

**Updated in November 2019 for Alignment to the IRBA Code of Professional Conduct (Revised November 2018)**

**Updated in November 2021 for conforming and consequential amendments to the IAASB's International Standards arising from the IAASB's Quality Management Standards.**

Effective date:

- a) Audits and reviews of financial statements for periods beginning on or after 15 December 2022; and
- b) Other assurance and related services engagements beginning on or after 15 December 2022.



*Revised Guide for Registered Auditors*

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**Assurance Engagements on the Annual Financial  
Statements and Annual Statutory Returns of a Medical  
Scheme**

**REVISED GUIDE FOR REGISTERED AUDITORS:  
ASSURANCE ENGAGEMENTS ON THE ANNUAL FINANCIAL STATEMENTS AND ANNUAL  
STATUTORY RETURNS OF A MEDICAL SCHEME**

This revised Guide has been prepared by a Committee for Auditing Standards (CFAS) Task Group that comprised technical staff representatives from auditing firms, the Council for Medical Schemes, the South African Institute of Chartered Accountants (SAICA) and the Independent Regulatory Board for Auditors (IRBA).

**The IRBA's Legislative Mandate**

The objects of the Auditing Profession Act, 2005 (Act No. 26 of 2005) (the Act), are set out in Section 2 and include, inter alia:

- (c) *“to approve the development and maintenance of internationally comparable ethical standards and auditing standards for auditors that promote investment and as a consequence employment in the Republic; and*
- (d) *to set out measures to advance the implementation of appropriate standards of competence and good ethics in the auditing profession”.*

To give effect to the objects of the Act, Section 4 sets out the general functions of the Regulatory Board and these include that *“the Regulatory Board must, in addition to its other functions provided for in this Act”*, take steps to meet certain specific requirements. These include Section 4(1), which specifies that the IRBA must:

- (e) *“prescribe standards of professional competence, ethics and conduct of registered auditors;” and*
- (f) *“prescribe auditing standards”.*

To enable the IRBA to meet these requirements, Section 4(2)(a) states that *“the IRBA may participate in the activities of international bodies whose main purpose it is to develop and set auditing standards and to promote the auditing profession”.*

**Statutory Responsibility of the CFAS**

The statutory responsibility of the CFAS is set out in Section 22(2), which requires that it “must assist the IRBA to:

- (a) *develop, maintain, adopt, issue or prescribe auditing pronouncements;*
- (b) *consider relevant international changes by monitoring developments by other auditing standard-setting bodies and sharing information where requested; and*
- (c) *promote and ensure the relevance of auditing pronouncements.”*

**Updated in November 2019 for Alignment to the IRBA Code of Professional Conduct (Revised November 2018)**

*This Guide for Registered Auditors: Assurance Engagements on the Annual Financial Statements and Annual Statutory Returns of a Medical Scheme has been updated to align with the IRBA Code of Professional Conduct for Registered Auditors (Revised November 2018), which became effective from 15 June 2019.*

**REVISED GUIDE FOR REGISTERED AUDITORS:  
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The revised Guide may be downloaded free-of-charge from the IRBA website at [www.irba.co.za](http://www.irba.co.za).

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**REVISED GUIDE FOR REGISTERED AUDITORS:  
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This Revised Guide for Registered Auditors: *Assurance Engagements on the Annual Financial Statements and Annual Statutory Returns of a Medical Scheme* provides guidance to a registered auditor of a medical scheme in implementing the audit requirements in the relevant International Standards to meet the additional regulatory reporting requirements of the Council for Medical Schemes (the Council).

Guides are developed and issued by the IRBA to provide guidance to auditors in meeting specific legislative requirements imposed by a Regulator. They do not impose requirements on auditors beyond those included in the International or South African Standard/s or South African regulatory requirements. Guides also do not change an auditor's responsibility to comply, in all material respects, with the requirements of the International or South African Standards or with South African regulatory requirements relevant to the audit, review, other assurance services or related services engagement.

An auditor is required to have an understanding of the entire text of every Guide to enable the auditor to assess whether or not any particular Guide is relevant to an engagement; and if so, to enable the auditor to apply properly the requirements of the particular International or South African Standard/s to which the Guide relates.

In terms of Section 1 of the Auditing Profession Act, No. 26 of 2005 (the Act), a Guide is included in the definition of "auditing pronouncements" in the Act; and in terms of the Act, the auditor must, in the performance of an audit, comply with those standards, practice statements, guidelines and circulars developed, adopted, issued or prescribed by the Regulatory Board.

# REVISED GUIDE FOR REGISTERED AUDITORS: ASSURANCE ENGAGEMENTS ON THE ANNUAL FINANCIAL STATEMENTS AND ANNUAL STATUTORY RETURNS OF A MEDICAL SCHEME

## Introduction

### Scope of this Guide

1. The purpose of this Revised Guide is to provide guidance to a registered auditor on conducting an assurance engagement on the annual financial statements and annual statutory returns of a medical scheme.
2. South African medical schemes are regulated by the Council for Medical Schemes (the Council) and there are significant regulatory requirements imposed by the Medical Schemes Act, No. 131 of 1998, and the related Regulations thereto, and Circulars.
3. The guidance relates to understanding the nature and characteristics of a medical scheme and the nature and extent of work in the engagement and, as a consequence, emphasises professional competencies and professional scepticism. This Guide provides implementation guidance on the application of International Standards of Auditing (ISAs), in respect of matters unique to the audit of a medical scheme. In conducting the audit in accordance with the ISAs an auditor complies with all the requirements of all the ISAs.
4. This Revised Guide only provides audit and assurance guidance. An auditor refers to the South African Institute of Chartered Accountants' (SAICA) *Medical Schemes Accounting Guide* for accounting guidance and the application of International Financial Reporting Standards (IFRS), the applicable financial reporting framework.<sup>1</sup>
5. This Revised Guide provides certain practical guidance to be considered in developing audit programmes. This Guide does not override the requirements of the ISAs; nor does it purport to deal with all special considerations that may be relevant in the circumstances of the engagement.
6. Refer to [Appendix 1 – Definitions](#) for medical schemes related definitions. Audit related definitions can be found in the APA and in the relevant pronouncements of the IRBA.

### Objectives

7. This Revised Guide is intended to assist an auditor of a medical scheme to:
  - a) Obtain an understanding of the business of the medical scheme;
  - b) Make judgements about the identification and assessment of risks of material misstatement;
  - c) Make judgements about how to respond to assessed risks; and
  - d) Address reporting considerations, including:
    - (i) Forming an opinion on the financial statements; and

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<sup>1</sup> <https://www.saica.co.za/TechnicalInformation/Publications/Guides/tabid/107/language/en-ZA/Default.aspx>.

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- (ii) Reporting on the annual statutory returns.
8. This Revised Guide is not intended to provide guidance on all audit responses to assessed risks as an auditor is required to comply with the ISAs in all respects.

**Nature of an engagement on a medical scheme**

9. An engagement on a medical scheme includes:

**a) ISA 700 (Revised) engagement – reporting on the financial statements**

An auditor expresses a reasonable assurance opinion on whether, for the relevant accounting period, a medical scheme's financial statements are fairly presented in accordance with IFRSs and the requirements of the Medical Schemes Act. For this purpose, an auditor will issue an ISA 700 (Revised)<sup>2</sup> report. The ISA 700 (Revised) report has two components: "Reporting on the Financial Statements" and "Report on Other Legal and Regulatory Requirements".

**b) ISAE 3000 (Revised) engagement – reporting on compliance with Sections 36(5) and 36(8) of the Act**

An auditor performs a compliance engagement in accordance with the requirements of Sections 36(5) and 36(8) of the Medical Schemes Act in order to provide the Registrar with limited assurance regarding compliance by a medical scheme with the Sections of the Act and related Regulations. This engagement is conducted in accordance with ISAE 3000 (Revised)<sup>3</sup>.

**c) ISA 800 (Revised) engagement – reporting on Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return; and ISRE 2410 engagement – reporting on Part 6.2 of the annual statutory return**

Section 36(8) of the Act requires an auditor to, "in respect of a return or statement which he or she is required to examine in terms of this Chapter, certify whether that return or statement complies with the requirements of the Act, also whether the return or statement, including any annexure thereto, presents fairly the matters dealt with therein as if such return or statement were a financial statement contemplated in section 20 of the Public Accountants' and Auditors' Act, 1991..." The term "certify" is not used in the audit environment as it may imply absolute assurance, while reasonable assurance is appropriate in the context of the Act.

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<sup>2</sup> ISA 700 (Revised), *Forming an Opinion and Reporting on Financial Statements*.

<sup>3</sup> ISAE 3000 (Revised), *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*.



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Section 37(2) of the Act states, inter alia, that the annual financial statements of a medical scheme include “such other returns as the Registrar may require”. This refers to the annual statutory return.

As the annual statutory return is seen as part of the annual financial statements, the annual statutory return is therefore required to be audited in terms of Section 37(3) of the Act.

A reasonable assurance opinion is provided on whether Parts 4 to 6.1 and 6.3 to 10 have been prepared in all material respects in accordance with the provisions of the Act and related Regulations. The audit engagement is performed in terms of the ISAs and the report is prepared using ISA 800 (Revised)<sup>4</sup>.

However, Part 6.2 of the annual statutory return is the “Monthly Statement of Net Healthcare Result” which contains monthly financial information that is not audited as part of the audit of the financial statements.

An auditor is able to express only a limited assurance conclusion on Part 6.2 of the annual statutory return. This review engagement is performed in terms of ISRE 2410<sup>5</sup>.

This auditor report is therefore a combined:

- ISA 800 (Revised) assurance report on Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return, providing a reasonable assurance opinion; and
- ISRE 2410 review report on Part 6.2 of the annual statutory return, providing a limited assurance conclusion.

Refer also to the section on [Reporting on Parts 4 to 10 of the annual statutory return](#).

### **d) ISA 810 (Revised) engagement, if summary financial statements are required to be prepared by the Rules**

An auditor reports whether the summary financial statements derived from the audited financial statements are consistent, in all material respects, with those financial statements, in accordance with the content and disclosure requirements of Circular 6 of 2013<sup>6</sup>. This is an ISA 810 (Revised)<sup>7</sup> engagement.

## Effective date

10. This Revised Guide is effective for engagements on accounting periods ending on or after 31 December 2018.

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<sup>4</sup> ISA 800 (Revised), *Special Considerations – Audits of Financial Statements Prepared in Accordance with Special Purpose Frameworks*.

<sup>5</sup> ISRE 2410, *Review of Interim Financial Information Performed by the Independent Auditor of the Entity*.

<sup>6</sup> Circular 6 of 2013, *Annual financial information provided to members*.

<sup>7</sup> ISA 810 (Revised), *Engagements to Report on Summary Financial Statements*.

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11. The auditor reports included in this Guide are effective for reporting on engagements as indicated in the illustrative auditor reports. The auditor reports have been issued by the Council.

### **Engagement acceptance**

12. An auditor applies ISA 210, *Agreeing the Terms of Audit Engagements*, and ISA 220 (Revised), *Quality Management for an Audit of Financial Statements*.
13. The appointment and reappointment of, and reporting by, an auditor is dealt with in Section 36 of the Act and in the Rules of the medical scheme. In terms of Section 36(2), the appointment and reappointment of an auditor (both individual and firm) are approved by the Registrar. Section 36(3) of the Act prohibits the appointment of certain persons as auditors. The Council also issues, from time to time, guidelines, Circulars and Notices on these matters.
14. In terms of Section 37(3) a medical scheme's annual financial statements are subject to an audit by an auditor registered in accordance with the Auditing Profession Act.
15. An auditor is required to comply with the "*Standards for authorisation of Auditors*"<sup>8</sup> as issued by the Council.
16. The Registrar may appoint an auditor for a medical scheme if that medical scheme, for any reason, fails to appoint an auditor; and such auditor will be deemed to have been appointed by that medical scheme.
17. An auditor is required to have a working knowledge of the Act, its Regulations and Circulars issued by the Council, in order to report on instances of non-compliance identified by an auditor in the regulatory report that accompanies the financial statements.
18. An auditor is required to comply with the IRBA *Code of Professional Conduct for Registered Auditors* (the IRBA Code)<sup>9</sup>, the requirements of the International Standard on Quality Management 1, *Quality Management for Firms that Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements* (ISQM 1), *International Standard on Quality Management 2, Engagement Quality Reviews* (ISQM 2) and the *International Standards on Auditing* (the ISAs) in the conduct of an audit of a medical scheme.

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<sup>8</sup> <http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/AuthStds.pdf>.

<sup>9</sup> The IRBA Code of Professional Conduct for Registered Auditors was revised in November 2018. Its effective date is as follows:

- Parts 1 and 3 of the Codes will be effective as of 15 June 2019.
- Part 4A relating to independence for audit and review engagements will be effective for audits and reviews of financial statements for periods beginning on or after 15 June 2019.
- Part 4B relating to independence for assurance engagements with respect to subject matter covering periods will be effective for periods beginning on or after 15 June 2019; otherwise, it will be effective as of 15 June 2019.

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19. When a medical scheme utilises a service organisation, an auditor applies ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*. If sufficient appropriate evidence cannot be obtained from that service organisation, this is not a scope limitation imposed as a result of the audit, and appropriate responses should be designed and implemented to address the assessed risks.
20. If an auditor's appointment is terminated for any reason, including resignation, that auditor is required in terms of Section 36(5)(c) of the Act to submit to the Registrar a statement setting out that auditor's understanding of the reason for the termination.

## **Planning of the engagement<sup>10</sup>**

### **Fraud considerations**

21. An auditor applies ISA 240 (Revised), *The Auditor's Responsibilities Relating to Fraud in an Audit of Financial Statements*.
22. An auditor considers common fraud indicators/types of transactions susceptible to fraud in a medical scheme environment, which may include:
  - a) Member and provider fraudulent claims (duplicate claims, inappropriate coding, invalid claims);
  - b) Non-members using a member's card to claim;
  - c) Inappropriate expenditure and/or medical claims by trustees;
  - d) Conflicts of interest, actual or perceived, particularly if members of the investment committee or the board of trustees have a financial interest in the medical scheme;
  - e) Poor corporate governance; and
  - f) Fraud at a service organisation. See the section on [Service organisations](#).
23. Fraud risk in a medical scheme environment may be mitigated by:
  - a) Internal controls;
  - b) A fraud policy approved by the board of trustees;
  - c) The activities of a forensic unit;
  - d) A hot-line facility (anonymous reporting); and
  - e) Internal audit.

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<sup>10</sup> ISA 300, *Planning an Audit of Financial Statements*.

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### Laws, the Regulations, the Circulars and the Rules

24. An auditor applies ISA 250, *Consideration of Laws and Regulations in an Audit of Financial Statements*.
25. For instances of non-compliance with laws, the Regulations, the Circulars and the Rules of the medical scheme detected by an auditor during the course of performing assurance procedures, refer to the section on [Reporting on non-compliance by both an auditor and a board of trustees of a medical scheme](#).
26. An auditor considers the following laws and regulations that are particularly applicable to a medical scheme:
  - a) Medical Schemes Act and related Regulations. Refer to [Appendix 3 – Extracts from and commentary on the Medical Schemes Act and Regulations](#);
  - b) Circulars issued by the Council. Refer to [Appendix 4 – Circulars relevant to financial statements](#);
  - c) Companies Act, 2008, as amended;
  - d) Consumer Protection Act, 2008;
  - e) Protection of Personal Information Act 4 of 2013;
  - f) Financial Advisory and Intermediary Services Act, 2002, as amended;
  - g) Financial Intelligence Centre Act, 2001, as amended;
  - h) Financial Institutions (Protection of Funds) Act, 2001;
  - i) National Credit Act, 2005;
  - j) Prescription Act 68 of 1969, as amended; and
  - k) Trust Property Control Act, 1988, as amended.

*This list is not necessarily exhaustive, but was up to date at the time this Guide was issued. For legislative changes after the date of issue of this Guide, refer to the websites of the relevant regulators.*

27. The medical scheme may appoint a compliance officer to establish policies and procedures to ensure compliance with laws, the Regulations, the Circulars and the Rules. Certain medical schemes may also rely on the compliance functions at the administrator.
28. As per Section 36(5)(a) of the Act, if an auditor reports a reportable irregularity to the IRBA in terms of Section 45 of the Auditing Profession Act, that auditor is required to submit the same report to the Registrar. Refer to the section on [Reporting on reportable irregularities](#).

### Risk assessment

29. An auditor applies ISA 315 (Revised), *Identifying and Assessing the Risks of Material Misstatement through Understanding the Entity and Its Environment*.

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30. Refer to [Appendix 2 – Understanding the business of a medical scheme](#).
31. An auditor obtains an understanding of the medical scheme and its environment; and then identifies and assesses risks of material misstatement.

### IT control environment

32. Due to the complexity of the business of a medical scheme and the volume of transactions, management places reliance almost entirely on the IT infrastructure. However, if the IT control environment is not effective, such reliance poses the risk of material misstatement and misappropriation of medical scheme assets.
33. IT risks arise from manual and electronic interventions. An auditor considers the IT environment as well as the general IT controls, application controls in IT as well as access controls and the extent to which different platforms interface.
34. It is essential that reconciliations be performed on a regular basis. Reconciliations not performed and reviewed on a monthly basis may constitute inadequate internal financial controls and may result in misstatements of the financial statements.
35. Where an administrator that is a service organisation is appointed, the relevant controls over the IT infrastructure are subject to the application by a medical scheme auditor of ISA 402<sup>11</sup> and the service auditor of ISAE 3402<sup>12</sup> (when applicable). The service auditor's report serves as audit evidence to the medical scheme auditor. Also refer to the section on [Service organisations](#).

### Analytical reviews and key ratio analysis

36. An auditor applies ISA 315 (Revised), paragraph (6b).
37. A medical scheme monitors key ratios on an ongoing basis. An auditor may use these to identify potential risks of material misstatement. The examples of key ratios listed below are not exhaustive:<sup>13</sup>
  - a) Average age of beneficiaries for the accounting period.
  - b) Pensioner ratio (beneficiaries >65 years).
  - c) Average risk contributions per member per month.
  - d) Average risk contributions per beneficiary per month.
  - e) Savings account contributions as percentage of gross contributions per option.
  - f) Average relevant healthcare expenditure incurred per member per month.
  - g) Average relevant healthcare expenditure incurred per beneficiary per month.

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<sup>11</sup> ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.

<sup>12</sup> ISAE 3402 – *Assurance Reports on Controls at a Service Organization*.

<sup>13</sup> Calculated at scheme and option levels.

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- h) Total non-healthcare expenditure per average beneficiary per month.
- i) Total non-healthcare expenditure per average member per month.
- j) Non-healthcare expenditure as a percentage of risk contribution income.
- k) Administration expenses as a percentage of risk contributions.
- l) Average administration expenditure per member per month.
- m) Average administration expenditure per beneficiary per month.
- n) Average accredited managed healthcare services per member per month.
- o) Average accredited managed healthcare services per beneficiary per month.
- p) Broker costs per member per month and as percentage of gross contributions (statutory limitations apply).
- q) Accumulated funds per member at year-end.
- r) Beneficiaries per member at year-end.
- s) Net relevant healthcare expenditure as a percentage of risk contribution income (risk claims ratio).
- t) Statutory solvency requirement as per Regulation 29.
- u) Current ratio: current assets to current liabilities.

### **Contributions**

38. Medical Schemes are required to manage contributions in accordance with the Act and Rules of the medical scheme. Below is a list of potential risks of material misstatements applicable to contributions.

*Contributions are incomplete*

39. Controls may not be adequate to ensure that all contributions receivable are accounted for.

*Inaccurate contributions*

40. Material misstatements may arise from:
- a) Contributions in respect of ancillary products raised and collected by a medical scheme (e.g. gym membership, funeral cover and loyalty programmes). The raising and collection of such amounts is in contravention of Section 26(1)(c), (4) and (11) of the Act.
  - b) Master file contribution tables loaded in the administration platform may contain errors, and may not be in terms of the registered Rules. They may also be susceptible to unauthorised changes or not be appropriately integrated into the algorithms of the platform.

