R400 per dose including the administration fee. A Project Management fee is also charged.

Wellness Odyssey provides valuable information on individuals who should be excluded from vaccination, or have it postponed due to the risk of an adverse reaction:

- Someone presenting with a high temperature or have symptoms of a cold or flu
- Someone with a known allergic reaction to a component of the vaccine (polyethylene glycol or polysorbate), a previous dose of the vaccine, or another vaccine or injectable medication
- Someone who has received any vaccine in the past 14 days
- Someone who has a weakened immune system due to conditions such as cancer or HIV
- Someone who has recently tested positive for COVID-19
- Someone who is pregnant or is breastfeeding
- Someone who has a bleeding disorder or takes blood thinners
- Someone who has had dermal fillers

The Afrocentric Corporate Services scope of COVID-19 services include:

- Sourcing and providing Personal Protective Equipment which could include branded safety screens, branded face masks and sanitizer stands with messaging
- Training and guides to managing and recovering from COVID-19 through their Employee Assistance Program
- Access to a COVID-19 pandemic support line
- COVID-19 testing, including rapid tests
- Screening programmes
- Clinical consultancy services
- Vaccination service

For most of the above instances, the vaccine can be taken later or subject to approval from the person's specialist. As can be expected there are specific number requirements for Afrocentric/Wellness Odyssey or other providers like Discovery to be able to deliver the services as described and your Simeka Health consultant will gladly introduce you to the correct channels.

Sources: Afrocentric/Wellness Odyssey Corporate onsite COVID-19 Vaccination Proposal 25 June 2021

Why vaccinate?

It is widely recognised that communities will only return to some kind of normality once a large enough percentage of the population has been vaccinated to reach herd immunity. Herd immunity is reached when enough people in a community have antibodies to develop a resistance to the disease, which prevents them from falling ill and further spreading the disease. The literature refers to around 66% of the adult population needing such resistance, either through developing antibodies from having had the disease or having been vaccinated. In South Africa's case, this requires 27 million adult people to have such resistance.

Scientists, like Professor Barry Schoub, Chair of the ministerial Advisory Committee on COVID-19 vaccines, calculate herd immunity by using the current reproductive number (number of persons on average being infected by one infected person). For herd immunity, that number should not be more than 1. According to the National Institute for Communicable Diseases, all provinces in South Africa had a reproductive rate of above 1 during all levels of the current third wave, using data sets related to deaths, admissions and number of cases.

Currently (18 August 2021), according to www.graphics.reuters.com in South Africa 9.55 million doses have been administered, resulting in only 8.2% of persons in South Africa being fully vaccinated. Even at the challenging target of 300 000 vaccinations per day, or around 1.5 million per week, a number of observers have indicated that the target will not be reached by the end of the year as initially envisaged. Given the double dose required for the Pfizer vaccine, this look more attainable by the end of the first quarter 2022. By that time a new strain might require a further jab.

We can be assured that our future will require ongoing, possibly annual vaccinations for COVID-19 and other viruses, similar to what is required to prevent the common flu.