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- c) Inaccurate membership data. Examples include the following:
  - (i) Members loaded on the incorrect option.
  - (ii) Contribution tables not calculating contributions according to the Rules.
  - (iii) When a contribution raised is a function of a member's salary, that contribution could be misstated if salary information obtained is inaccurate.
  - (iv) Membership database inadequately maintained.
  - (v) Employer group information not reconciled monthly.
- d) Contributions receivable may be raised for invalid members, resulting in the misstatement of contribution income as well as the related receivable. Examples include:
  - (i) Duplicated beneficiaries.
  - (ii) Contributions raised for the same member under more than one option in the same month.
  - (iii) Members for whom the system omitted to raise contributions.
  - (iv) Inaccurate member data on the administration platform.
- e) Back-dated membership updates, which include resignations as well as new memberships, processed subsequent to the year-end, which may result in the over/understatement of contribution income and the related receivable and may also affect the insurance receivable impairment calculation.
- f) Contributions receivable in respect of a child dependant. Regulation 9B states that contributions of a child dependant may be less than those determined in respect of other beneficiaries. This concession will, however, be in terms of the registered Rules.

*Contribution penalties not accounted for correctly*

- 41. A late joiner penalty may not be applied correctly and accurately to a member or any adult dependant. Regulation 13 deals with late joiner penalties.

*Contributions are not paid within three days of becoming due*

- 42. Contributions are payable directly to a medical scheme within three days after becoming due, as required by Section 26(7) of the Act. In order to determine the date upon which the payment of due contributions will be regarded as being in contravention of the Act, an auditor determines the event "becoming due", as specified in the Rules. The event may differ from medical scheme to medical scheme as contributions in some may become due at the beginning of a month while it might be at the end of a month for others. An auditor considers the medical scheme's approved credit policy in the circumstances and whether the policy has been implemented.

*Contributions not paid directly into the medical scheme's bank account*

- 43. Regulation 23 states that an administrator must deposit any medical scheme monies under administration into a bank account opened in the name of the medical scheme, not later than the business day following the date of receipt of these monies. Regulation

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23 also states that when medical scheme monies, including contributions, are paid by means of an electronic funds transfer, such monies shall be deposited directly into a bank account opened in the name of the medical scheme. Monies received shall at no time be deposited in any bank account other than that of the medical scheme.

*Savings contributions not paid over to the PMSA trust investment account within seven days of receipt in the event that the Rules create a trust agreement between the member and the medical scheme in terms of which savings belong to the member*

44. In the event that the Rules create a trust agreement, savings contributions received must be retained in a trust bank account, separate from any of a medical scheme's bank accounts. Circular 38 of 2011<sup>14</sup> allows PMSA contributions to be collected together with the risk contributions, but the savings portion must be transferred to a separate trust bank account within seven days of receipt.

*Arrear contribution receivable*

45. A medical scheme's credit policy might not be applied correctly in respect of the suspension of benefits and termination of membership.
46. Misstatement of arrear contributions receivable may include, inter alia:
- a) Inaccurate contributions, discussed in paragraph 40.
  - b) Arrear contributions not recoverable that have not been adequately impaired.
  - c) Cash receivable not being allocated to the debt to which it relates, resulting in the ageing being unreliable for the purposes of considering impairments.
  - d) Unallocated amounts relating to arrear contributions being disclosed under current liabilities and not set off against the receivable to which they relate.
  - e) Unallocated amounts not relating to arrear contributions being set off against contributions receivable, resulting in the understatement of arrear contributions receivable and current liabilities.
  - f) Amounts received may not be allocated on a member level. This may arise where amounts received are allocated at a medical scheme or group level only. This risk is mainly applicable to large open medical schemes.
  - g) Bad debts being written off, not in accordance with a medical scheme's approved credit control policy, or in terms of the accounting policy as included in the financial statements, and/or without the necessary authority.
47. Refer to [Appendix 11 – Contribution CAATS](#) for examples of CAATs used in the audit of a medical scheme.

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<sup>14</sup> Circular 38 of 2011, *Personal Medical Savings Accounts*.



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**Healthcare benefits**

48. A risk in the payment of claims relates to the manner in which claims are submitted to a medical scheme (EDI and “paper” claims) and the related controls. The majority of claims are received via EDI.
49. In some cases, a medical scheme may be unable to pay a claim electronically and may pay a claim by way of a cheque payment. An auditor considers whether there are risks applicable to cheque payments that are not dealt with below.

*Claims are incomplete*

50. Controls may not be adequate to ensure that all claims payable are accounted for.
51. Claims are not complete due to EDI claims not interfacing correctly between the clearing houses and the administration system.
52. Manual claims not processed.
53. Claims are back-dated or reversed subsequent to year-end.

*Invalid claims*

54. Claims are inherently susceptible to fraud and error. Material misstatements may arise from:
  - a) Claims processed for services not rendered to members, i.e. fictitious claims.
  - b) Stale claims processed for payment. Typically claims received for payment that are older than four months from date of service are regarded as stale and, as a consequence, are invalid. However, the Rules may extend the validity of the claim period.
  - c) Tariff coding on submitted claims being inaccurate or not aligning to the nature of treatment received by a member.
  - d) Recording claims twice, i.e. via the claims payment process as well as through claims incurred but not yet reported (IBNR).
  - e) The administration system not restricting or flagging potential duplicate claims.
  - f) Human errors.
  - g) Unauthorised ex-gratia claims.
  - h) Unauthorised release of benefit payments.
  - i) Benefits payment files uploaded with incorrect banking details.
  - j) Claims paid in respect of suspended or terminated members.
  - k) Claims processed against invalid practice numbers.
  - l) Claims processed against bogus (dummy) practice or member numbers.
  - m) Claims paid where the service date is after the payment date.
  - n) Hospital claims paid without pre-authorisation granted by the medical scheme.

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- o) Level of care and level of stay as per the pre-authorisation differ from claims submitted by the service provider, and no explanation is provided.
55. The auditor obtains an understanding of the role that the internal audit/forensic audit department plays within the medical scheme in identifying fraudulent claims.

*Claims not paid within 30 days of receipt*

56. Section 59(2) of the Act requires a medical scheme to pay a member or a supplier of a service any benefit owing to that member or supplier within 30 days of receiving a valid claim. Reference should be made to Regulation 6(4) for queried claims.

*Inaccurate claims processed*

57. The following may result in inaccurate claims being processed:
- a) Master file healthcare benefit limits and tariff codes loaded in the administration platform that may be inaccurate, not in terms of the approved benefits, or contain inappropriate and/or unauthorised changes or overrides.
  - b) A member's benefit option not correctly loaded.
  - c) The application of an incorrect risk benefit or savings categories.
  - d) Prescribed minimum benefits (PMBs) not paid in full or from savings accounts.
58. Typical audit procedures such as agreeing the claims per administration system to original documentation signed as evidence of receipt, which may be appropriate in other environments, are not always feasible here. As such, an auditor may need to make use of a range of tests. An effective way of performing substantive tests may be through the use of CAATs on the data. CAATs can be designed to efficiently interrogate the full population of data and identify exceptions that could then be subject to an audit. It is essential that an auditor reconciles the data received to the administration platform as well as the general ledger before the CAATs are generated. Refer to [Appendix 10 – Claims CAATs](#) for examples of typical claims CAATs used in a medical scheme environment.

*Accredited managed healthcare services*

59. The following risks of material misstatement relating to transactions between the accredited managed healthcare organisations and the relevant medical scheme need to be mitigated during the performance of an auditor's annual audit procedures<sup>15</sup>. Also refer to the section on [Service organisations](#).
- a) Controls underlying the compilation of the accredited managed healthcare information are not functioning.
  - b) The information received from the accredited managed healthcare organisation is incomplete and/or inaccurate, resulting in incorrect disclosure in the financial statements.

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<sup>15</sup> The non-accredited managed healthcare benefit management services form part of the administration expenditure.

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- c) Completeness and accuracy of the disclosure of the accredited managed healthcare information in terms of IFRS 4<sup>16</sup> and IFRS 7<sup>17</sup> is at risk.
- d) The managed healthcare organisation is not accredited with the Council.
- e) Cut-off of information for disclosure purposes is inappropriately applied.
- f) Claims for other medical schemes are included in the information for the medical scheme being audited.
- g) A contract governing the service is not in place.

*Risk transfer arrangements*

60. The following risks of material misstatement relating to transactions between the third party and the relevant medical scheme need to be mitigated during the performance of an auditor's annual audit procedures. Also refer to the section on [Service organisations](#).
- a) Controls underlying the compilation of the risk transfer information are not functioning.
  - b) Completeness and accuracy of the disclosure of the risk transfer information in terms of IFRS 4<sup>18</sup> and IFRS 7<sup>19</sup> is at risk.
  - c) The claims information relating to the risk transfer agreements is incomplete and/or inaccurate, resulting in incorrect disclosure in the financial statements.
  - d) Cut-off of claims information for disclosure purposes is inappropriately applied.
  - e) Claims for other medical schemes are included in the information for the medical scheme being audited.
  - f) A contract governing the service is not in place.
  - g) Risk transfer arrangement gross-up in terms of IFRS 4 is inaccurate or incomplete. This could be affected by utilisation statistics as well as the benefit tariffs applied to the calculation being inappropriate.

*Claims incurred but not yet reported (IBNR)*

61. Risks of material misstatements could include the following:
- a) Unauthorised adjustments are made to the IBNR provision in order to overstate the medical scheme's surplus or understate the medical scheme's deficit in order to manipulate the solvency ratio.
  - b) Invalid assumptions and inaccurate data used in the IBNR models to calculate the IBNR provision.

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<sup>16</sup> IFRS 4, *Insurance Contracts*.

<sup>17</sup> IFRS 7, *Financial Instruments: Disclosures*.

<sup>18</sup> IFRS 4, *Insurance Contracts*.

<sup>19</sup> IFRS 7, *Financial Instruments: Disclosures*.

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- c) Invalid IBNR models used or there is a change in IBNR models used during the year.
  - d) Claims in respect of services provided after year-end are included in the calculation of the IBNR provision.
  - e) Risk transfer information omitted from the IBNR calculation.
62. Based on the assessed risks of material misstatement, an auditor considers:
- a) Whether management has appropriately applied the requirements of IFRS relevant to the accounting estimate.
  - b) Whether the methods for making the accounting estimates are appropriate and have been applied consistently; and whether changes, if any, in accounting estimates or in the method for making those estimates from the prior period are appropriate in the circumstances.
  - c) The quality of data that is used to calculate the IBNR provision.
63. Factors to be considered by an auditor in evaluating the computed provision include:
- a) The period elapsed between year-end and the reporting date.

In terms of the Act, members have at least four months from the date on which the service was rendered to submit their claims. This period is referred to as the “run off” period. (Note that some Rules may allow for longer periods.)<sup>20</sup>

The longer the period elapsed between year-end and the reporting date, the higher the likelihood that the provision will approximate the actual liability, based on actual claims submitted after year-end but relating to service dates prior to year-end.
  - b) Changes in a medical scheme's membership.

Significant changes in a medical scheme’s membership may have an impact on the claims experience and would need to be taken into account in arriving at the provision.
  - c) Changes in a medical scheme’s administration.

Differing processes at different administrators may change the claims experience pattern. In addition, a change in administrators close to year-end may give rise to a backlog in the receipt of claims, and this would need to be taken into account in computing the provision.
  - d) A backlog in the processing of claims.

The backlog in processing will change the pattern of the claims experience, and incorrect projections may arise if these are not taken into account.

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<sup>20</sup> Refer to Regulation 6(4) which specifies the different timeframes for invalid claims.

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- e) Management controls.

An auditor considers any management controls over the computation, including a consideration of significant changes between the current and prior years.

- f) A medical scheme's authorisation process.

A number of medical schemes operate on a pre-authorisation basis which requires potential claims to be pre-authorised before the service may be rendered.

- g) Use of an expert.

Refer to the section on [Auditor and management experts](#).

**Non-healthcare expenditure – broker commissions**

64. The risk of material misstatement related to broker commissions could include, but is not limited to:

- a) No written agreement is in place between the broker and the medical scheme.
- b) No written agreement is in place between the broker and the member.
- c) Broker commissions are calculated and paid based on contributions raised and not received.
- d) Broker commissions are paid in advance in lieu of broker services to be provided.
- e) Broker commissions paid are in excess of the maximum amount determined by the Minister of Health in the Government Gazette.
- f) Broker commissions are paid by a medical scheme to brokers who are not meeting service levels agreed with the medical scheme.
- g) Broker commissions are paid by a medical scheme in respect of unaccredited brokers.
- h) Broker commissions are not discontinued when the medical scheme receives notice from that member (or the relevant employer, in the case of an employer group) that the member or employer no longer requires the services of that broker.
- i) More than one broker is compensated for the same member.

**Non-healthcare expenditure based on membership**

65. Non-healthcare expenditure based on membership includes a risk of material misstatement through the incorrect back-dating of expenditure based on changes in membership numbers.

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## **Investments**

66. The following is not an exhaustive list of all the risks of material misstatement applicable to the investment cycle; rather, the list only includes risks that are specific to a medical scheme.

### *Investments held not in compliance with the Act*

67. Section 35(6) of the Act prohibits a medical scheme from:
- a) Encumbering its assets;
  - b) Allowing its assets to be held by another person on its behalf;
  - c) Directly or indirectly borrowing money; or
  - d) By means of suretyship or any other form of personal security, whether under a primary or accessory obligation, giving security in relation to obligations between other persons
- without the prior approval of the Council.
68. Section 35(8) of the Act precludes a medical scheme from holding investments (including the granting of loans to) in:
- a) A participating employer;
  - b) Any administrator or arrangement associated with the medical scheme;
  - c) Any other medical scheme;
  - d) Any administrator; and
  - e) Any person associated with the abovementioned parties.
69. Regulation 30 prescribes limits for the kinds and categories of assets to be held by a medical scheme. Over and above the risk that the medical scheme may not have complied with the limitations, an auditor also needs to consider whether the assets have been looked-through correctly for the purposes of this assessment. The information obtained for the purposes of this assessment is usually from investment managers; so, an auditor will also need to consider the implications of dealing with information obtained from a service organisation.

### *Derivative compliance testing based on incorrect values*

70. Derivatives are included in category 7 of Annexure B. There is a risk that the derivatives are not included at their gross position, but that compliance to the limitations imposed by Annexure B is tested based on their net effective exposure value.
71. Compliance is separately tested on the total negative derivative position held, and on the total positive derivative position held, i.e. the two positions are not offset.

### *Investments incorrectly derecognised*

72. A risk exists that a medical scheme may manipulate its solvency calculations by disinvesting from portfolios with the intention of releasing unrealised fair value gains, and then immediately reinvesting into the same investment risk profile. This type of transaction is commonly known as a wash-sale transaction. Assuming all other variables

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in the calculation being constant, realised gains would have a positive impact on the solvency calculation of a medical scheme. This is, therefore, an avenue through which medical schemes could manipulate their solvency ratio. Having regard for the derecognition criteria, such transactions would typically need to be reversed.

### Personal medical savings accounts (PMSAs)

73. Medical schemes are required to manage PMSAs in accordance with the Act and Rules of the medical scheme. Below is a list of potential risks of material misstatements applicable to PMSAs.

#### *Restrictions on PMSA contributions and claims*

74. In accordance with Section 10 of the Act, a maximum of 25% of the total gross contribution in respect of a member can be allocated to a PMSA. This limit needs to be applied at an individual member level. The percentage of total gross contributions in respect of a PMSA will also be prescribed in the registered Rules. These savings may only be used for healthcare services as provided for in the medical scheme's Rules and are only refundable as provided for in Regulation 10. The funds in a PMSA shall not be used to pay for the costs of a PMB or a member's portion relating to a PMB.
75. Accordingly, the following risks of material misstatement may arise:
- a) Inaccurate member records impacting on the accuracy of PMSA balances or claims being paid from PMSA balances where the member in fact still has available benefits.
  - b) PMSA balances are not refunded to the intended recipient. This risk is exacerbated where the account relates to a member who has been inactive for an extended period of time.
  - c) Savings contributions allocated, at a member level, may not be in accordance with the requirements of the Act or the registered Rules.
  - d) PMSAs may be used for the payment of non-healthcare services.
  - e) PMBs and members' portions of PMBs are paid from PMSAs.
  - f) PMSA balances are inappropriately set off against arrear contribution debt or credit savings account balances. Regulation 10(5) states: "Funds deposited in a member's personal medical savings account shall be available for the exclusive benefit of the member and his or her dependants but may not be used to offset contributions, provided that the medical scheme may use funds in a member's personal medical savings account to offset debt owed by the member to the medical scheme following that member's termination of membership of the medical scheme."

#### *PMSA balances written off*

76. There is a risk that long outstanding PMSA balances (credit balances) are written off prior to the claim having prescribed, in contravention of the Prescription Act 68 of 1969.
77. Old credit balances may be written back to medical scheme funds to the extent that they have prescribed in terms of the Prescription Act 68 of 1969.

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78. Should the Rules have created a trust agreement between the member and the medical scheme in terms of which savings belong to the member, a risk exists that long outstanding PMSA balances (credit balances) are written off thereby contravening Regulation 10(3) of the Act. Old credit balances (longer than five years) must be paid over to the Guardian's Fund, in terms of Section 93 of the Administration of Estates Act 66 of 1965.<sup>21</sup>

*Incorrect interest allocated to PMSAs (where trust agreement was created in the Rules)*

79. There is a risk that interest accrued on PMSAs to the credit of members may not be based on the effective interest method.
80. There is a risk that interest may be charged on PMSAs funded by the trust monies in contravention of Circular 38 of 2011<sup>22</sup>.

*PMSAs monies not invested separately (where a trust agreement was created in the Rules)*

81. There is a risk that PMSAs may not be invested separately from medical scheme assets, as required in terms of the Protection of Funds Act.
82. There is a risk that there are mismatches between the PMSA assets and the related PMSA liability.
83. There is a risk that PMSAs may not be invested in bank deposits and call accounts or instruments with similar risk and liquidity characteristics, as required by Circular 38 of 2011.

*Prescribed disclosure not adhered to (where a trust agreement was created in the Rules)*

84. There is a risk that the medical scheme does not adhere to the Circular 5 of 2012<sup>23</sup> prescribed minimum disclosure requirements relating to PMSA trust investments and trust liabilities.

*Overdrawn PMSAs*

85. There is a risk that advances are made from PMSAs plan monies and not from a medical scheme's funds.

**Auditor and management experts**

86. An auditor applies ISA 620, *Using the Work of an Auditor's Expert*; ISA 500, *Audit Evidence*; and ISA 540, *Auditing Accounting Estimates, Including Fair Value Accounting Estimates, and Related Disclosures*.
87. An auditor may use experts in order to obtain evidence. Experts within a medical scheme environment may include, but are not limited to, the following:

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<sup>21</sup> Cognisance should be taken of any guidance issued by the Council in this regard.

<sup>22</sup> Circular 38 of 2011, *Personal Medical Savings Accounts*.

<sup>23</sup> Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts*.



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- a) Actuary:
  - (i) An actuary *may* be used within a medical scheme environment to assist the medical scheme in assessing the adequacy of the IBNR provision.<sup>24</sup>
  - (ii) Refer to the section on [Risk assessment](#) for risk assessment relating to the IBNR provision.
- b) Valuation specialists:
  - (i) Where the medical scheme holds complex investments, an auditor may require the use of an expert.
- c) Other:
  - (i) An auditor considers all areas where significant estimates are made within the medical scheme where an expert may be required, for example, post-retirement benefit plans, investment property and property, plant and equipment.

### Service organisations

- 88. An auditor applies ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.
- 89. The obligation for obtaining audit evidence from the service organisation is that of a medical scheme. It would be helpful to an auditor if a contract between a medical scheme and a service organisation provides for a requirement for an independent report (preferably in compliance with ISAE 3402<sup>25</sup>) by the service organisation on its control environment.
- 90. The auditor applies judgement and documents considerations regarding the audit of service organisations.

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<sup>24</sup> As per Circular 33 of 2013, *Guidance on benefit changes and contribution increases for 2014*, the medical scheme is not required to use an actuary in the pricing of their benefits:

As indicated in Circular 29 of 2012, a report that is sent together with the proposed amendments must take into account the requirements of the Advisory Practice Note (APN) published by the Actuarial Society of South Africa, and specifically APN303 – Advice to South African Medical Schemes on Adequacy of Contributions (replaces PGN303). This report must be prepared by a person with the appropriate actuarial and/or statistical skills and should include the following detailed information:

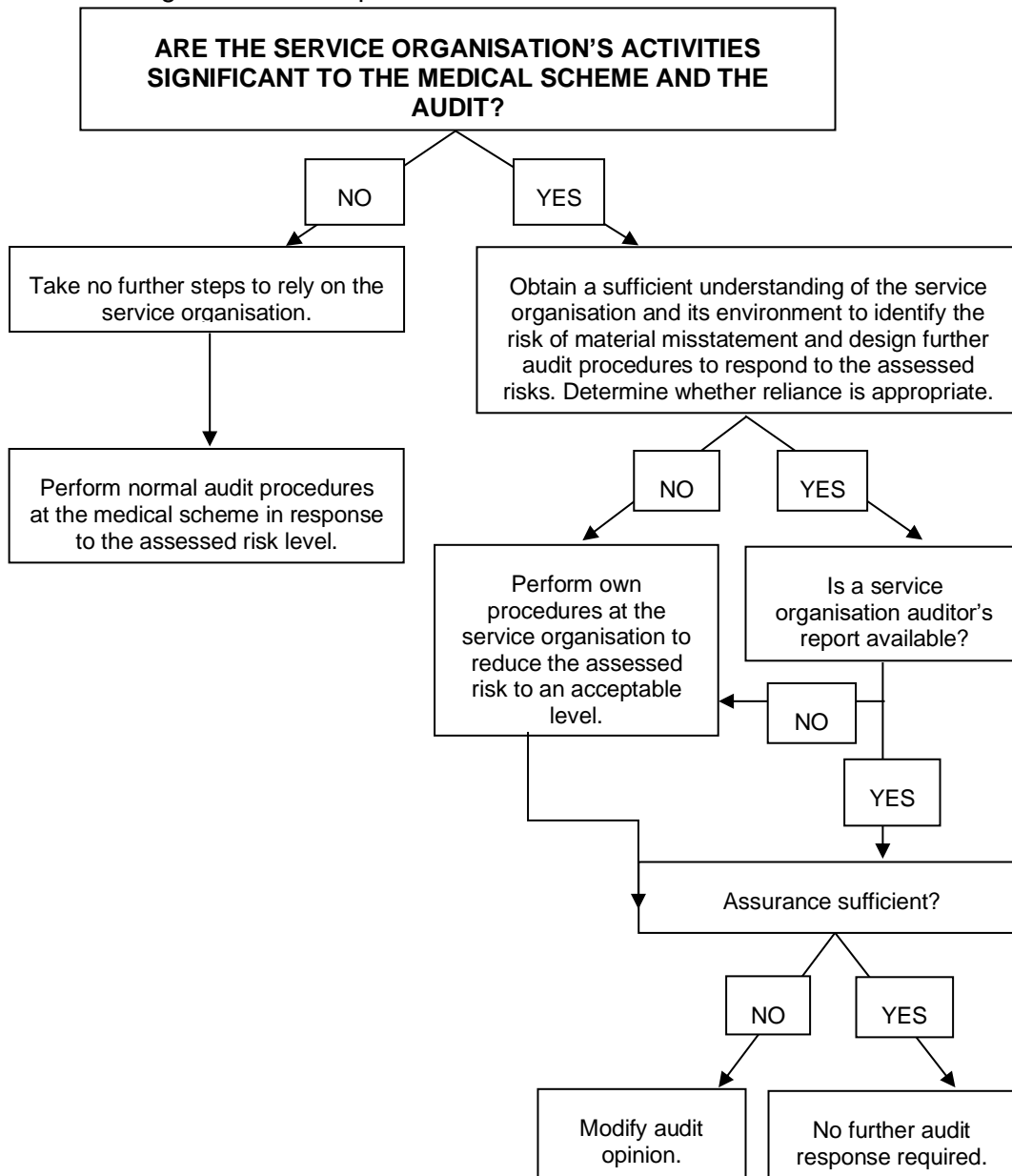
- benefit changes
- contributions increases
- non-healthcare expenses
- assumptions
- financial projections

This Advisory Practice Note is published by the Actuarial Society of South Africa and can be found on their website, [www.actuarialsociety.org.za](http://www.actuarialsociety.org.za).

<sup>25</sup> ISAE 3402, *Assurance Reports on Controls at a Service Organization*.

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91. The decision tree below illustrates the aspects an auditor considers when reliance on a service organisation is required:



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### Related parties

92. An auditor applies ISA 550, *Related Parties*.
93. The SAICA *Medical Schemes Accounting Guide*<sup>26</sup> provides guidance on the identification of related parties and the disclosures required.
94. An auditor considers whether a medical scheme has followed due process for the identification of all related party relationships, as well as the identification of related party transactions and balances, and that the disclosure thereof has been provided in accordance with IAS 24<sup>27</sup>.

### Sundry considerations

#### *Statutory solvency requirements*

95. Regulation 29(2) of the Act specifically states that a medical scheme must maintain accumulated funds, expressed as a percentage of gross annual contributions for the accounting period under review, which may not be less than 25%.
96. Regulation 29(3A) further states that a medical scheme that is registered for the first time after these Regulations came into effect must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than:
  - a) 10% during the first year after the medical scheme was registered;
  - b) 13.5% during the second year;
  - c) 17.5% during the third year; and
  - d) 22% during the fourth year.

For example, should a medical scheme be registered in June 2017, the medical scheme only needs to obtain a 10% solvency level at 31 December 2018.

97. Circular 13 of 2001<sup>28</sup> provides further guidance on what items need to be excluded from the computation of accumulated funds for solvency purposes:
  - a) Funds set aside for specific non-claims purposes;
  - b) Encumbered assets in respect of non-medical scheme liabilities; and
  - c) Accumulated net unrealised gains.

Accumulated net losses are ignored, for solvency purposes, and not added back. This is done in an attempt to be more conservative.

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<sup>26</sup> Refer to the SAICA website at <https://www.saica.co.za/TechnicalInformation/Publications/Guides/tabid/107/language/en-ZA/Default.aspx>.

<sup>27</sup> International Accounting Standard 24, *Related Party Disclosures*.

<sup>28</sup> Circular 13 of 2001, *Non-Distributable Reserves in Solvency Calculation*.

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98. Consolidated results should also be excluded from solvency calculations as they are deemed not to be realised for medical scheme purposes.
99. Where a medical scheme fails to comply with the requirements of these Regulations, for a period of 90 days, it must notify the Registrar in writing of such failure, and must provide information relating to:
- a) The nature and causes of the failure; and
  - b) The course of action being adopted to ensure compliance therewith.

The Registrar will approve such course of action and monitor the medical scheme's performance versus the approved requirements.

*Exemptions in terms of Section 8(h)*

100. The Council may, under exceptional circumstances, grant exemption from the requirements of the Act, in the form of a directive.
101. The directive given by the Council relating to the exemption request sets certain new compliance Rules that the medical scheme needs to comply with. These "new" compliance Rules need to be complied with as if they were the initial Rules as set by the Act. An auditor considers whether the medical scheme has understood the new compliance Rules and whether the medical scheme has complied with all the reporting requirements to the Registrar. (It must be noted that compliance with the amended Rules, as set by the Registrar, does not remove the obligation from either the medical scheme or an auditor to report on the primary non-compliance with the Act.)

*Allocation of income and expenses between different benefit options*

102. In terms of Section 33 of the Act, each benefit option is required to be financially sound and self-supporting in terms of membership and financial performance. In terms of Section 37(4)(d) of the Act, read together with Section 33, accounting records for each benefit option should be maintained. These accounting records should be maintained in such a way that the net surplus/deficit for the year for each benefit option can be determined.
103. Circular 4 of 2008<sup>29</sup> effected the requirement that the annual financial statements should include the results of the benefit options offered by a medical scheme, indicating the financial performance thereof and the number of members enrolled per option in terms of the provisions of Section 37(2)(e). These benefit option results (as part of the annual financial statements) are required to be audited.
104. The statement of comprehensive income is allocated to the benefit options in the manner described in the accounting policies. An auditor is also aware of the disclosure requirements of changes in the accounting policy.

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<sup>29</sup> Circular 4 of 2008, *Inclusion of Benefit Options Results in the Annual Financial Statements*.

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## **Auditor reporting and the reporting responsibilities of the board of trustees**

### **Schedule of reporting responsibilities**

105. The schedules are a summary of reporting responsibilities of an auditor of a medical scheme and a board of trustees<sup>30</sup>:

<b>Board of trustees</b>		
<b>Requirement in legislation</b>	<b>Preparing and disclosing:</b>	<b>Section in guide below</b>
Section 37(2) and Section 37(4)(d), read together with Circular 4 of 2008	Financial statements, which include the benefit option results	<a href="#">Preparing of the annual financial statements by the board of trustees</a>
Circular 41 of 2012	Prescribed minimum disclosure requirements relating to PMSA trust investments and trust liabilities <sup>31</sup>	<a href="#">Preparing of the annual financial statements by the board of trustees</a>
Section 37(5)	Report of the board of trustees	<a href="#">Report of the board of trustees</a>
Circular 11 of 2006	Non-compliance in the notes to the financial statements and in the report of the board of trustees	<a href="#">Reporting on non-compliance by both an auditor and a board of trustees of a medical scheme: Report on Other Legal and Regulatory Requirements</a>

<sup>30</sup> Although the purpose of this section is to aid an auditor of a medical scheme in understanding auditor reporting, the reporting responsibilities of a board of trustees are included:

- a) In order for an auditor to distinguish between the relative reporting responsibilities;
- b) In order for an auditor to understand how to report on non-compliance that has been reported in the report of the board of trustees; and
- c) For the sake of completeness.

<sup>31</sup> This Circular is applicable in the event that the Rules create a trust agreement.

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<b>Auditor</b>				
<b>Requirement in legislation</b>	<b>Reporting on:</b>	<b>Type of auditor report</b>	<b>Section in guide below</b>	<b>Appendix</b>
Section 37(2)	Annual financial statements	ISA 700 (Revised)	<a href="#">Reporting on the annual financial statements</a>	<a href="#">5</a>
Sections 36(8), 37(3) read in conjunction with 37(2)	Parts 4 to 10 of the annual statutory return	ISA 800 (Revised) and ISRE 2410	<a href="#">Reporting on Parts 4 to 10 of the annual statutory return</a>	<a href="#">6</a>
Sections 36(5)(b) and 36(8)	Compliance with Sections 36(5)(b) and 36(8) of the Act	ISAE 3000 (Revised)	<a href="#">Report on Compliance with Sections 36(5)(b) and 36(8) of the Act</a>	<a href="#">7</a>
Circular 11 of 2006	Non-compliance in the auditor report to the financial statements	“Report on Other Legal and Regulatory Requirements” section of the ISA 700 (Revised) report – compliance reporting	<a href="#">Reporting on non-compliance by both an auditor and a board of trustees of a medical scheme: Report on Other Legal and Regulatory Requirements</a>	<a href="#">5</a>
Circular 6 of 2013	Summary financial statements	ISA 810 (Revised)	<a href="#">Report on summary financial statements</a>	<a href="#">8</a>
Section 36(5)(a)	Reportable irregularities	“Report on Other Legal and Regulatory Requirements” section of the ISA 700 (Revised) report	<a href="#">Reporting on reportable irregularities</a>	<a href="#">5</a>
Circular 65 of 2015	Auditor’s Reports: Key Audit Matters			
Circular 57 of 2017	Non-compliance with Laws and Regulations (NOCLAR)			
Other reporting responsibilities to the <i>Council</i> include: Reasons for termination, Auditor Approval Questionnaire, including declaration on application regarding internal control weaknesses, management report and other duties provided for in the Act.			<a href="#">Other reporting responsibilities to the Council</a>	
Communication with <i>those charged with governance</i>			<a href="#">Communication with those charged with governance</a>	

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**Preparing of the annual financial statements by the board of trustees**

106. In terms of Section 37(2) of the Act, a board of trustees is responsible for preparing the annual financial statements of a medical scheme for every financial year. It then furnishes copies of the statements, together with the report of the board of trustees, to the Registrar within four months after the end of the financial year.
107. The annual financial statements comprise, inter alia:
- a) Statement of financial position;
  - b) Statement of comprehensive income;
  - c) Statement of changes in members' funds and reserves;
  - d) Statement of cash flows;
  - e) Independent auditor's report; and
  - f) Any such other returns as the Registrar may require, including the annual statutory return.
108. The annual financial statements must, in terms of Section 37(4)(d), also include the benefit options' financial results, including membership. These results are required to be audited in terms of Circular 4 of 2008.
109. For the purpose of this Guide, the annual financial statements may include, inter alia, reports by the audit committee and investment committee or any other committees with a fiduciary responsibility towards a medical scheme and its members.
110. The financial statements of a medical scheme are prepared in accordance with IFRSs, and in the manner required by the Act. Refer to the *SAICA Medical Schemes Accounting Guide*<sup>32</sup> for guidance on certain financial reporting issues specific to the medical schemes industry and for guidance on the form and content of the report of the board of trustees. Also refer to the format of the statement of comprehensive income as well as the minimum disclosure requirements relating to PMSA trust investments and trust liabilities<sup>33</sup> prescribed by the Council, in terms of Circular 41 of 2012<sup>34</sup>, for use by medical schemes.
111. The duties and responsibilities of the board of trustees are set out in Sections 57(4) and 57(6) of the Act. These include ensuring that proper registers, books and records of all operations of a medical scheme are kept, and that proper internal control systems are employed by or on behalf of a medical scheme.

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<sup>32</sup> Refer to the SAICA website at <https://www.saica.co.za/TechnicalInformation/Publications/Guides/tabid/107/language/en-ZA/Default.aspx>.

<sup>33</sup> This is in the event that the Rules create a trust agreement.

<sup>34</sup> Circular 41 of 2012, *Prescribed format for the Statement of Comprehensive Income and disclosures required in respect of PMSA*.

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### Report of the board of trustees

112. In accordance with Section 37(5) of the Act, the trustees' report is to deal with every matter that is material for the appreciation by members of a medical scheme of the state of affairs and the business of a medical scheme and the results thereof. Also, it must contain relevant information indicating whether or not the resources of a medical scheme have been applied economically, efficiently and effectively.
113. The report of the board of trustees does not form part of the audited financial statements; however, an auditor has a responsibility in terms of ISA 720 (Revised)<sup>35</sup> in relation to other information in documents containing audited financial statements.

### Reporting on the annual financial statements

114. An auditor is required to report on the annual financial statements prepared by a medical scheme in terms of Section 37(2) of the Act.
115. An auditor performs an ISA 700 (Revised)<sup>36</sup> engagement. An auditor obtains reasonable assurance that the financial statements, taken as a whole, are free from material misstatement, whether caused by fraud or error.
116. Refer to [Appendix 5 – Report on the Financial Statements \(ISA 700 \(Revised\) Report\)](#) for the template report.<sup>37</sup>

### Reporting on Parts 4 to 10 of the annual statutory return

117. Section 36(8) of the Act requires an auditor to, "in respect of a return or statement which he or she is required to examine in terms of this Chapter, certify whether that return or statement complies with the requirements of the Act, also whether the return or statement, including any annexure thereto, presents fairly the matters dealt with therein as if such return or statement were a financial statement contemplated in Section 20 of the Public Accountants' and Auditors' Act, 1991..." The term "certify" is not used in the audit environment, as it may imply absolute assurance, while reasonable assurance is appropriate in the context of the Act.
118. Section 37(2) of the Act states, inter alia, that the annual financial statements of a medical scheme include "such other returns as the Registrar may require". This refers to the annual statutory return.
119. Section 39(3) of the Act elaborates that a medical scheme would be deemed not to have complied unless any income statement, cash flow statement, balance sheet or return required to be submitted is "certified" by the auditor of the medical scheme.

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<sup>35</sup> ISA 720 (Revised), *The Auditor's Responsibilities Relating to Other Information*.

<sup>36</sup> ISA 700 (Revised), *Forming an Opinion and Reporting on Financial Statements*.

<sup>37</sup> Refer also to ISA 705 (Revised), *Modifications to the Opinion in the Independent Auditor's Report*; and ISA 706 (Revised), *Emphasis of Matter Paragraphs and Other Matter Paragraphs in the Independent Auditor's Report*.



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120. As the annual statutory return is seen as part of the annual financial statements, the annual statutory return is therefore required to be audited in terms of Section 37(3) of the Act.
121. Parts 4 to 10 of the annual statutory return comprise information from the financial statements, prepared in accordance with IFRS, and additional historical financial information extracted from the underlying accounting records of the medical scheme, for the purpose of reporting to the Registrar. A reasonable assurance opinion is provided on whether Parts 4 to 6.1 and 6.3 to 10 have been prepared in all material respects in accordance with the provisions of the Act and related Regulations. The audit engagement is performed in terms of the ISAs and the report is prepared using ISA 800 (Revised). For the purpose of this engagement, an auditor obtains additional evidence necessary to provide a reasonable basis for the auditor's opinion in addition to the evidence obtained during the course of the audit of the financial statements.
122. Part 6.2 of the annual statutory return is the "Monthly Statement of Net Healthcare Result" and it contains monthly financial information that would not be audited as part of the audit of the financial statements.
123. An auditor is able to express only a limited assurance conclusion on Part 6.2 of the annual statutory return. A limited assurance conclusion is provided on whether anything has come to the attention of the auditor that causes the auditor to believe that Part 6.2 of the annual statutory return is not prepared in all material respects in accordance with the provisions of the Act and related Regulations. This review engagement is performed in terms of ISRE 2410. For the purpose of this engagement, an auditor obtains additional evidence necessary to provide a limited assurance conclusion, in addition to the evidence obtained during the course of the audit of the financial statements.
124. This auditor report is therefore a combined:
- a) ISA 800 (Revised)<sup>38</sup> assurance report on Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return, providing a reasonable assurance opinion; and
  - b) ISRE 2410<sup>39</sup> review report on Part 6.2 of the annual statutory return, providing a limited assurance conclusion.
125. Refer to [Appendix 6 – Report on Parts 4 to 10 of the Annual Statutory Return \(combined ISA 800 \(Revised\) and ISRE 2410 Report\)](#) for the template report.

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<sup>38</sup> ISA 800 (Revised), *Special Considerations – Audits of Financial Statements Prepared in Accordance with Special Purpose Frameworks*.

<sup>39</sup> ISRE 2410, *Review of Interim Financial Information Performed by the Independent Auditor of the Entity*.