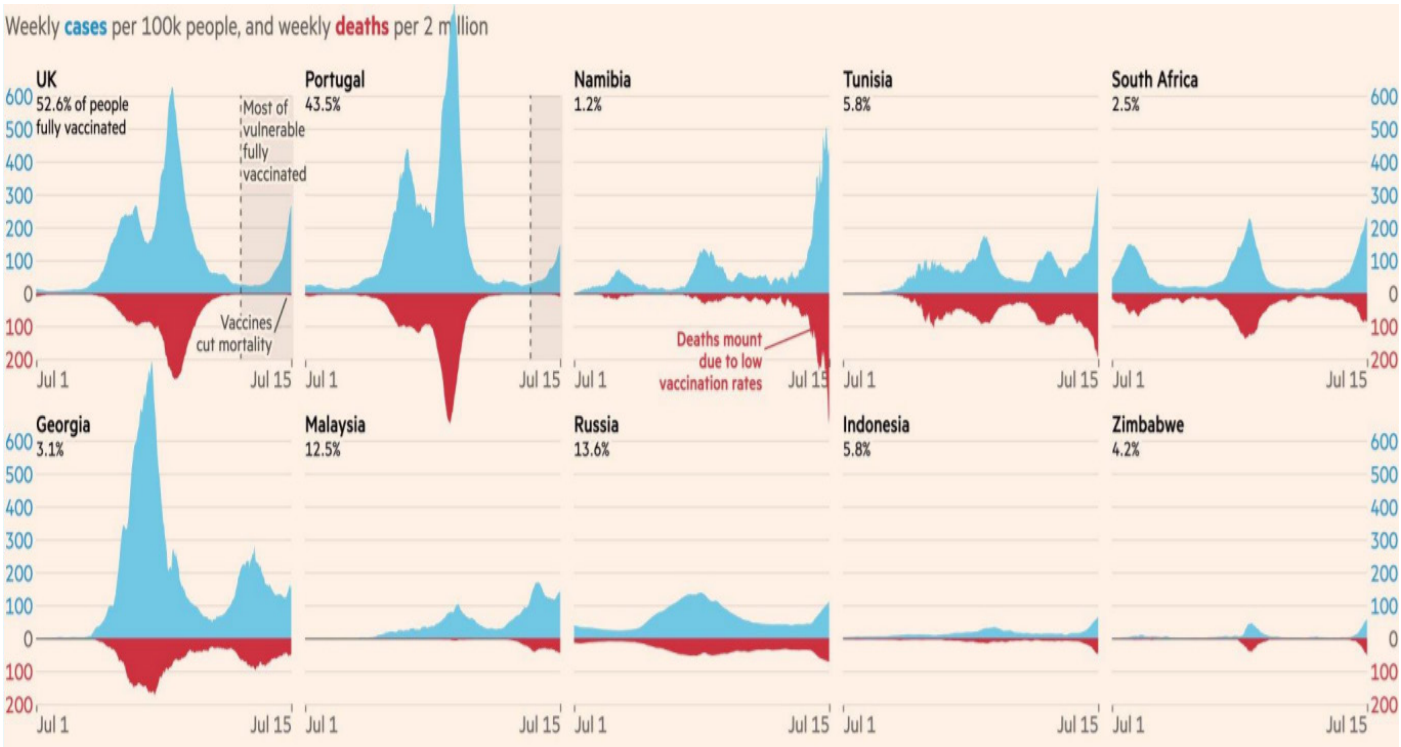
The benefits of vaccination become quite clear when you compare the COVID-19 mortality rate of countries who have had substantial numbers of vaccinations administered versus those who have been lagging.

During a webinar hosted on 21July 2021, Damian McHugh, Marketing and Distribution Executive at Momentum Health Solutions shared interesting statistics regarding the relationship between vaccination and mortality, linked to COVID-19. In the UK, where 52.6% of people (mostly the vulnerable section of the population) have been fully vaccinated, the current wave has resulted in very low mortality, whereas during their first wave and prior to vaccinations, they had a very high mortality rate. In a country like Tunisia or South Africa, where vaccination has been slow, the mortality is still very high during the current wave. This is one of the clearest scientific indicators of the success of vaccinations.

Source: www.nicd.ac.za; Momentum webinar (2021/07/21)

Covid cases and death rates - vaccinations

In well-vaccinated countries, the Delta surge in **cases** is no longer mirrored in **deaths**.
In countries where few have been vaccinated, **death rates** are reaching record highs.



Source: FT analysis of data from Johns Hopkins CSSE. Cases shifted forward to account for lag between infection and death

COVID-19 tests

The table below, provided by Bonitas, highlights the differences between the different types of COVID-19 tests available.

	PCR (polymerase chain reaction) test	Antigen test	Antibody test
Purpose	• Identifies Sars-CoV-2 virus infection • Confirms you have COVID-19	• Identifies Sars-CoV-2 virus infection • Screening tool, which requires PCR test for confirmation	• Identifies antibodies against Sars-CoV-2 virus infection
How	• Nasal or throat swab	• Nasal or throat swab	• Blood from a vein or from a finger prick
Where	• Tested in a lab • Some larger clinics may have a PCR machine	• Tested in a lab or • Rapid Antigen test at workplace clinic, pharmacy, or GP	• Tested in a lab or • Rapid Antibody test at workplace clinic, pharmacy, or GP
Waiting time	• Usually 24-48 hours • Can be longer during surges in new cases	• Rapid Test: Approx. 20 minutes	• Rapid Test: Approx. 20 minutes
Best time to test	• When you are experiencing symptoms • If no symptoms (contact tracing), not sooner than 5 days after contact with a COVID-19	• When you are experiencing symptoms • If no symptoms (contact tracing), not sooner than 6 days after contact with a COVID-19	• Antibody levels peak around 21 days after contact and start to wane after around 30
Advantages	• Very sensitive (can pick up viral fragments in very low concentrations) • Very specific to SARS-CoV2 (the test does not confuse SARS-CoV-2 with other viruses)	• Fast • Cheaper than PCR • Greater availability (clinics, GPs, etc.)	• Identifies past exposure