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**Reporting on non-compliance by both an auditor and a board of trustees of a medical scheme**

***Report on Other Legal and Regulatory Requirements***

126. To provide further guidance, the Council issued Circular 11 of 2006<sup>40</sup> in terms of which the following non-compliance disclosures are required:

- a) All non-compliance matters should be reported in the *report of the board of trustees*, irrespective of whether an auditor considers them to be material or not. The Council does not consider it sufficient to make reference to the relevant notes in the financial statements – *this disclosure is the responsibility of the board of trustees*.
- b) All non-compliance matters noted should be disclosed in the *notes to the audited financial statements*, irrespective of whether an auditor considers them to be material or not – *this disclosure is the responsibility of the board of trustees*; and
- c) All non-compliance matters, which are considered to be material by an auditor, should be reported in the *auditor's ISA 700 (Revised) report*, under the sub-heading "Report on Other Legal and Regulatory Requirements" – *this reporting is the responsibility of the auditor*. Where no material instances of non-compliance have come to an auditor's attention, a statement to this effect should be made. The auditor considers the needs of the users of the financial statements in applying his/her judgement as to what a material instance of non-compliance with the Medical Schemes Act is, when the non-compliance with the Act comes to the attention of the auditor during the course of the audit.

127. The board of trustees is required to disclose the following information with regards to non-compliance matters:

- a) Nature and cause of the non-compliance;
- b) Possible impact of the non-compliance; and
- c) The course of action being adopted to ensure compliance therewith, including the period in which compliance will be achieved.

128. In conducting the audit of the financial statements, an auditor has regard to the legal and regulatory framework applicable to a medical scheme. As part of the audit procedures, an auditor considers a medical scheme's compliance, procedural and other obligations imposed by the Act, the related Regulations, the Circulars and the Rules of the medical scheme.

129. An auditor remains alert to the possibility that other audit procedures applied for the purpose of forming an opinion on financial statements may bring instances of possible non-compliance to an auditor's attention.

130. In determining what non-compliance matters to report, an auditor considers:

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<sup>40</sup> Circular 11 of 2006, *Issues to be Addressed in the Audited Financial Statements of Medical Schemes*.

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- a) Non-compliance with those laws and regulations generally recognised by an auditor to have a direct effect on the determination of material amounts and disclosures in the financial statements; and
  - b) Non-compliance with laws and regulations that does not have a direct effect on the determination of the amounts and disclosures in the financial statements, while compliance may be fundamental to a medical scheme's ability to continue its business or to avoid material penalties that may have a material effect on the financial statements.
131. In particular, there may be laws and regulations, relating principally to the operating aspects of a medical scheme, which typically do not have a material effect on the financial statements and are not captured by a medical scheme's accounting and internal control information systems relevant to financial reporting. An auditor's report relates specifically to the financial statements and the auditor may therefore not consider compliance with laws and regulations that do not have a material impact on the financial statements.
132. The auditor's attention is drawn to the requirements listed in [Appendix 3 – Extracts from and commentary on the Medical Schemes Act and Regulations](#), and [Appendix 9 – Non-compliance matters](#).
133. *At the time that this Guide was issued there had been no changes to the applicable legislation. For legislative changes after the date of issue of this Guide, refer to the websites of the relevant regulators.*
134. The course of action adopted to ensure compliance could include exemptions obtained in terms of Section 8(h).

**Report on Compliance with Sections 36(5)(b) and 36(8) of the Act**

135. Section 36(5)(b) requires an auditor to inform the Registrar in writing of *any* matter relating to the affairs of the medical scheme of which he or she became aware in the performance of his or her functions as auditor and which, in the opinion of the auditor, may prejudice the medical scheme's ability to comply with that Chapter of the Act (Financial Matters).
136. Section 36(8)(a) requires an auditor, in respect of a return or statement which he or she is required to examine in terms of that Chapter of the Act (Financial Matters), to certify whether that return or statement complies with the requirements of the Act and whether the return or statement, including any annexure thereto, presents fairly the matters dealt with therein.
137. The Registrar therefore requires an auditor to perform a limited assurance engagement, in terms of ISAE 3000 (Revised)<sup>41</sup>, to conclude on whether the medical scheme complied with the criteria identified in the limited assurance report.

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<sup>41</sup> ISAE 3000 (Revised), *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*.

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138. An auditor concludes whether anything has come to the auditor's attention that causes the auditor to believe that the medical scheme has not complied, *in all material respects*, with the specified Sections of the Act and related Regulations. Materiality is, however, set as *one*, as *any* non-compliance is required to be reported on by the Council. Therefore, *all* instances of non-compliance are regarded as material and, therefore, *all* are listed. *Any* instance of non-compliance will therefore result in a qualified conclusion.
139. The ISAE 3000 (Revised) report (which is submitted as part of the annual statutory return) is the auditor report that the Council requires for an auditor to report on compliance with Section 36(5)(b). The Medical Schemes Task Group agreed on the Sections of the Act and related Regulations (the "criteria") on which an auditor reports. These criteria are limited to the financial aspects of the Act that an auditor will include in the auditor's normal audit procedures.
140. Refer to [Appendix 7 – Assurance Report on Compliance with Sections 36\(5\) and 36\(8\) of the Act \(ISAE 3000 \(Revised\) Report\)](#) for the template report.

#### **Reporting on summary financial statements<sup>42</sup>**

141. Medical schemes that distribute summary financial statements to their members are required to prepare and present the summary financial statements in accordance with the criteria specified by the Registrar in terms of Circular 6 of 2013<sup>43</sup>. An auditor reporting on the summary financial statements derived from the audited financial statements is the same auditor that reported on the financial statements. An auditor reporting on summary financial statements does so after completing the financial statement audit and issuing an auditor's report on the financial statements. An auditor complies with ISA 810 (Revised)<sup>44</sup>. Refer to [Appendix 8 – Report on the Summary Financial Statements \(ISA 810 \(Revised\) Report\)](#) for the template report.
142. As per the requirements of this Circular, medical schemes whose Rules require them to distribute summary financial statements to their members should ensure that such financial statements:
- a) Are prepared in accordance with the recognition and measurement requirements of IFRS;
  - b) Are prepared in the manner required by the Act;
  - c) As a minimum, adhere to the presentation and disclosure requirements of IAS 34<sup>45</sup>; and

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<sup>42</sup> Circular 6 of 2013 refers to a highlights document that a medical scheme provides to its members. The highlights document contains certain prescribed minimum information. An auditor is not required to perform any work on the highlights document, in terms of ISA 720 (Revised), *The Auditor's Responsibilities Relating to Other Information*. An auditor may read the highlights document "as a courtesy".

<sup>43</sup> Circular 6 of 2013, *Annual financial information provided to members*.

<sup>44</sup> ISA 810 (Revised), *Engagements to Report on Summary Financial Statements*.

<sup>45</sup> IAS 34, *Interim financial reporting*.

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- d) Provide information on where a member can obtain a full set of annual financial statements.

### Reporting on reportable irregularities

143. An auditor is required to furnish the Registrar with a copy of both the first and second reports of an auditor furnished to the IRBA in terms of Section 45 of the Auditing Profession Act, as per Section 36(5)(a) of the Act. Refer to *Reportable Irregularities: A Guide for Registered Auditors* issued by the IRBA for guidance on reportable irregularities.<sup>46</sup>
144. An auditor considers the impact of the reportable irregularity on the audit opinion, and discloses the reportable irregularity in the ISA 700 (Revised) report under “Report on Other Legal and Regulatory Requirements”, if applicable.

### Audit tenure

145. Circular 38 of 2018 requires the auditor’s reports on the annual financial statements to disclose the number of years both the audit firm and the engagement partner have been the auditor of a medical scheme (audit tenure). This is applicable for audit reports on the annual financial statements of all medical schemes for periods ending on or after 31 December 2018.
146. Audit tenure refers to the length of the auditor-client relationship. Thus, tenure includes the period that the firm, any predecessor audit firms (where there have been mergers/de-mergers or other combinations in the audit firm) and the specific engagement partner have issued audit reports on the medical scheme. The audit tenure disclosed in the audit report should reflect the number of years the audit firm and the engagement partner each served as auditor.

### Key Audit Matters

147. ISA 700 (Revised) is applicable for the audits of financial statements for periods ending on or after 15 December 2016.
148. Paragraph 31 of ISA 700 (Revised) refers the auditor to ISA 701, *Communicating Key Audit Matters in the Independent Auditor’s Report* (ISA 701), for the reporting of key audit matters (KAM) in the auditor’s report.
149. ISA 701 defines key audit matters as those matters that were, in the auditor’s professional judgement, of the most significance in the audit of the financial statements. These matters are selected from matters communicated with those charged with governance.<sup>47</sup>

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<sup>46</sup> Available on the IRBA website ([www.irba.co.za](http://www.irba.co.za)).

<sup>47</sup> ISA 701, paragraph 8.

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150. As per Circular 65 of 2015, the Council requires auditors of medical schemes to report on KAM in their audits of medical schemes' financial statements for years ending 31 December 2016 onwards.<sup>48</sup>

### Non-compliance with Laws and Regulations

151. The Independent Regulatory Board for Auditors (IRBA) Code of Professional Conduct (IRBA Code) was updated in December 2016 to include ethics requirements and guidance to assist registered auditors in dealing with non-compliance with laws and regulations (NOCLAR). Section 225<sup>49</sup> 50 of the IRBA Code sets out the registered auditor's responsibilities in responding to NOCLAR or suspected NOCLAR. This sections is effective as of 15 July 2017.
152. The registered auditor also refers to Circular 57 of 2017, *Non-compliance with Laws and Regulations (NOCLAR)*, for guidance from the Council on how to report NOCLAR.

### Other reporting responsibilities to the Council

#### *Reasons for termination*

153. Section 36(5)(c) of the Act requires an auditor to report to the Registrar in writing what the auditor believes to be the reason for the termination (including a resignation) of the auditor.

#### *Standards for Authorisation of Auditors*

154. Both the audit firm and the individual auditor are required, in terms of the "*Standards for authorisation of Auditors*"<sup>51</sup>, to apply for authorisation as a medical scheme auditor. The audit firm and individual auditor need to submit the following documentation required in terms of the abovementioned Standard:
- The authorisation application forms;
  - The necessary declarations, with the required supporting documentation;
  - Proof of payment of the relevant administration fees; and
  - Other documents, where applicable, which would be communicated via a Circular.
155. The authorisation status is granted for a period of three years. Thereafter, the audit firm and the individual auditor can apply for renewal four months prior to the expiry date of authorisation in order to be eligible for appointment in that financial year.

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<sup>48</sup> Circular 65 of 2015, *Auditor's Reports: Key Audit Matters*.

<sup>49</sup> [https://www.irba.co.za/upload/58\\_%20NOCLAR%20-%20Final.pdf](https://www.irba.co.za/upload/58_%20NOCLAR%20-%20Final.pdf).

<sup>50</sup> Section 360 in the IRBA Code of Professional Conduct for Registered Auditors (Revised November 2018).

<sup>51</sup> <http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/AuthStds.pdf>.

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156. During the period of authorisation, the audit firm and the individual auditor need to submit an annual declaration (refer to the addendums to the *“Standards for authorisation of Auditors”*).
157. The audit firm and the individual auditor must inform the Registrar, within five working days of receiving notification, of the following:
- The outcome of a firm or file review performed by the IRBA together with the decision letter from the IRBA;
  - The fact that the audit firm or the individual auditor was party to (either by advising or signing off on financial statements or other information prior to publication) an investigation that resulted in a conclusion that the medical scheme’s financial statements or other information were not in compliance with IFRS;
  - The fact that the individual auditor is no longer employed or associated with the firm and that his/her name should be removed from the authorisation list;
  - The fact that the audit firm or individual auditor, or the previous auditor in an instance where there was a change in auditors, issued an audit or review opinion on information that was subsequently amended;
  - The outcome of any legal or disciplinary processes of any professional body of which the audit firm or individual auditor is a member or the regulator to which it is accountable; and
  - Any other matter that may be of relevance to the audit firm or individual auditor’s ongoing obligations and responsibilities in terms of the Act.

***Management report***

158. An auditor’s management report that includes all internal control weaknesses and housekeeping issues identified during the audit, together with management comments, must be included as part of the annual submission to the Council. In instances where no management report was issued by an auditor, the Council will require official confirmation from an auditor that there were no material matters that should be reported to either the medical scheme or the Council.<sup>52</sup>

***Other duties provided for in the Act***

159. Section 36(8)(b) further requires an auditor to carry out the other duties provided for in the Act.

**Communication with those charged with governance**

160. An auditor is required to report housekeeping matters to management, while audit matters need to be communicated to those charged with governance. In determining

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<sup>52</sup> Refer to Circular 23 of 2011, *General Concerns Noted during the Analysis of the 2010 Annual Financial Statements and Statutory Returns*.

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what matters should be reported to the Registrar, an auditor considers the guidance in ISA 260<sup>53</sup> and ISA 265<sup>54</sup>.

### Appendix 1 – Definitions

*The definitions below were correct at the time that this Guide was issued. For legislative revisions resulting in changes to definitions after the date of issue of this Guide, refer to the websites of the relevant regulators.*

For the purpose of this Guide, the following terms have the meanings attributed below:

**Accounting period** – The financial period ending at the year-end date (31 December), or shorter period, as applicable.

**Act** – The Medical Schemes Act, No. 131 of 1998, as amended, and related Regulations.

**Actuary** – Any fellow of an institute, faculty, society or chapter of actuaries approved by the Minister of Finance of South Africa.

**Administration expenses** – The costs incurred to administer the medical scheme in terms of the Rules and the Act.

**Administration expenditure: benefit management services** – The cost of managing healthcare expenditure, such as bill review, claims audits, medical advisors, peer review, provider network management, statistical analysis, nurse advice lines and wellness programmes but does not include the cost of any relevant healthcare services.

**Administrator** – Any legal person who has been accredited by the Council, in terms of Section 58 of the Act to be an administrator, and shall, where any obligation has been placed on a medical scheme in terms of this Act, also mean a medical scheme. The board of trustees will, through a service level agreement, authorise the administrator to perform the administration and accounting function of a medical scheme.

**Annual statutory return** – The prescribed return to be submitted to the Council in terms of Section 37(2)(e) of the Act.

**Auditing Profession Act** – Auditing Profession Act, No. 26 of 2005.

**Auditor** – A registered auditor as defined in the Auditing Profession Act; the individual and the firm approved by the Registrar of Medical Schemes to be appointed as auditor to a medical scheme in terms of the “*Standards for authorisation of Auditors*”<sup>55</sup>.

**Beneficiary** – A member and a person admitted as a dependant of a member (commonly referred to as “belly-buttons” or “lives”).

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<sup>53</sup> ISA 260, *Communication of Audit Matters with Those Charged with Governance*.

<sup>54</sup> ISA 265, *Communicating Deficiencies in Internal Control to those Charged with Governance and Management*.

<sup>55</sup> <http://www.medicalschemes.com/files/Guidelines%20and%20Manuals/AuthStds.pdf>.



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**Appendix 2**

**Benefit option** – A defined set of healthcare benefits, approved by the Registrar, applicable to a specific group of members and/or employers that have selected such benefits in terms of the Rules of the medical scheme.

**Benefit period** – normally January to December, but may differ from the accounting period.

**Board of trustees** – The board of trustees charged with managing of the affairs of a medical scheme as set out in Section 57 of the Act, and which has been elected or appointed under its Rules.

**Broker** – An accredited person whose business, or part thereof, entails providing broker services, but does not include:

- An employer or employer representative who provides service or advice exclusively to the employees of that employer; or
- A trade union or trade union representative who provides service or advice exclusively to members of that trade union; or
- A person who provides service or advice exclusively for the purposes of performing his or her normal functions as a trustee, principal officer, employee or administrator of a medical scheme,

unless a person referred to in subparagraph (i), (ii) or (iii) of the definition of broker as per the Act elects to be accredited as a broker in terms of section 65 of the Act, or actively markets or canvasses for membership of a medical scheme.

**Broker services** –

- The provision of a service or advice in respect of the introduction or admission of members to a medical scheme; or
- The ongoing provision of a service or advice in respect of access to, or benefits or services offered by, a medical scheme.

**Business of a medical scheme** – The business of undertaking liability in return for a contribution:

- To make provision for the obtaining of any relevant health service;
- To grant assistance in defraying expenditure incurred in connection with the rendering of any relevant healthcare service; and
- Where applicable, to render a relevant healthcare service, whether by the medical scheme itself or by any supplier or group of suppliers of a relevant healthcare service or by any person, in association with or in terms of an agreement with a medical scheme.

**Capitation agreement** – An arrangement entered into between a medical scheme and a person whereby the medical scheme pays to such person a pre-negotiated fixed fee in return for the delivery or arrangement for the delivery of specified benefits to some or all of the members of the medical scheme.

**Commercial reinsurance** – Any contractual arrangement whereby some element of risk contained in the Rules is transferred to a reinsurer in return for some consideration.

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**Council** – The Council for Medical Schemes established by Section 3 of the Act.

**Dependant** –

- The spouse or partner, dependant children or other members of the member's immediate family in respect of whom the member is liable for family care and support; or
- Any other person who, under the Rules, is recognised as a dependant of a member and is eligible for benefits under the Rules of the medical scheme.

**Designated service provider (DSP)** – Means a healthcare provider or group of providers selected by the medical scheme concerned as the preferred provider or providers to provide its beneficiaries with diagnosis, treatment and care in respect of one or more PMB conditions or any other relevant health service covered by the medical scheme.

**Electronic claims clearing houses** – Electronic claims clearing houses provide clearing services in respect of claims submitted to the scheme (e.g. pharmacy claims).

**Electronic Data Interchange (EDI)** – A common interface between two or more computer applications. It is commonly used by entities for e-commerce purposes, such as the submission of claims to medical schemes by pharmacies.

**Employer** – is any employer group that negotiates certain terms and conditions of the contract of membership with a medical scheme for and on behalf of its employees.

**Experts** – An auditor may use the work of the following experts in obtaining evidence:

- *Auditor's expert* – An individual or organisation possessing expertise in a field other than accounting or auditing, whose work in that field is used by the auditor to assist the auditor in obtaining sufficient appropriate audit evidence. An auditor's expert may be either an auditor's internal expert (who is a partner<sup>56</sup> or staff, including temporary staff, of the auditor's firm or a network firm), or an auditor's external expert.<sup>57</sup>
- *Management's expert* – An individual or organisation possessing expertise in a field other than accounting or auditing, whose work in that field is used by the entity to assist the entity in preparing the financial statements.<sup>58</sup>

**Gross claims paid and reported** – The total costs of settling all claims in respect of registered benefits (before deducting claims paid from personal medical savings accounts) that arise from healthcare events that have occurred in the period and those that have occurred previously, and for which no provision was made. These include claims settled by third party providers in terms of risk transfer arrangements and costs for accredited managed healthcare services. Gross claims also include own facility costs for services rendered to members.

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<sup>56</sup> "Partner" and "firm" should be read as referring to their public sector equivalents where relevant.

<sup>57</sup> ISA 620, *Using the Work of an Auditor's Expert*.

<sup>58</sup> ISA 500, *Audit Evidence*.

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**Gross contributions** – Monies (contributions) payable by members and/or employers, in terms of the Rules of the medical scheme, for the purchase of healthcare benefits. Gross contributions comprise personal medical savings contributions and risk contributions.

**Healthcare benefits** – A members' entitlement to healthcare services, in terms of the Rules and the Act, also known as claims.

**Incurred but not reported (IBNR)** – Refer to “outstanding risk claims provision”.

**Internal financial controls** – Controls which are established in order to ensure a reasonable safeguarding of assets against unauthorised use or disposition, the maintenance of proper accounting records and the reliability of financial information used within the business of the administrator and the medical scheme.

**Investment income** – Includes interest (inclusive of interest received on bank accounts and on arrear balances), dividends, rental and policy income as well as net realised gains or losses on available-for-sale financial assets and net gains or losses on financial assets at fair value through profit or loss.

**Investment manager** – An investment manager is responsible for managing a medical scheme's investments, usually through an investment mandate from the board of trustees.

**Linked policy** – A long-term policy in relation to which the liabilities of the long-term insurer are linked liabilities as defined in the Long-term Insurance Act.

**Managed healthcare** – Clinical and financial risk assessment and management of healthcare, with a view to facilitating appropriateness and cost-effectiveness of relevant health services within the constraints of what is affordable, through the use of Rules-based and clinical management-based programmes.

- Only accredited managed care services (as specified in Circular 13 of 2014) are included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate (evidence-based medicine) healthcare benefits to beneficiaries of medical schemes. This includes the following services: active disease risk management services, disease risk management support services, dental benefit management services, hospital benefit management services, managed care network management services and risk management, pharmacy benefit management services and healthcare services (where risk transfer takes place).

**Managed healthcare organisation** – A person who has contracted with a medical scheme in terms of Regulation 15A to provide a managed health care service (usually a company or a close corporation).

**Medical scheme** – Any medical scheme registered under Section 24(1) of the Act.

**Member** – A person who has been enrolled or admitted as a member of a medical scheme, or who, in terms of the Rules of a medical scheme, is a member of such medical scheme.

**Member's portion** – The part of the amount paid to a supplier of healthcare services for which the member is responsible, in terms of the Rules. Also referred to as “co-payment” or “shortfall”.

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**Minimum accumulated funds (solvency ratio)** – A medical scheme must maintain accumulated funds expressed as a percentage of gross annual contributions for the accounting period under review, which accumulated funds may not be less than 25% of the gross annual contributions. The minimum accumulated funds are sometimes referred to as the “solvency ratio” or the “accumulated funds ratio” and are the minimum capital requirement that medical schemes are required to maintain. Circular 13 of 2001<sup>59</sup> provides further information on what should be excluded from the amount of the accumulated funds, for purposes of calculating the minimum accumulated funds.

**Net claims incurred** – Risk claims incurred net of third party recoveries (such as the Road Accident Fund (RAF)).

**Non-healthcare expenditure** – Comprises broker service fees, administration fees and other operating expenses incurred in operating a medical scheme (including administration expenditure: benefit management services), as well as impairment losses incurred in respect of trade and other receivables.

**Outstanding risk claims provision** – A provision made for the estimated cost of healthcare benefits that have occurred before the end of the accounting period but have not been reported to the medical scheme by that date. This provision is determined as accurately as possible on the basis of a number of factors, which may include previous experience in claims reporting patterns, claims settlement patterns, changes in the nature and number of members according to gender and age, trends in claims frequency, changes in the claims processing cycle, and variations in the nature and average cost incurred per claim. The provision is net of estimated recoveries from members for co-payments, and for savings plan accounts. This provision is also known as provision for claims “incurred but not reported (IBNR)”.

**Own facility costs** – Represent costs incurred by a medical scheme in operating its own medical equipment, hospital, clinic, pharmacy, pathology laboratory and radiology facility or any other related services.

**Personal medical savings account (PMSA), also personal medical savings account liability** – Funds accrued and received from members by the medical scheme with the monthly contributions to fund day-to-day healthcare benefits that are not covered by the option of the medical schemes that the member belongs to. PMSAs are savings contributions to be used for the payment of healthcare benefits that are for the account of the member, in terms of the Rules of the medical scheme. A credit balance in a member’s savings plan account is only refundable as provided for in Regulation 10 of the Act.

**Personal medical savings account trust investment** – Represents the amounts invested in respect of contributions received from members to their personal medical savings accounts and any interest or investment income accrued thereon, net of any payments made in respect of the registered benefits. These monies are held in trust and managed by the medical schemes on their members’ behalf in terms of the trust agreement created in the Rules.

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<sup>59</sup> Circular 13 of 2001, *Non-distributable reserves in solvency calculation*.

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**Policy income** – Represents income, for example, interest and dividends, earned from an investment policy with an insurer.

**Prescribed minimum benefits (PMBs)** – The benefits contemplated in Section 9(1)(o) of the Act, and consist of the provision of the diagnosis, treatment and care costs of:

- The Diagnosis and Treatment Pairs listed in Annexure A, subject to any limitations specified in Annexure A:
  - A limited set of approximately 270 medical conditions; and
  - 25 chronic disease list conditions (CDLs) as well as other chronic diagnosis treatment pairs (DTPs) and chronic conditions (currently only HIV and menopause); and
- Any emergency medical condition.

**Protection of Funds Act** – Financial Institutions (Protection of Funds) Act 28 of 2001.

**Registrar** – Registrar of Medical Schemes appointed in terms of Section 18 of the Act.

**Reinsurer** – An insurer:

- Registered as a long-term insurer in terms of Section 9 of the Long-term Insurance Act 52 of 1998, unless that insurer is prohibited from engaging in the practice of reinsurance in terms of Section 10 of that Act; or
- Registered as a short-term insurer in terms of Section 9 of the Short-term Insurance Act 53 of 1998, unless that insurer is prohibited from engaging in the practice of reinsurance in terms of Section 10 of that Act.

**Relevant healthcare expenditure** – Represents net claims incurred and net income/(expense) on risk transfer arrangements.

**Relevant health service** – Any healthcare treatment of any person by a person registered in terms of any law, which treatment has as its object:

- The physical or mental examination of that person;
- The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- The giving of advice in relation to any such defect, illness or deficiency;
- The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
- The prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
- Nursing or midwifery.

And includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practiced, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy.

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**Report of the board of trustees** – The report as per Section 37(5) of the Act. The report is issued by those persons with a fiduciary responsibility towards the medical scheme.

**Restricted membership medical scheme** – A medical scheme the Rules of which restrict the eligibility for membership by reference to:

- Employment or former employment or both employment or former employment in a profession, trade, industry or calling;
- Employment or former employment or both employment or former employment by a particular employer, or by an employer included in a particular class of employers;
- Membership or former membership or both membership or former membership of a particular profession, professional association or union; or
- Any other prescribed matter.

**Risk claims incurred** – Risk claims paid and reported adjusted by the outstanding risk claims provision at the beginning and end of the accounting period.

**Risk claims paid and reported** – Gross claims assessed, accrued and paid for services rendered during the accounting period and for services rendered during the previous accounting period but not included in the previous period's outstanding risk claims provision, excluding savings claims, and net of recoveries from members for co-payments, deductibles, and discount received from service providers.

**Risk contribution income** – Represents revenue for which the medical scheme is at risk, and is calculated as gross contributions less savings contributions, during the accounting period.

**Risk transfer arrangement** – A reinsurance contract as defined in IFRS 4<sup>60</sup>. This is a contractual arrangement in terms of which a third party undertakes to compensate a medical scheme for all or a significant part of the loss that the medical scheme may suffer as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce a medical scheme's primary obligations to its members and their dependants, but the arrangements only decrease the loss the medical scheme may suffer as a result of carrying on the business of a medical scheme. This can take the form of a capitation agreement or commercial reinsurance.

**Rules** – The Rules of a medical scheme including:

- The provisions of the law, or other document by which the medical scheme is constituted;
- Rules for the conduct of the business of the medical scheme; and
- The provisions relating to the benefits that may be granted by and the contributions that may become payable to the medical scheme.

**Rules-based and clinical management-based programmes** – A set of formal techniques designed to monitor the use of, and evaluate the clinical necessity, appropriateness, efficacy

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<sup>60</sup> IFRS 4, *Insurance Contracts*.

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and efficiency of, healthcare services, procedures or settings, on the basis of which appropriate managed healthcare interventions are made.

**Savings claims** – Healthcare benefits paid from members’ personal medical savings accounts in terms of the medical scheme’s registered Rules.

**Savings contributions** – The amount allocated to a member’s personal medical savings account in terms of the medical scheme’s Rules to a maximum of 25% of the gross amount contributed by the member.

**Savings plan liability** – Constitutes saving plan contributions held on behalf of members to be used for the payment of healthcare benefits that are payable by the member, in terms of the Rules.

**Service auditor** – A professional accountant in public practice who, at the request of the service organisation, provides an assurance report on controls at a service organisation.

**Service organisation** – A third-party organisation (or segment of a third-party organisation) that provides services to user entities that are part of those entities’ information systems that are relevant to financial reporting.

**Solvency ratio (accumulated funds ratio)** – The accumulated funds, as defined by the Act, expressed as a percentage of annualised gross contributions for the accounting period under review. Also see the “Minimum accumulated funds (solvency ratio)” definition.

**Trust agreement** – Any relationship (or agreement) between parties that prescribes how the trust property should be dealt with.

**Waiting periods** –

- *Condition-specific waiting period* – A period during which a beneficiary is not entitled to claim benefits in respect of a condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12-month period ending on the date on which an application for membership was made; or
- *General waiting period* – Up to a three-month period in which a beneficiary is not entitled to claim any benefits.

In the event that a member had a break of more than 90 days in membership (i.e. was uncovered), both waiting periods may be imposed, and the waiting periods would apply to PMBs. If the break was less than 90 days, the waiting periods do not apply to PMBs if:

- The previous membership was 24 months and longer, but a general waiting period might be imposed;
- The previous membership was shorter than 24 months (previous waiting periods may still be in place), but a condition-specific waiting period may be imposed; and
- Regardless of previous membership, if the member changed medical schemes due to a change in employment or the employer changing or terminating a medical scheme, but no waiting period may be imposed.

**Wash-sale transaction** – A transaction whereby a financial asset is purchased immediately before or soon after the sale of the same asset.

## **Appendix 2 – Understanding the Business of a Medical Scheme<sup>61</sup>**

The purpose of this appendix is to provide information and explanations on the nature of the business of a medical scheme in order to assist an auditor in applying ISA 315 (Revised), *Identifying and Assessing the Risks of Material Misstatement through Understanding the Entity and Its Environment*.

The descriptions hereunder are not intended to be exhaustive and should not be used as a substitute for the underlying legislation and Rules.

### **Nature of business**

1. The term “medical scheme” refers to a scheme that carries on the business of a medical scheme and that is registered under the Act. This excludes healthcare insurance products provided by a long-term or short-term insurer registered in terms of the Long-term Insurance Act 52 of 1998 or the Short-term Insurance Act 53 of 1998. In terms of the new Demarcation Regulations, Medical Expense Shortfall policies (gap cover) and non-medical expense cover as a result of hospitalisation policies (hospital cash plans) are still governed by insurance laws, while Primary Healthcare insurance policies now fall under the Act. The providers of the latter have been exempted from full compliance with the Medical Schemes Act for a two-year period that lapses on 31 March 2019.
2. A medical scheme is classified as not-for-profit under the Act and is similar to a mutual fund in that the members (policy holders) own the scheme.
3. Business is introduced to a medical scheme by direct selling or by brokers accredited in terms of the Act.
4. The main sources of business are from employer groups that wish to arrange healthcare benefits for their employees and their employees’ dependants and from individuals who wish to cover themselves and their dependants.
5. Some medical schemes are formed with the primary objective of providing healthcare benefits to the employees of particular organisations, members of certain professions, or members of a union, and are registered as restricted membership medical schemes. Other medical schemes admit members from any employer group or members of the public, and these are referred to as open medical schemes. Open medical schemes must accept all applicants as members, but may impose waiting periods.

### **Rules**

6. The business of a medical scheme is subject to the Rules of that medical scheme. In terms of Section 24(3) of the Act, the Registrar approves the Rules of a medical scheme upon the initial registration of such medical scheme. This approval is evidenced by a stamp on each page of the Rules. Any amendments to the Rules are required to be

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<sup>61</sup> ISA 315 (Revised), *Identifying and Assessing the Risks of Material Misstatement through Understanding the Entity and Its Environment*.



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similarly approved by the Registrar (Section 31(2)) and registered in accordance with Section 31(3) of the Act. The medical scheme may revise its contribution tables and benefits on an annual basis. The annual changes to the contribution tables and the benefits provided are made via Rule changes. These Rule changes need to be registered by the Registrar in terms of Section 31 of the Act.

**Membership**

7. A medical scheme may manage its risk by imposing general waiting periods of up to three months and/or condition-specific waiting periods of up to 12 months, and late joiner penalties on new members and dependants once they meet certain conditions.
8. According to Section 29A of the Act, risk-rating (pricing based on the specific risk associated with that individual or any other individual criteria) by way of imposing waiting periods is limited and even prohibited in certain instances. For example, no waiting period may be imposed by a medical scheme on the birth of a child-dependant, or where a change in medical schemes within a specified period is due to a change in employment. If an applicant has been a beneficiary of any medical scheme for a continuous period of up to 24 months and terminated such membership less than 90 days prior to the application, the waiting periods imposed will not be applicable to the diagnosis and treatment of PMBs.
9. The following table summarises the various types of waiting periods that medical schemes may apply when admitting new members:

<i>(Uncovered period – time between your last day of notice period of previous medical scheme to the date of application for membership with the new medical scheme)</i>			
Break MORE than 90 days	Break LESS than 90 days (0 to 89 days)		
<i>Previous membership period</i>			
Regardless of previous membership	24 months and longer	Shorter than 24 months (previous waiting periods may still be in place)	Regardless of previous membership <i>*Change of employment *Employer changing/terminating medical scheme</i>
<ul style="list-style-type: none"> <li>▪ General waiting period – three months</li> <li>▪ Condition specific – 12 months</li> <li>▪ <b>Waiting period applies to PMBs</b></li> </ul>	<ul style="list-style-type: none"> <li>▪ General waiting period – three months</li> <li>▪ Waiting period <b>does not</b> apply to PMBs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Condition specific – two months</li> <li>▪ Waiting period <b>does not</b> apply to PMBs</li> </ul>	<ul style="list-style-type: none"> <li>▪ No general or condition specific waiting periods may be imposed</li> </ul>

10. Late joiner penalties may be imposed on any beneficiary who at the date of the application is 35 years or older and who has not enjoyed continuous coverage (except

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for a break of less than three months) with any medical scheme since 1 April 2001. Such late joiner penalties, though, may not exceed the limitations imposed by Regulation 13 to the Act.

11. Each individual member is required to sign a separate contract with a medical scheme. An individual may join any open medical scheme in that individual's personal capacity or may join a restricted membership medical scheme should that individual qualify for membership. An individual may not be a beneficiary of more than one medical scheme.
12. Contracts are entered into between the principal member and a medical scheme in terms of the Rules of that medical scheme. The contract may be terminated only in terms of the Rules of that medical scheme, which may provide for termination in the following circumstances:
  - a) Non-payment of contributions;
  - b) Death of a member;
  - c) Committing of any fraudulent act against the medical scheme;
  - d) Non-disclosure of material information;
  - e) Prior termination of the contract, in terms of the Rules, by either party; and
  - f) Liquidation of a medical scheme.

**Benefit options and pricing**

13. A medical scheme may have more than one defined set of benefit options in terms of the Rules of that medical scheme. A member may belong to only one benefit option in one medical scheme at any given time.
14. A member of a medical scheme may elect to change benefit options on an annual basis and this shall take effect at the commencement of the benefit year (generally 1 January). Should a member not elect to change their benefit option, that member is defaulted to the benefit option they already belong to for the following year. Depending on the Rules, a member may downgrade to a lower cost option with lower benefit entitlements at any time during the year and/or upgrade to a higher cost option with more benefit entitlements during the benefit year.
15. Contracts with an individual may not be priced based on the specific risk associated with that individual or any other individual criteria (i.e. underwriting/risk-rating is prohibited). Contributions may be varied on the basis of income or the number of dependants or both. A medical scheme sets prices that fully reflect the risk associated with each benefit option on an annual basis, subject to the cross-subsidisation as explained below.
16. Community rating refers to the concept of cross-subsidising the level of contributions for sick members by using those of healthy members. Cross-subsidising may occur in the benefit option and may also occur between benefit options.

## **Contributions**

17. Refer to the SAICA *Medical Schemes Accounting Guide* for accounting guidance and the application of International Financial Reporting Standards with respect to contributions.
18. In accordance with Sections 26(1)(c) and 26(4) of the Act, a medical scheme is not allowed to collect fees payable by a member to a third party, e.g. a funeral fund, on behalf of that third party. Therefore, gross contributions should not include such fees. Gross contributions should only include contributions made in terms of the Rules of a medical scheme, which must be in compliance with the Act.
19. Gross contributions are paid as determined by the Rules in compliance with Sections 26(6) and 26(7) of the Act. A medical scheme undertakes to accept, either wholly or in part, the risks arising from providing healthcare services to a member and a member's dependants in terms of healthcare benefits defined in the Rules of that medical scheme.
20. Section 26(7) of the Act requires that gross contributions be paid directly to a medical scheme not later than three days after payment thereof becoming due (in terms of the medical scheme's Rules).

## **Healthcare benefits**

21. Healthcare benefits are prescribed in the Rules, which usually contain healthcare benefit limits and exclusion clauses in addition to the minimum benefits prescribed in the Act.
22. A medical scheme has to cover the full costs related to the diagnosis, treatment and care of PMBs. PMBs include certain medicines required in the treatment of specific chronic conditions/diseases. A member is entitled to these benefits regardless of the medical scheme option selected.
23. Healthcare benefit limits (exclusive of PMBs) are normally set for a benefit period. Claims may be incurred by the member, and the member's dependants, from the first month of the benefit period until healthcare benefit limits are fully used, after which the member bears the risk, either through self-payment or the member's PMSA, if applicable. These healthcare benefit limits may be apportioned for a period of the year in which the contract is first entered into after the commencement of the benefit period. No apportionment of limits is permitted should a contract be terminated prior to the end of a benefit period. Unexpended benefits may not be accumulated by a beneficiary from one year to the next other than as provided for in the PMSAs.
24. A member carries the risk for payment of amounts charged by the provider of healthcare services in excess of the healthcare benefits provided by a medical scheme, which could be in the form of a member's portion (co-payment) paid to the provider or a refund of amounts paid, lent or advanced by a medical scheme, in terms of the Rules, on behalf of a member. Co-payments on PMBs are not permitted in terms of the Act but may occur when a member has voluntarily not made use of a medical scheme's DSP, where a DSP has been identified in the Rules. However, co-payments may not be levied for emergencies. Co-payments on PMBs may not be funded from PMSA monies.

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25. A member of a medical scheme has four months, or such longer period as per the Rules of that medical scheme, from the date of service to submit claims to that medical scheme.
26. The audit of claims takes cognisance of the manner in which claims are received by a medical scheme and the supporting documentation provided. Most medical schemes receive a large number of claims via EDI switches. Typically, these claims are received from the service provider (e.g. pharmacy or doctor) directly via EDI. The service provider does not submit any evidence of the service being received (e.g. an invoice signed by the member).
27. Certain risks may be reinsured by a medical scheme, in terms of which some risks for healthcare benefits are underwritten by another party. This transfer of risk may take the form of:
  - a) A commercial reinsurance contract with a registered insurer; or
  - b) A capitated arrangement with a provider or accredited managed healthcare organisation.

Entering into a risk transfer arrangement does not reduce a medical scheme's primary obligations to its members and their dependants.