NDOH guide on where to use	• Sole diagnostic test confirming infection	• Screening at SA ports of entry
		• Additional categories considered:
		  • Screening a person with symptoms
		  • Screening healthcare workers
		• Contact tracing (close contacts)
			• For use in surveys

Disadvantages	• Generally, only available in a lab • Long turn-around time • Expensive • Unpleasant sampling in nose	• Lower sensitivity than PCR tests • Unpleasant sampling in nose • Requires confirmation by PCR test	• Some people who get COVID-19 produce relatively small antibody responses, especially those who had mild or asymptomatic illness, which can be missed by the test • High rates of false negatives & false positives • More suitable for epidemiological surveys
Costs (Dis-Chem)	• R850	• R350	• R150

Source: Bonitas Poster know the diff PCR vs AG vs Ab (2020-02-02)

03 Medical scheme cover after retirement

We are all confronted with the scary thought of having to provide for medical cover after retirement. Whereas most expenses might reduce after retirement, medical expenses are bound to increase, whether funded from one's own funds or funded via a medical scheme contribution.

As we approach retirement, one can actually save on medical expenses as children leave the home and parents only have to fund medical expenses for themselves. Often, the financial position of families is also such that some risk can be taken upon themselves, given the financial reserves at their disposal, hence downgrades could be considered.

As you reach retirement age, it becomes quite risky to remain on lower plans, as ongoing treatment of health issues might escalate. It is important to note though, that Prescribed Minimum Benefit (PMB) chronic benefits typically provide cover for not only the medicines required, but also for GP visits and other non-medicine treatment which might be required for the treatment of the approved chronic illness. Certain schemes also have specific disease management programs which provide for additional treatment for illnesses such as diabetes.

Most medical schemes offering plans with savings accounts, do allow members to build up funds in their savings accounts over years and this can also be considered as some form of prefunding for retirement, either through using the excess funds to fund contributions, or to provide additional reserves for when normal benefits run out, or to be able to afford not going onto a more expensive option.

One could argue that a Gap Cover product might be efficient to increase/support cover into retirement and yes, this is true, as it provides additional cover for shortfalls in hospital payments and co-payments. Normally, Gap Cover products have a substantially higher premium if you join only after age 60 or 65 and therefore it is critical to join these products while you can still qualify for the normal, lower contribution, which continues at that level, even after reaching the older age. However, Gap Cover products do not offer any cover for extended day-to-day claims.

It is important to note that generally, GAP Cover products are short term by nature and as such the costs and benefits are only guaranteed for a year and can be reviewed by the insurer annually. There is therefore no guarantee that your Gap Cover product will remain affordable over many years, especially with the claiming trends now being experienced.

Another factor to consider is the ability to change options. While the industry norm is for members to be given the option to upgrade annually in January, certain schemes like Bonitas and Fedhealth do allow upgrades during the year, after certain life- changing events. This provides some safety net to members opting for lower options.

National Health Insurance (NHI) might provide some resolve in the future. Pensioners might be on the receiving end of some form of cross-subsidy under NHI. With the monetary restraints faced by the fiscus, it is not expected for NHI to offer more than a basic set of benefits and medical schemes will then still be able to provide cover for the benefits falling outside of NHI, yet these might become quite expensive as many young and healthy persons will opt out of medical schemes. This will cause medical scheme membership costs to increase due to the loss of the cross-subsidising effect of younger, healthier members being part of the risk pool.

There are no clear solutions. We are sure that medical costs do increase with age. Members should be aware of this and try to provide for additional money during retirement and - very importantly - try to remain as healthy as possible, for as long as possible, by maintaining a healthy lifestyle.

The principle remains:

You need to put aside now what you will be needing after retirement. If you are expected to live 20 years after retirement, you need to save an amount equal to your current annual medical scheme contribution for at least 20 years. Do the calculation. This is the portion of your retirement savings which you need for medical expenses.