28. When a medical scheme enters into a commercial reinsurance contract with a registered insurer, the medical scheme adheres to the requirements imposed by Section 20 of the Act. Section 20(2) of the Act states that a medical scheme shall not purchase any insurance policy in respect of any relevant health service other than to reinsure a liability in terms of Section 26(1)(b) of the Act. In terms of Section 20(3), the board of trustees must furnish the Registrar with a copy of the contract or the amendment thereof and an evaluation of the need for the proposed commercial reinsurance contract. The Registrar may then, in terms of Section 20(4), raise any matter in respect of the said contract that needs to be addressed by the board of trustees. The results of a commercial reinsurance contract are considered to be non-healthcare expenditure in nature.
29. With capitated arrangements with providers or accredited managed healthcare organisations, the provider is paid a monthly amount or capitation fee to provide defined services, during a specified period, according to the needs of members of a medical scheme. The provider carries the risk of the number of incidents (utilisation risk) that occur during the specified period and the cost of providing the service (price risk). Any capitated agreement entered into must adhere to the requirements imposed by Regulation 15. Regulation 15F requires that any such contract must be in a member's best interest, the premiums must be reasonable, and a genuine transfer of risk should take place. Premiums/fees and recoveries for claims relating to risk transfer arrangements are disclosed separately in respect of each risk transfer arrangement so that the financial extent of such arrangements may be clearly demonstrated.
30. The aim of managed healthcare initiatives is to ensure (through the use of clinical and financial risk assessments and management of healthcare) appropriate, affordable and cost-effective healthcare. This is achieved through the use of, inter alia, the following interventions:

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- a) Accredited managed healthcare services with no transfer of risk; and
  - b) Accredited managed healthcare services with risk transfer.
31. Administration expenditure: benefit management services is administrative in nature and represents the cost of managing healthcare expenditure. This type of service does not make use of the techniques as specified in the definition of managed healthcare. This service may include services such as bill review, claims audits, medical advisors, peer review, provider network management, statistical analysis, nurse advice lines and wellness programmes. It is important to note that this service does not include the cost of any relevant healthcare services. Administration expenditure: benefit management services forms part of the medical scheme's non-healthcare expenditure incurred.
32. Accredited managed healthcare services with no transfer of risk may only be provided by accredited managed healthcare organisations. This expenditure normally represents the arranging of/management of fee-for-service healthcare benefits included in managed healthcare contracts, as well as the cost of the provision of managed healthcare services.
33. Accredited managed healthcare services with risk transfer may be provided by either an accredited managed healthcare organisation or a provider. Such a provider would normally be the DSP for the related healthcare benefit. These arrangements are capitation agreements in which the accredited managed healthcare organisation or provider carries the risk in variances in the utilisation and cost of the related healthcare services. Refer to paragraph 29 for a more detailed explanation on what these contracts entail.

**Non-healthcare expenditure**

34. Non-healthcare expenditure consists of administration expenditure (which includes administration expenditure: benefit management services – refer to paragraph 31), broker costs, commercial reinsurance results (refer to paragraph 28) and net impairment: trade and other receivables.
35. Administration expenditure consists mainly of administration fees. Other expenditure, such as trustee remuneration and principal officer remuneration, is also included in this expense item.
36. Broker costs consist of regulated broker commissions as well as distribution fees that are incurred in managing broker networks. A medical scheme may not directly or indirectly (i.e. via the distribution networks) compensate brokers other than through the said regulated broker commissions. Reference should be made to Section 65 and Regulation 28 of the Act for the specific requirements and limitations imposed on the payment of broker commissions.

**Personal medical savings accounts (PMSAs)**

37. Some medical schemes provide for PMSAs to assist members in managing cash flow for the payment of healthcare services for which they are responsible. In accordance with the Act, a maximum of 25% of the total gross contribution in respect of a member

can be allocated to a PMSA. If applicable, a medical scheme's Rules will prescribe the allowable percentage that may be allocated per benefit option. These savings may only be used for healthcare services as provided for in the medical scheme's Rules and are only refundable as provided for in Regulation 10. PMSAs may not be utilised for benefits and members' portions relating to PMBs.

38. Where the Rules create a trust agreement between the member and the medical scheme, PMSAs constitute trust money as defined in Section 1 of the Protection of Funds Act read together with Regulation 10 to the Medical Schemes Act. The board of trustees manages and invests these monies on a member's behalf. PMSAs must be kept separately from medical scheme funds, in terms of Section 4(5) of the Protection of Funds Act. Interest earned on these funds must be credited to a member's individual PMSAs. No advances may be paid from the PMSA monies. In terms of Section 93 of the Administration of Estates Act 66 of 1965, medical schemes must pay PMSAs that have remained unclaimed for a period of five years or more over to the Guardian's Fund.
39. Unexpended savings at the end of the accounting period are carried forward to meet future expenses for which the members are responsible. The savings plan liability represents the savings plan contributions that are a deposit component of the insurance contracts.
40. In terms of a Constitutional Court judgement rendered on 6 June 2017<sup>62</sup>, the medical scheme is the right holder of the funds (unless the Rules create a trust agreement between the member and the medical scheme). The judgement does not affect the entitlement of members to access these funds, other than in the case of liquidation where members' savings monies will be divided among the creditors of the medical scheme, along with the other assets of the medical scheme. The Prescription Act 68 of 1969 applies to unclaimed members' savings accounts; and when these claims prescribe after three years, the amounts are written back to the medical scheme.
41. Savings advances must be funded from medical scheme assets. From this, it follows that no impairments may be charged or recovered from PMSA monies.

### **Investments**

42. A medical scheme shall have such assets in the particular kinds or categories as may be prescribed in Section 35, read together with Regulation 30 and Annexure B of the Regulations. Annexure B of the Regulations states that a medical scheme should demonstrate on a "look-through" basis that assets such as collective investment schemes, managed funds and investment insurance policies were not utilised to circumvent the limitations of these Regulations.
43. Trustees of a medical scheme may choose to have some or all of a medical scheme's assets invested in a range of products, for example, deposits, securities, immovable properties, unit trusts, linked policies, etc.

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<sup>62</sup> <http://www.saflii.org/za/cases/ZACC/2017/16media.pdf>.

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44. These investments may either be through direct ownership (where the medical scheme invests directly with the investee or makes investments through a broker) or through indirect ownership (where the medical scheme invests through an asset manager in linked policies).
45. Where the Rules create a trust agreement between the member and the medical scheme, PMSA monies should be separately invested from medical scheme assets, in terms of the Protection of Funds Act. Circular 38 of 2011<sup>63</sup> clarifies that Annexure B restrictions are not applicable to PMSA trust investments. However, as the nature of the PMSA trust liability is short term, the funds may only be invested in bank deposits and call accounts or instruments with similar risk and liquidity characteristics.

### **Solvency**

46. A medical scheme is required to maintain minimum accumulated funds, expressed as a percentage of gross annual contributions, which may not be less than 25%. New medical schemes are, however, subject to the phase-in periods as prescribed in Regulation 29(3A). A medical scheme that for a period of 90 days fails to meet the minimum accumulated funds must notify the Registrar in writing of this failure, and must provide information relating to the nature and cause of the failure and the course of action being adopted to ensure compliance with the Regulation. Refer to paragraphs 92 to 96 of this Guide.

### **Service organisations<sup>64</sup>**

47. The different service organisations within a medical scheme environment include, but are not limited to, the following:
  - a) Administrators;
  - b) Accredited managed healthcare organisations;
  - c) Designated service providers;
  - d) Investment managers; and
  - e) Electronic claims clearing houses.
48. Service level agreements should be in place to ensure that appropriate controls exist at the service organisations.
49. Refer to the section on [Service organisations](#) for guidance on service organisations.

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<sup>63</sup> Circular 38 of 2011, *Personal Medical Savings Accounts*.

<sup>64</sup> ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.

## **Appendix 3 – Extracts from and Commentary on the Medical Schemes Act and Related Regulations**

*At the time that this Guide was issued there had been no changes to the legislation. For legislative changes after the date of issue of this Guide, refer to the website of the Council.*

This appendix contains a summary of the Sections of the Act and related Regulations most often referred to during the course of an audit. However, all Sections/aspects of the Act and related Regulations may be relevant to a medical scheme and its auditors, depending on the circumstances.

### **The Act**

1. Section 20 of the Act places a legal obligation on all organisations that carry on the business of a medical scheme to apply to the Registrar for registration under the Act. Non-registration of such a business will constitute a reportable irregularity as defined in the Auditing Professions Act, 2005, and is prohibited in terms of Section 20 of the Act.
2. Section 24 gives the Registrar the power to register medical schemes, with the concurrence of the Council, and to impose such terms and conditions that are deemed appropriate.
3. Section 27 of the Act gives the Registrar the power to cancel or suspend the registration of a medical scheme if, after investigation, the Council is of the opinion that such registration should be so cancelled or suspended.
4. Sections 20(2) to 20(7) of the Act require certain conditions to be adhered to in respect of commercial reinsurance contracts entered into by a medical scheme.
5. Section 26(1)(c) of the Act requires a bank account to be established under the medical scheme's direct control into which shall be paid every amount received as subscription or contribution paid by or in respect of a member, and received as income, discount, interest, accrual or payment of whatever kind.
6. Section 26(4) of the Act sets out the items that may be debited to a medical scheme's bank account.
7. Section 26(5) prohibits the payment of dividends, rebates and bonuses.
8. Section 26(6) of the Act states that no person other than an employer shall receive, hold or in any manner deal with the subscription or contribution that is payable to a medical scheme by, or on behalf of, a member of that medical scheme.
9. Section 26(7) of the Act requires that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becoming due.
10. Section 26(11) prohibits medical schemes from carrying on any business other than the business of a medical scheme.



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11. Section 29 details the minimum matters for which the medical scheme's Rules must provide. Section 30 continues to detail the general provisions that may be included in the medical scheme's Rules. Sections 31 and 32 provide further information on the amendment of Rules and the binding force thereof.
12. Section 29A of the Act stipulates the conditions under which a medical scheme may apply general and specific waiting periods.
13. Section 33(2) of the Act contains provisions relating to the approval of new benefit options and the conditions that must be addressed to the satisfaction of the Registrar before approval of such benefit options can occur.
14. Chapter 7 of the Act contains provisions relating to the financial matters of a medical scheme, covering, inter alia, the following:
  - a) Financial arrangements (Section 35)
    - (i) A medical scheme shall maintain its business in a financially sound condition (Sections 35(1) and 35(2));
    - (ii) A medical scheme shall not encumber its assets, allow its assets to be held on its behalf, borrow money or give security to obligations between other persons without the prior approval of, or subject to directives issued by, the Council (Section 35(6)); and
    - (iii) A medical scheme shall not invest any of its assets in the business of, or grant loans to, an employer that participates in the medical scheme, or any administrator or any arrangement associated with the medical scheme, any other medical scheme, any administrator, and any person associated with any of the abovementioned (Section 35(8)).
  - b) Auditor and audit committee
    - (i) The appointment of the auditor and the audit committee (Section 36).<sup>65</sup>
  - c) Annual financial statements
    - (i) Section 37(1) requires the trustees to prepare the annual financial statements and to submit these together with the report of the board of trustees to the Registrar by 30 April each year;
    - (ii) Section 37(2) specifies what statements/reports are considered to form part of the annual financial statements;
    - (iii) Sections 37(4) and (5) detail the requirements in respect of the accounting framework and further information that needs to be included in the annual financial statements; and

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<sup>65</sup> Refer to paragraph 13 of this Guide for further details on the requirements imposed by Section 36.

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- (iv) The disclosure of financial information in respect of every benefit option offered by the medical scheme is required in terms of Section 37(4)(d). This is required to be audited in terms of Circular 4 of 2008<sup>66</sup>.
15. Section 44: The Registrar may order an inspection of a medical scheme:
- a) If he/she is of the opinion that such an inspection will provide evidence of any irregularity or non-compliance with the Act; or
  - b) To routinely monitor compliance with the Act by a medical scheme or any other person.
16. Section 44(8) provides the Registrar with the power to place restrictions on the administration expenditure of medical schemes.
17. In terms of Section 51(1) of the Act, the Registrar may, with the consent of the Council, apply to the court for an order for judicial management, curatorship or winding up, in terms of the conditions laid down in the Act.
18. Section 57 of the Act sets out the duties of the board of trustees, which are significant, to ensure good governance.
19. Section 57(4)(f) requires the trustees to take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.
20. Section 59(2) of the Act and Regulation 6 set out the payment periods by the medical scheme to a member or a supplier of service in the case where an account has been rendered.
21. Section 61 of the Act speaks to undesirable business practices.
22. Section 63(14) of the Act states that the relevant assets and liabilities of the parties to amalgamations shall vest in and become binding upon the amalgamated body; or the relevant assets and liabilities of the party effecting the transfer shall vest in and become binding upon the party to which the transfer is effected. The medical scheme making the transfer is still responsible for submitting annual financial statements and an annual return for the period to the date of transfer.
23. A medical scheme may only compensate a broker in accordance with Section 65 of the Act, and Regulation 28, for the introduction or admission of a member to the medical scheme, and the provision of ongoing service or advice to that member.<sup>67</sup>
24. Section 66 contains details on offences and penalties.

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<sup>66</sup> Circular 4 of 2008, *Inclusion of Benefit Options Results in the Annual Financial Statements*.

<sup>67</sup> Circular 38 of 2009, *Increase in Fees Payable to Brokers with effect from 1 January 2009* (date later amended to 1 January 2010) provides the latest approved maximum statutory limitations imposed on broker fees.

## **The Regulations**

25. Regulation 2(3) states that the minimum number of members required for a medical scheme is 6 000.
26. Regulation 4(4) prohibits ring-fencing.
27. Regulation 6A sets out the requirements for the disclosure of trustees' remuneration.
28. Regulation 8 and Annexure A provide information on prescribed minimum benefits.
29. Regulation 9A states that a medical scheme may not provide in its Rules for the accumulation of unexpended benefits by a beneficiary from one year to the next, other than as provided for in the PMSA.
30. Regulation 10 stipulates the requirements in respect of savings accounts:
  - a) Regulation 10(1) limits the amount of the total gross contribution that is allocated to the member's PMSA to 25%;
  - b) Regulation 10(4) states that credit balances in a member's PMSA shall be transferred to another medical scheme or benefit option with a PMSA, as the case may be, when such member changes medical schemes or benefit options;
  - c) Regulation 10(5) requires that credit balances in a member's personal medical savings account must be taken as a cash benefit, subject to applicable laws, when the member terminates his or her membership of a medical scheme or benefit option without enrolling in another medical scheme; or enrolls in another medical scheme without a personal medical savings account provision; or selects a benefit option without a savings plan; and
  - d) Regulation 10(6) stipulates that savings plan account facilities may not be utilised to provide for benefits and members' portions relating to PMBs.
31. Managed care agreements are regulated in terms of Chapter 5 of the Regulations.
32. The administration of a medical scheme by a third party should comply with Chapter 6 of the Regulations.
33. Regulation 23 states that an administrator must deposit any medical scheme monies under administration into a bank account opened in the name of the medical scheme, not later than the business day following the date of receipt of these monies. When medical scheme monies, including contributions, are paid by means of electronic funds transfer, such monies shall be deposited directly into a bank account opened in the name of the medical scheme. Monies received shall at no time be deposited into any bank account other than that of the medical scheme.
34. The conditions to be complied with by brokers are set out in Chapter 7.
35. The minimum accumulated funds to be maintained by a medical scheme are regulated by Chapter 8 of the Regulations.
36. Regulation 29 sets out the minimum accumulated funds to be maintained by a medical scheme – the amount is determined as a percentage of gross annual contributions. In

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terms of Regulation 29(1) the term “accumulated funds” for the purpose of this regulation means “the net asset value of the medical scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves”.<sup>68</sup>

37. Regulation 30 and Annexure B limit the asset exposure in the different asset categories. Explanatory note 8 to Annexure B states that medical schemes should demonstrate on a “look-through” basis that assets such as collective investment schemes, managed funds and insurance policies were not utilised to circumvent the limitations of these Regulations.
38. Where a trust agreement is created in the Rules between the member and the medical scheme, and as clarified in Circular 5 of 2012<sup>69</sup>, due to the nature of PMSAs (i.e. these do not form part of medical scheme assets), the limitations imposed by Regulation 30 and Annexure B are not applicable to these trust monies. Circular 38 of 2011<sup>70</sup> provides clarity as to the type of instruments these trust monies may be invested in.
39. Refer to [Appendix 4 – Circulars relevant to financial statements](#) for a complete list of Circulars issued by the Council that are relevant for financial statement purposes.

## Appendix 4 – Circulars Relevant to Financial Statements

*This was the complete list at the time that this Guide was issued. For Circulars issued after the date of issue of this Guide, refer to the website of the Council.*

The following Circulars issued by the Council are relevant for financial statement purposes:

Circular number	Subject
38 of 2018	Audit tenure
22 of 2018	SAICA Accounting Guide
21 of 2018	Impact of VAT increase in the medical schemes industry
20 of 2018	Imposition of levies for medical schemes 2018/19
13 of 2018	Annual Statutory Returns for the financial year ended 31 December 2017
12 of 2018	Prescribed ISAE 3000 (Revised) Report template

<sup>68</sup> Refer to paragraphs 78 to 82 for more details on the items that should be taken into account for solvency purposes.

<sup>69</sup> Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts*.

<sup>70</sup> Circular 38 of 2011, *Personal Medical Savings Accounts*.

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<b>Circular number</b>	<b>Subject</b>
7 of 2018	Categorisation of assets in terms of Annexure B to the Regulations
2 of 2018	Personal medical savings accounts and Scheme Rules
57 of 2017	Non-compliance with Laws and Regulations (NOCLAR)
56 of 2017	Personal medical savings accounts
45 of 2017	Guidance on benefit changes and contribution increases for 2018
40 of 2017	General concerns noted during the analysis of the 2016 Annual Financial Statements (AFS)
6 of 2017	Categorisation of assets in terms of Annexure B to the Regulations
2 of 2017	Adjustment of fees payable to brokers with effect from 1 January 2017
49 of 2016	Prescribed auditor report templates
35 of 2016	General concerns noted during the analysis of the 2015 Annual Financial Statements (AFS)
31 of 2016	Standards for authorisation of auditors
65 of 2015	Auditor's report – Key Audit Matters
56 of 2016	Accounting for accredited managed care services
43 of 2015	General concerns noted during the analysis of the 2014 Annual Financial Statements and Statutory Returns
51 of 2014	Managed healthcare agreements – unwarranted performance or profit sharing incentives
48 of 2014	Classification and disclosure of administration costs included in the contracted third-party administration fees
34 of 2014	Guidance on benefit changes and contribution increases for 2015
30 of 2014	General concerns noted during the analysis of the 2013 Annual Financial Statements and Statutory Returns
28 of 2013	General concerns noted during the analysis of the 2012 Annual Financial Statements and Statutory Returns
10 of 2013	Funding of PMBs from personal medical savings accounts when members are discharged from hospital

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<b>Circular number</b>	<b>Subject</b>
6 of 2013	Annual financial information provided to members
41 of 2012	Prescribed format for the Statement of Comprehensive Income and disclosures required in respect of PMSA
23 of 2012	Explanatory Note 2 of Annexure B
22 of 2012	General concerns noted during the analysis of the 2011 Annual Financial Statements and Statutory Returns
5 of 2012	Clarification of Circular 38 of 2011 regarding personal medical savings accounts
38 of 2011	Personal Medical Savings Accounts
23 of 2011	General concerns noted during the analysis of the 2010 Annual Financial Statements and Statutory Returns
3 of 2011	Categorisation of assets in terms of Annexure B to the Regulations
52 of 2010	Granting of loans by medical schemes to members must stop
5 of 2010	Audit reports to the Annual Statutory Returns
2 of 2010	Categorisation of assets in terms of Annexure B to the Regulations
37 of 2009	Non-compliance by the medical schemes industry in respect of the provision and payment of prescribed minimum benefits (PMBs) <ul style="list-style-type: none"> <li>• Extension for compliance has been granted in Circular 7 of 2010</li> </ul>
23 of 2009	Annual Financial Statements
21 of 2009	Issues encountered during the evaluation of medical scheme administrators regarding the auditing of medical schemes
4 of 2008	Inclusion of benefit options results in the Annual Financial Statements
49 of 2007	Financial reporting by managed care organisations
25 of 2007	Auditor approval applications
41 of 2006	2006 audited financial statements: <ul style="list-style-type: none"> <li>• Reporting of non-compliance</li> </ul>
11 of 2006	Issues in audited financial statements: <ul style="list-style-type: none"> <li>• Reporting of non-compliance matters</li> </ul>

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<b>Circular number</b>	<b>Subject</b>
	<ul style="list-style-type: none"><li>• Fair value of assets for Annexure B</li></ul>
33 of 2005	Pre-funded post retirement funds – notice for removal of pre-funding reserves or funds
13 of 2001	Non-distributable reserves in solvency calculation

## Appendix 5 – Report on the Financial Statements (ISA 700 (Revised) Report)

*This auditor report template is effective for year-ends of medical schemes ending on and after 31 December 2018*

### Circumstances

- Audit of a complete set of financial statements of a medical scheme prepared in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa. The audit is not a group audit (i.e. ISA 600 does not apply).
- The auditor has concluded an unmodified (i.e. “clean”) opinion is appropriate based on the audit evidence obtained.
- The auditor has obtained all the other information prior to the date of the auditor’s report and has not identified a material misstatement of the other information.
- Based on the audit evidence obtained, the auditor has concluded that a material uncertainty does not exist in relation to events or conditions that may cast significant doubt on the entity’s ability to continue as a going concern.
- Key audit matters have been communicated, as required by Circular 65 of 2015: *Auditor’s Reports: Key Audit Matters*, issued by the Council for Medical Schemes on 27 October 2015.
- The auditor has reported on compliance/non-compliance with the Medical Schemes Act of South Africa in the Report on Other Legal and Regulatory Requirements section.
- A reportable irregularity has been identified and reported in terms of Section 45 of the Auditing Profession Act. The reportable irregularity does not affect the fair presentation of the financial statements and is not considered a key audit matter. The reportable irregularity is reported in the Report on Other Legal and Regulatory Requirements section.
- Audit tenure has been disclosed as required by Circular 38 of 2018, *Audit Tenure*, issued by the Council for Medical Schemes on 3 August 2018.



## Independent Auditor's Report

To the Members of <name of scheme>

### Report on the Financial Statements

#### *Opinion*

We have audited the financial statements of <name of scheme> (the Scheme), set out on pages <xx> to <xx>, which comprise the statement of financial position as at <insert date of year/period end >, and the statement of profit or loss and other comprehensive income, the statement of changes in members' funds and the statement of cash flows for the <year/period> then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, these financial statements present fairly, in all material respects, the financial position of <name of scheme> as at <insert date of year/period end>, and its financial performance and cash flows for the <year/period> then ended, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.

**[For auditors' reports issued on or after 15 June 2019 in respect of audits of financial statements for financial periods beginning before or on 14 June 2019] [Delete block if not applicable]**

#### *Basis for Opinion*

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the group in accordance with the sections 290 and 291 of the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors (Revised January 2018)*, parts 1 and 3 of the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors (Revised November 2018)* (together the IRBA Codes) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities, as applicable, in accordance with the IRBA Codes and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Codes are consistent with the corresponding sections of the International Ethics Standards Board for Accountants' *Code of Ethics for Professional Accountants* and the International Ethics Standards Board for Accountants' *International Code of Ethics for Professional Accountants (including International Independence Standards)*

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respectively. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

**[For audits of financial statements for financial periods beginning on or after 15 June 2019]** [Delete block if not applicable]

*Basis for Opinion*

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the group in accordance with the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors* (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants' *International Code of Ethics for Professional Accountants (including International Independence Standards)*. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

*Key Audit Matters*

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

[Description of each key audit matter in accordance with ISA 701, Key Audit Matters.]

*Other Information*

The Scheme's trustees are responsible for the other information. The other information comprises <insert description>. The other information does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to

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be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

*Responsibilities of the Scheme's Trustees for the Financial Statements*

The Scheme's trustees are responsible for the preparation and fair presentation of the financial statements, in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa, and for such internal control as the Scheme's trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Scheme's trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the Scheme's trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

*Auditor's Responsibilities for the Audit of the Financial Statements*

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Scheme's trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists in relation to events or conditions that may cast significant doubt on the

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Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with the Scheme's trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

From the matters communicated with the Scheme's trustees, we determine those matters that were of most significance in the audit of the financial statements of the current period and are therefore the key audit matters. We describe these matters in our auditor's report, unless law or regulation precludes public disclosure about the matter or when, in extremely rare circumstances, we determine that a matter should not be communicated in our report because the adverse consequences of doing so would reasonably be expected to outweigh the public interest benefits of such communication.

### **Report on Other Legal and Regulatory Requirements<sup>71</sup>**

#### *Non-compliance with the Medical Schemes Act of South Africa<sup>72</sup>*

As required by the Council for Medical Schemes, we report that there are no material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa that have come to our attention during the course of our audit.

Or

As required by the Council for Medical Schemes, we report the following material instances of non-compliance with the requirements of the Medical Schemes Act of South Africa, as amended, that have come to our attention during the course of our audit:

1. *<List instances of non-compliance>*.
- 2.

#### *Reportable Irregularities<sup>73</sup>*

In accordance with our responsibilities in terms of Sections 44(2) and 44(3) of the Auditing Profession Act, we report that we have identified a reportable irregularity in terms of the Auditing Profession Act. We have reported such matter to the Independent Regulatory Board

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<sup>71</sup> ISA 700 (Revised), paragraphs 43 to 45.

<sup>72</sup> Delete the paragraph that is not applicable.

<sup>73</sup> Delete the paragraph if it is not applicable.

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for Auditors. [The matter pertaining to the reportable irregularity has been described in note x to the financial statements<sup>74</sup>.]

*Audit tenure*

As required by the Council for Medical Schemes' Circular 38 of 2018, *Audit Tenure*, we report that XX firm has been the auditor of X Medical Scheme for X years.

The engagement partner, XX, has been responsible for X Medical Scheme's audit for X years.

[*Auditor's Signature*]

[*Name of individual registered auditor*]

[*Capacity, if not a sole practitioner: e.g. Director or Partner*]

Registered Auditor

[*Date of auditor's report*]

[*Auditor's address*]

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<sup>74</sup> Insert this sentence when disclosure is made in the financial statements. Where the Scheme's trustees have not made adequate and appropriate disclosure and the financial statements are fairly presented, in all material respects, the auditor discloses the information relating to the reportable irregularity in the auditor's report.

## Appendix 6 – Report on Parts 4 to 10 of the Annual Statutory Return (Combined ISA 800 (Revised) and ISRE 2410 Reports)

*This auditor report template is effective for year-ends of medical schemes ending on and after 31 December 2018.*

### Circumstances

#### **ISA 800 (Revised) report**

- Work performed for Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return is regarded as sufficient for an audit opinion to satisfy the requirement for the auditor to report as required by Sections 36(8) and 37(3), read in conjunction with Sections 37(2) and 39(3).
- The use of the auditor's report is restricted to the Registrar of Medical Schemes.
- Based on the audit evidence obtained, the auditor has concluded that a material uncertainty does not exist in relation to events or conditions that may cast significant doubt on the entity's ability to continue as a going concern.
- The auditor has not identified a reportable irregularity in terms of the Auditing Profession Act, 2005.

#### **ISRE 2410 report**

- The auditor of this engagement is the auditor of the Scheme.
- Work performed for Part 6.2 of the annual statutory return is regarded as sufficient for a review conclusion to satisfy the requirement for the auditor to report as required by Sections 36(8) and 37(3), read in conjunction with Sections 37(2) and 39(3).
- The use of the auditor's report is restricted to the Registrar of Medical Schemes.

## Independent Auditor's Report<sup>75</sup>

*To the Board of Trustees of [name of scheme]*

### Auditor's Report on Parts 4 to 6.1 and 6.3 to 10 of the Return

#### *Opinion on Parts 4 to 6.1 and 6.3 to 10 of the Return*

We have audited Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return (the Return) of <Name of Scheme> (the Scheme) set out on pages <xx> to <xx> for the year ended <insert date>, comprising information from the financial statements, prepared in accordance with International Financial Reporting Standards, and additional historical financial information extracted from the underlying accounting records of the Scheme.

In our opinion, Parts 4 to 6.1 and 6.3 to 10 of the Return of the Scheme for the year ended <insert date> are prepared, in all material respects, in accordance with the provisions of the Act, related Regulations, the Guidance Manual for the completion of the Return and the applicable Circulars issued by the Council for Medical Schemes (the Act and related Regulations).

**[For auditors' reports issued on or after 15 June 2019 in respect of audits of financial statements for financial periods beginning before or on 14 June 2019] [Delete block if not applicable]**

#### *Basis for Opinion*

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the group in accordance with the sections 290 and 291 of the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors (Revised January 2018)*, parts 1 and 3 of the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors (Revised November 2018)* (together the IRBA Codes) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities, as applicable, in accordance with the IRBA Codes and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Codes are consistent with the corresponding sections of the

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<sup>75</sup> The Office of the Registrar requires auditors to submit this report on the auditor's letterhead.

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International Ethics Standards Board for Accountants' *Code of Ethics for Professional Accountants* and the International Ethics Standards Board for Accountants' *International Code of Ethics for Professional Accountants (including International Independence Standards)* respectively. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

**[For audits of financial statements for financial periods beginning on or after 15 June 2019]** [Delete block if not applicable]

*Basis for Opinion*

We conducted our audit in accordance with International Standards on Auditing (ISAs). Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of the group in accordance with the Independent Regulatory Board for Auditors' *Code of Professional Conduct for Registered Auditors* (IRBA Code) and other independence requirements applicable to performing audits of financial statements in South Africa. We have fulfilled our other ethical responsibilities in accordance with the IRBA Code and in accordance with other ethical requirements applicable to performing audits in South Africa. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants' *International Code of Ethics for Professional Accountants (including International Independence Standards)*. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

*Emphasis of Matter – Basis of Accounting and Restriction on Use*

We emphasise that Parts 4 to 6.1 and 6.3 to 10 of the Return are prepared in accordance with the provisions of the Act and related Regulations, which are designed to meet the information needs of the Registrar of Medical Schemes (the Registrar). As a result, parts 4 to 6.1 and 6.3 to 10 of the Return may not be suitable for another purpose. The purpose of our report is to report to the Registrar as required by Sections 36(8) and 37(3), read in conjunction with Sections 37(2) and 39(3) of the Medical Schemes Act No. 131 of 1998; and the report is not to be used for any other purpose. Our report is provided solely for the information of the Registrar. Our opinion is not modified in respect of this matter.

*Other Matter*

We completed our audit of the annual financial statements of the Scheme for the year ended <insert date> on which we issued an unmodified opinion on <insert date of audit report>. Our audit of the financial statements was conducted in accordance with International Standards



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on Auditing. In conducting our audit of Parts 4 to 6.1 and 6.3 to 10 of the Return we considered evidence obtained during our audit of the financial statements of the Scheme.

*Other Information*

The trustees are responsible for the other information. The other information comprises <insert description>. The other information does not include Parts 4 to 6.1 and 6.3 to 10 of the Return and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express an audit opinion or any form of assurance conclusion thereon.

In connection with our audit of Parts 4 to 6.1 and 6.3 to 10 of the Return, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with Parts 4 to 6.1 and 6.3 to 10 of the Return or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

*Responsibilities of the Trustees for Parts 4 to 6.1 and 6.3 to 10 of the Return*

The trustees are responsible for the preparation of Parts 4 to 6.1 and 6.3 to 10 of the Return from the financial statements and information contained in the underlying accounting records of the Scheme, in accordance with the provisions of the Act and related Regulations, and for such internal control as the trustees determine is necessary to enable the preparation of Parts 4 to 6.1 and 6.3 to 10 of the Return that is free from material misstatement, whether due to fraud or error.

In preparing Parts 4 to 6.1 and 6.3 to 10 of the Return, the Scheme's trustees are responsible for assessing the Scheme's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting, unless the Scheme's trustees either intend to liquidate the Scheme or to cease operations, or have no realistic alternative but to do so.

*Auditor's Responsibilities for Parts 4 to 6.1 and 6.3 to 10 of the Return*

Our objectives are to obtain reasonable assurance that Parts 4 to 6.1 and 6.3 to 10 of the Return are prepared, in all material respects, in accordance with the provisions of the Act and related Regulations. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of Parts 4 to 6.1 and 6.3 to 10 of the Return.

As part of an audit in accordance with ISAs, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

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- Identify and assess the risks of material misstatement of Parts 4 to 6.1 and 6.3 to 10 of the Return, whether due to fraud or error; design and perform audit procedures responsive to those risks; and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Scheme's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the trustees.
- Conclude on the appropriateness of the Scheme's trustees' use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists in relation to events or conditions that may cast significant doubt on the Scheme's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Scheme to cease to continue as a going concern.

We communicate with the trustees regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

### **Review Report on Part 6.2 of the Return**

We have reviewed Part 6.2 of the annual statutory return (the Return) of <Name of Scheme> (the Scheme) set out on pages <xx> to <xx> for the year ended <insert date>, comprising information extracted from the financial statements, which have been prepared in accordance with International Financial Reporting Standards, and additional historical financial information extracted from the underlying accounting records of the Scheme.

#### *Responsibilities of the Trustees for Part 6.2 of the Return*

The trustees are responsible for the preparation of Part 6.2 of the Return from the financial statements and information contained in the underlying accounting records of the Scheme, in accordance with the provisions of the Act, related Regulations, the Guidance Manual for the completion of the Return and the applicable Circulars issued by the Council for Medical Schemes (the Act and related Regulations), and for such internal control as the trustees

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determine is necessary to enable the preparation of Part 6.2 of the Return that is free from material misstatement, whether due to fraud or error.

*Auditor's Responsibility for Part 6.2 of the Return*

Our responsibility in terms of Sections 36(8) and 37(3), read in conjunction with Sections 37(2) and 39(3) of the Act, is to express a conclusion on Part 6.2 of the Return based on the review. We conducted our review in accordance with International Standard on Review Engagements (ISRE) 2410, which applies to a review of historical financial information performed by the independent auditor of the entity. ISRE 2410 requires us to conclude whether anything has come to our attention that causes us to believe that Part 6.2 of the Return is not prepared in all material respects in accordance with the provisions of the Act and related Regulations. This standard also requires us to comply with relevant ethical requirements.

A review of Part 6.2 of the Return in accordance with ISRE 2410 is a limited assurance engagement. We perform procedures, primarily consisting of making inquiries of the trustees and others within the entity, as appropriate, and applying analytical procedures; and evaluate the evidence obtained.

The procedures performed in a review are substantially less than and differ in nature from those performed in an audit conducted in accordance with International Standards on Auditing. Accordingly, we do not express an audit opinion on Part 6.2 of the Return.

*Other Matter*

We completed our audit of the annual financial statements of the Scheme for the year ended <insert date> on which we issued an unmodified opinion on <insert date of audit report>. Our audit of the financial statements was conducted in accordance with International Standards on Auditing. In conducting our review of Part 6.2 of the Return we considered evidence obtained during our audit of the financial statements of the Scheme.

*Conclusion on Part 6.2 of the Return*

Based on our review, nothing has come to our attention that causes us to believe that Part 6.2 of the Return of the Scheme for the year ended <insert date> is not prepared, in all material respects, in accordance with the provisions of the Act and related Regulations.

*Basis of Accounting and Restriction on Use*

Without modifying our conclusion, we emphasise that Part 6.2 of the Return is prepared in accordance with the provisions of the Act and related Regulations, which are designed to meet the information needs of the Registrar. As a result, Part 6.2 of the Return may not be suitable for another purpose. The purpose of our report is to report to the Registrar as required by Sections 36(8) and 37(3), read in conjunction with Sections 37(2) and 39(3) of the Medical Schemes Act No. 131 of 1998; and the report is not to be used for any other purpose. Our report is provided solely for the information of the Registrar.

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*[Auditor's Signature]*

*[Name of individual registered auditor]*

*[Capacity, if not a sole practitioner: e.g. Director or Partner]*

Registered Auditor

*[Date of auditor's report]*

*[Auditor's address]*

## Appendix 7 – Assurance Report on Compliance with Sections 36(5) and 36(8) of the Act (ISAE 3000 (Revised) Report)

*This auditor report template is effective for year-ends of medical schemes ending on or after 31 December 2018.*

### Circumstances

- Limited assurance engagement conducted in terms of ISAE 3000 (Revised).
- Materiality –is set as one, as any non-compliance is required to be reported to the Council. Therefore, all instances of non-compliance are regarded as material and are all listed. Any instance of non-compliance will therefore result in a qualified conclusion.
- Both an unmodified (i.e. “clean”) conclusion (appropriate based on the evidence obtained) and a qualified conclusion are illustrated.

### Independent Auditor’s Limited Assurance Report in Accordance with the Requirements of Sections 36(5) and 36(8) of the Medical Schemes Act No. 131 of 1998<sup>76</sup>

*To the Board of Trustees of [name of scheme]*

We have undertaken our engagement in accordance with the requirements of Sections 36(5) and 36(8) of the Medical Schemes Act of South Africa (the Act) in order to provide the Registrar of Medical Schemes (the Registrar) with limited assurance regarding compliance by <name of scheme> (the Scheme) with the Sections of the Act and related Regulations specified below (the specified Sections of the Act and related Regulations) for the year ended <insert date>.

1. Section 24(5) and/or Regulation 2 (1)(j); and/or Sections 33(3) and 44(9)(b) as applicable, relating to the furnishing of financial guarantees;
2. Section 26(1)(c) relating to the establishment of a bank account under the scheme’s direct control;
3. Section 26(4) relating to the restriction of payments made from the scheme’s bank account; and Section 26(5) relating to the prohibition on any dividend, rebate or bonus payment by a Scheme;
4. Section 26(7) relating to the period within which all subscriptions or contributions are to be paid directly to the Scheme;

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<sup>76</sup> The Office of the Registrar requires auditors to submit this report on the auditor’s letterhead.

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5. Section 26(11) relating to the prohibition on a registered medical Scheme from carrying on any other business;
6. Section 37(4)(d) relating to disclosures in the annual financial statements in respect of benefit options offered, read together with Section 33 relating to approval and withdrawal of benefit options;
7. Sections 35(4), 35(5), 35(7) and 35(8) relating to assets and investments held by the Scheme, as well as Regulation 30 relating to limitations on assets held, read together with Annexure B of the Regulations, which specifies the limitations on percentages of different categories of assets that may be held;
8. Section 35(6) relating to prohibition on encumbrances of Scheme assets without the prior approval of the Council for Medical Schemes;
9. Sections 36(10) and 36(11) relating to the appointment of an audit committee and the composition of the majority of its members;
10. Section 57(4)(f) regarding the duties of the Trustees to take out and maintain an appropriate level of professional indemnity and fidelity insurance<sup>77</sup>;
11. Section 59(2) relating to the payment within 30 days of a benefit to be paid to a member or supplier of service, read together with Regulations 6(1), 6(2), 6(3) and 6(4) relating to the manner of payment of benefits;
12. Regulation 9A relating to a prohibition on any provision in the rules of a Scheme that permits an accumulation of unexpended benefits by a beneficiary from one year to the next, other than as provided for in personal medical savings accounts;
13. Section 30(1)(e) relating to the Rules allocating a personal medical savings account to a member within the limit and in the manner prescribed from time to time for payment of any relevant health service;
14. Regulations 10(1), 10(4), 10(5) and 10(6) relating to personal medical savings accounts;
15. Sections 10 and 11(d) of the Prescription Act 68 of 1969 relating to the prescription of a debt owed to a member in respect of personal medical savings accounts;

**Or** where the Rules state that personal medical savings accounts belong to members:

Sections 4(1), 4(2), 4(4) and 4(5) of the Protection of Funds Act relating to the investment of personal medical savings account monies and the separation thereof from scheme assets, read together with Section 2(c) of the Protection of Funds Act relating to the allocation of investment income earned in respect of these monies;<sup>78</sup>

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<sup>77</sup> In terms of this section, instances of non-compliance that may be identified may include that the Scheme either failed to take out a fidelity guarantee and professional indemnity, or the cover provided in policy <insert policy number> to the value of <insert sum insured> was not in accordance with Section 57(4)(f) of the Act, and/or the premiums for the policy were not fully paid up.

<sup>78</sup> Delete the paragraph that is not applicable.

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16. Regulation 15 relating to the provision of managed health care; Regulation 18 relating to provisions to be included in administration agreements; and Regulation 19 relating to requirements of the parties on termination of an administration agreement;
17. Section 65 relating to broker services and commission, read together with Regulations 28(1), 28(2) and 28(5) relating to compensation of brokers by a Scheme, and Regulation 28B relating to requirements for accreditation of brokers by the Council for Medical Schemes; and
18. Regulation 29 relating to the minimum accumulated funds to be maintained by a Scheme.

*Trustees' Responsibility*

The trustees are responsible for compliance by the Scheme with the specified Sections of the Act and related Regulations and for such internal control as they determine is necessary to ensure compliance with the specified Sections of the Act and related Regulations.

*Our independence and quality management*

We have complied with the independence and other ethical requirements of the *Code of Professional Conduct for Registered Auditors* issued by the Independent Regulatory Board for Auditors (IRBA Code), which is founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. The IRBA Code is consistent with the corresponding sections of the International Ethics Standards Board for Accountants' *International Code of Ethics for Professional Accountants (including International Independence Standards)*.

*[Name of firm]/[The firm]* applies International Standard on Quality Management (ISQM) 1, *Quality Management for Firms that Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements* which requires the firm to design, implement and operate a system of quality management including policies or procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

*Auditor's Responsibility*

Our responsibility, in accordance with Sections 36(5)(b) and 36(8)(b) of the Act, is to express a limited assurance conclusion whether, based on our work performed, anything has come to our attention that causes us to believe that the Scheme has not complied with the specified Sections of the Act and related Regulations.

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We conducted our engagement in accordance with the International Standard on Assurance Engagements (ISAE) 3000 (Revised), *Assurance Engagements Other Than Audits or Reviews of Historic Financial Information*, issued by the International Auditing and Assurance Standards Board. That standard requires that we plan and perform this engagement to obtain limited assurance on whether the Scheme has complied with the specified Sections of the Act and related Regulations.

A limited assurance engagement is substantially less in scope than a reasonable assurance engagement in relation to both risk assessment procedures, including an understanding of internal control, and the procedures performed in response to the assessed risks. The procedures we performed were based on our professional judgement and included inquiries, observation of processes followed, inspection of documents, analytical procedures, evaluating the appropriateness of quantification methods and reporting policies, and agreeing or reconciling with underlying records.

We completed our audit of the annual financial statements of the Scheme for the year ended <insert date>, prepared in accordance with International Financial Reporting Standards (IFRS) and the requirements of the Medical Schemes Act of South Africa, on which we issued an <unmodified/modified><sup>79</sup> opinion on <insert date of audit report>. Our audit was performed in accordance with International Standards on Auditing. Where appropriate, we have drawn on evidence obtained regarding instances of non-compliance with the specified Sections of the Act and related Regulations identified during the course of our audit that might materially affect the annual financial statements, and have performed such additional procedures as we considered necessary, and those included:

- Making inquiries of the Scheme's management primarily responsible for financial and accounting matters and regulatory compliance;
- Re-performance of calculations;
- Performance of substantive analytical review procedures; and
- Inspection of supporting documentation considered necessary to assess compliance with the specified Sections of the Act and related Regulations.

The procedures performed in a limited assurance engagement vary in nature from, and are less in extent than for, a reasonable assurance engagement. Consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had we performed a reasonable assurance engagement. Accordingly, we do not express a reasonable assurance opinion regarding whether the Scheme has complied with the specified Sections of the Act and related Regulations.

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<sup>79</sup> Where a modified opinion has been expressed on the annual financial statements, the auditor considers the implications for the limited assurance conclusion expressed in this report.



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*Basis for Qualified Limited Assurance Conclusion*

< List all instances of non-compliance ><sup>80</sup>.

*Qualified Limited Assurance Conclusion*<sup>81</sup>

Based on the procedures performed and the evidence obtained, except for the instances of non-compliance described in the Basis for Qualified Conclusion section of our report, nothing has come to our attention that causes us to believe that the Scheme has not complied, in all material respects, with the specified Sections of the Act and related Regulations for the year ended <insert date>.

**OR**

*Limited Assurance Conclusion*<sup>82</sup>

Based on the procedures we have performed and the evidence we have obtained, nothing has come to our attention that causes us to believe that the Scheme has not complied with the specified Sections of the Act and related Regulations for the year ended <insert date>.

*Restriction on Use*

Without modifying our conclusion, we emphasise that the specified Sections of the Act and related Regulations are designed to meet the information needs of the Registrar. As a result, our report is not suitable for another purpose. Our report is presented solely for the information of the Registrar.

[Auditor's Signature]

[Name of individual registered auditor]

[Capacity, if not a sole practitioner: e.g. Director or Partner]

Registered Auditor

[Date of auditor's report]

[Auditor's address]

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<sup>80</sup> Refer to paragraph A182 of ISAE 3000 (Revised). Delete this paragraph if the conclusion is unmodified.

<sup>81</sup> Delete this paragraph if the conclusion is unmodified.

<sup>82</sup> Delete this paragraph if the conclusion is modified.

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## Appendix 8 – Report on the Summary Financial Statements (ISA 810 (Revised) Report)<sup>83</sup>

*This auditor report template is effective for year-ends of medical schemes ending on and after 31 December 2018.*

### Circumstances

- An unmodified opinion is expressed on the audited financial statements.
- Established criteria for the preparation of summary financial statements exist.
- The auditor's report on the summary financial statements is dated later than the date of the auditor's report on the financial statements from which the summary financial statements are derived.
- The auditor's report on the audited financial statements includes a Material Uncertainty Related to Going Concern section.
- The auditor's report on the audited financial statements includes communication of key audit matters.
- Audit tenure has been disclosed as required by Circular 38 of 2018, *Audit Tenure*, issued by the Council for Medical Schemes on 3 August 2018.

### Independent Auditor's Report on Summary Financial Statements

*To the Members of the <name of scheme>*

#### *Opinion*

The summary financial statements, as set out on pages <xx> to <xx>, which comprise the summary statement of financial position as at <date of year/period end>, the summary statement of comprehensive income, the summary statement of changes in members' funds, the summary cash flow statement for the <year/period> then ended and related notes, are derived from the audited financial statements of <name of scheme> (the Scheme) for the <year/period> ended <date of period end>.

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<sup>83</sup> In terms of Circular 6 of 2013, *Summarised Financial Statements*.

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In our opinion, the accompanying summary financial statements are consistent, in all material respects, with the audited financial statements, in accordance with the content and disclosure requirements of Circular 6 of 2013 issued by the Council for Medical Schemes.

*Summary Financial Statements*

The summary financial statements do not contain all the disclosures required by International Financial Reporting Standards and the Medical Schemes Act of South Africa. Reading the summary financial statements and the auditor's report thereon, therefore, is not a substitute for reading the audited financial statements and the auditor's report thereon. The summary financial statements and audited financial statements do not reflect the effects of events that occurred subsequent to the date of our report on the audited financial statements.<sup>84</sup>

*The Audited Financial Statements and Our Report Thereon*

We expressed an unmodified audit opinion on the audited financial statements in our report dated <xxxxx>. That report also includes:

- A *Material Uncertainty Related to Going Concern* section that draws attention to Note <xx> in the audited financial statements. Note <xx> indicates that..... <Insert explanation, including a description of the effect(s) thereof, if any, on the summary financial statements>.
- The communication of key audit matters.<sup>85</sup>

*Trustees' Responsibility for the Summary Financial Statements*

The trustees are responsible for the preparation of the summary financial statements in accordance with the content and disclosure requirements of Circular 6 of 2013 issued by the Council for Medical Schemes.

*Auditor's Responsibility*

Our responsibility is to express an opinion on whether the summary financial statements are consistent, in all material respects, with the audited financial statements, based on our

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<sup>84</sup> If the report is dated on the same day as the auditor's report, do not include the following sentence: "The summary financial statements and audited financial statements do not reflect the effect of events that occurred subsequent to the date of our report on the audited financial statements".

<sup>85</sup> ISA 810 (Revised), paragraph A21: Paragraph 19(i) of this ISA requires the auditor to include a statement in the auditor's report on the summary financial statements when the auditor's report on the audited financial statements includes communication on one or more key audit matters described in accordance with ISA 701, *Key Audit Matters*. However, the auditor is not required to describe the individual key audit matters in the auditor's report on the summary financial statements.

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procedures, which were conducted in accordance with International Standards on Auditing (ISA) 810 (Revised), *Engagements to Report on Summary Financial Statements*.

*Report on Other Legal and Regulatory Requirements*

As required by the Council for Medical Schemes' Circular 38 of 2018, *Audit Tenure*, we report that XX firm has been the auditor of X Medical Scheme for X years.

The engagement partner, XX, has been responsible for X Medical Scheme's audit for X years.

[Auditor's signature]

[Name of individual registered auditor]

[Capacity, if not a sole practitioner: e.g. Director or Partner]

Registered Auditor

[Date of auditor's report]

[Auditor's address]

## **Appendix 9 – Non-compliance Matters**

*At the time that this Guide was issued there had been no changes to the legislation. For legislative changes after the date of issue of this Guide, refer to the Council's website.*

An auditor remains alert during the performance of an auditor's normal audit procedures to the following non-compliance matters that are reported in:

- The report of the board of trustees;
- The auditor report on the financial statements under the "Report on Other Legal and Regulatory Requirements" section (refer to [Appendix 5 – Report on the Financial Statements \(ISA 700 \(Revised\) Report\)](#)); and
- The notes to the financial statements by the board of trustees.

### **General**

- The scheme was registered as a medical scheme as per Sections 20 and 24 of the Act, and such registration has not been cancelled or suspended in terms of Section 27.
- The scheme's Rules contain the minimum matters prescribed in Section 29. Other general matters included in the Rules are in accordance with Section 30.
- Amendments to the Rules were registered in accordance with the Act and Regulations (Sections 31 and 32).
- Meeting requirements were complied with (as per Sections 29 and 36).
- Decisions were properly recorded in minutes, as required by Section 57 of the Act.
- Financial guarantees were received by the scheme from a third party to ensure the financial soundness of the scheme and its benefit options, where required by the Registrar (Section 24(5) and/or Regulation 2 (1)(j); and/or Sections 33(3) and 44(9)(b) as applicable).
- An appropriate level of professional indemnity insurance and fidelity guarantee insurance was taken out and maintained (Section 57(4)(f)).
- The scheme's business was maintained in a financially sound condition (Sections 35(1) and 35(2)).
- The annual financial statements, statutory return/reports and the trustees' report were submitted by 30 April and have not been rejected by the Registrar (Section 37(1)).
- The board of trustees appointed an audit committee, in accordance with Section 36(10) of the Act, of at least five members, with at least two being members of the board of trustees, while the majority are not officers of the medical scheme or the third party administrator,

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the controlling company of the administrator or any subsidiary of its controlling company (Section 36(11)); or exemption was obtained in terms of Section 36(13) of the Act.

- The medical scheme did not conduct any declared undesirable business practices (Section 61) (reference should be made to Government Gazette No. 26516).
- The scheme did not carry on any other business other than the business of a medical scheme (Section 26(11)).
- No funds were ring-fenced (Regulation 4(4)).

**Membership**

- The scheme had more than 6 000 members (Regulation 2(3)).
- General and specific waiting periods were applied in accordance with the conditions imposed by Section 29A.

**Benefit options**

- The contribution rates and member benefits per benefit option, as contained in the Rules, were registered and approved by the Registrar, and such approval has not been withdrawn (Section 33).
- Separate accounting records were maintained in respect of each benefit option offered, and this was adequately disclosed in the annual financial statements (Section 37(4)(d)).

**Administration agreements**

- The written administration agreement adhered to the requirements imposed by Regulation 18.
- In the event that the administration agreement was terminated, such termination adhered to the requirements imposed by Regulation 19.
- On appointing a new administrator, such appointment adhered to the requirements of Board Notice 73 of 2004.

**Managed healthcare agreements (managed healthcare services)**

- All managed healthcare agreements adhered to the provisions imposed by Regulation 15.

### **Contributions**

- No person other than an employer received, held or in any manner dealt with the subscription or contribution that is payable to a medical scheme by or on behalf of a member of that medical scheme (Section 26(6)).
- All subscriptions or contributions were paid directly to the scheme within the specified period (Section 26(7) and the scheme's Rules).
- The administrator deposited any medical scheme monies under administration into a bank account opened in the name of the medical scheme, not later than the business day following the date of receipt of these monies. In the event of medical scheme monies, including contributions, paid by means of electronic funds transfer, such monies were deposited directly into a bank account opened in the name of the medical scheme. Monies received had at no time been deposited into any bank account other than that of the medical scheme (Regulation 23).

### **Relevant healthcare expenditure**

- Benefits were paid to members or suppliers of services within 30 days after the receipt of the claims (Section 59(2)), except in cases where the claims were deemed to be erroneous or unacceptable and where different timeframes applied (Regulations 6(1), 6(2), 6(3) and 6(4)).
- Unexpended benefits had not been accumulated by a beneficiary from one year to the next, other than as provided for in PMSA (Regulation 9A).
- The scheme adhered to the requirements imposed by Regulation 8 and Annexure A in respect of prescribed minimum benefits.

### **Commercial reinsurance**

- Commercial reinsurance contracts were furnished to the Office of the Registrar and the content of the contracts was to the satisfaction of the Registrar, as required by Sections 20(2) to 20(7) of the Act.

### **Administration expenditure**

- The scheme adhered to any restrictions placed on its administration expenditure by the Registrar in terms of Section 44(8).

### **Trustee remuneration**

- Trustee remuneration was adequately disclosed in the annual financial statements in terms of Regulation 6A.



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**Brokers**

- There was compliance with all the provisions relating to broker services and commissions (Section 65, read together with Regulations 28(1), 28(2), 28(5) relating to the compensation of brokers by a scheme and Regulation 28B relating to requirements for the accreditation of brokers by the Council).

**Investments**

- The medical scheme did not encumber its assets, allow its assets to be held on its behalf, borrow money or give security to obligations between other persons without the prior approval of, or subject to directives issued by, the Council (Section 35(6)).
- The medical scheme did not invest any of its assets in the business of, or grant loans to, an employer that participates in the medical scheme, or any administrator or any arrangement associated with the medical scheme, any other medical scheme, any administrator, and any person associated with any of the abovementioned (Section 35(8)).
- The scheme's assets were invested in accordance with Regulation 30, read together with Annexure B of the Act.
- In the event that the scheme invested in collective investment schemes, managed funds and insurance policies, the scheme had demonstrated on a look-through basis that these investments were not utilised to circumvent the limitations of Regulation 30 and Annexure B.
- Where the Rules create a trust agreement between the member and the scheme, PMSA trust monies were separately invested from the scheme's assets in terms of the requirements imposed by the Protection of Funds Act. These monies were only invested in the instruments allowed for in Circular 38 of 2011, or in terms of the scheme's Rules.

**Bank account**

- In terms of the Act and Regulations, money flowing into a medical scheme should flow on a timely basis in order to ensure, inter alia, that returns are earned by the scheme.
- A bank account was established under the scheme's direct control in terms of Section 26(1)(c), and into it shall be paid every amount:
  - Received as subscription or contribution paid by or in respect of a member; and
  - Received as income, discount, interest, accrual or payment of whatsoever kind.
- Payments made from the bank account adhered to the requirements of Section 26(4), including:
  - The payment of benefits in terms of the scheme's Rules;
  - Costs incurred in the carrying on of business as a medical scheme; and
  - Amounts invested by the board of trustees in accordance with Section 35(7).

- No dividends, rebates or bonuses<sup>86</sup> were paid (Section 26(5)).
- Where the Rules create a trust agreement between the member and the scheme, PMSA monies must be kept separately from scheme assets in terms of the Protection of Funds Act. Circular 38 of 2011 requires the scheme to open a trust bank account.

### **Depositing of medical scheme monies**

- Regulation 23 further requires that:
  - An administrator must deposit any medical scheme monies under administration into a bank account opened in the name of the medical scheme, not later than the business day following the date of receipt thereof.
  - When medical scheme monies, including contributions, are paid by means of electronic funds transfer, such monies shall be deposited directly into a bank account opened in the name of the medical scheme.
  - Monies contemplated in sub-regulations (1) or (2) shall at no time be deposited into any bank account other than that of the medical scheme.
- Circular 38 of 2011 allows PMSA contributions to be collected together with the risk contributions, but the savings portion must be transferred to a separate trust account within seven days of receipt.

### **Guarantees**

- In terms of the Act and Regulations thereto, guarantees may be required by the Registrar at various levels. These would be taken into account by the auditor in their assessment of the going concern assumption and the accounting for or disclosure thereof, as appropriate.
  - Administrator: Section 24(5) of the Act stipulates that the Registrar may demand from the person who manages the business of a medical scheme, which is in the process of being established, such financial guarantees as will, in the opinion of the Council, ensure the financial stability of the medical scheme.
  - Principal officer: In Section 33 dealing with the approval and withdrawal of benefit options, subsection (3) stipulates that the Registrar may demand from the principal officer such financial guarantees that will, in the opinion of the Council, ensure the financial soundness of benefit options.
  - Medical scheme: Further, in Section 44 on inspection and reports, in terms of subsection (9), the Registrar may, if he or she is – on account of an inspection or investigation in terms of this Act or on account of any report, document, statement or information furnished to him or her under this section – of the opinion that a medical scheme is or may be rendered not financially sound at any time, demand from the

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<sup>86</sup> This does not relate to bonuses paid to the scheme's employees in terms of employment contracts.

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medical scheme such financial guarantees and guarantee deposits that will, in the opinion of the Registrar, ensure the financial stability of the medical scheme.

**Professional indemnity insurance**

- The board of trustees should in terms of Section 57, *General provisions on governance*, subsection (4)(f), take out and maintain an appropriate level of professional indemnity insurance and fidelity guarantee insurance.

**Borrowings and overdrafts**

- In terms of Section 35(6) a scheme may not encumber its assets, allow its assets to be held by another person on its behalf, borrow money or provide suretyships without the prior approval of the Council.

**Personal medical savings accounts**

- Where the Rules state that funds in a savings account belong to members, thereby creating a trust agreement between the member and the scheme, PMSAs must be kept separately from scheme funds, in terms of Section 4(5) of the Protection of Funds Act. Interest earned on these funds must be credited to a member's individual PMSA. Circular 56 of 2017<sup>87</sup> also clarifies that no advances may be made out of these monies.
- The scheme adhered to its Rules in respect of the allocation of a PMSA to a member for payment of any relevant health service, in terms of Section 30(1)(e).
- The contribution allocated to the PMSA of each individual member did not exceed 25% of the total gross contribution per said individual (Regulation 10(1)).
- Credit balances in a member's PMSA were transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be, when such member changed medical schemes or benefit options (Regulation 10(4)).
- Credit balances in a member's PMSA were taken as a cash benefit, subject to applicable laws, when the member terminated his or her membership of a medical scheme or benefit option without enrolling in another medical scheme or another medical scheme that has no PMSA provision or selected a benefit option without a savings plan (Regulation 10(5)).
- The Prescription Act 68 of 1969 applies to unclaimed members' savings accounts and when these claims prescribe after three years the amounts are written back to the scheme.

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<sup>87</sup> Circular 56 of 2017, *Personal Medical Savings Accounts*.

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- Circular 5 of 2012<sup>88</sup> clarifies that in terms of Section 93 of the Administration of Estates Act 66 of 1965, schemes must pay PMSAs that have remained unclaimed for a period of five years or more over to the Guardian's Fund in instances where the Rules create a trust agreement between the member and the scheme.
- Savings plan account facilities were not utilised to provide for benefits and co-payments relating to PMBs (Regulation 10(6)).

**Solvency**

- The scheme maintained the minimum accumulated funds as required by Regulation 29.
- Failure, for any period of 90 days, to meet the solvency ratio required in terms of the Regulations was reported to the Registrar in writing.

**Amalgamation**

- The amalgamating scheme (the scheme ceasing to exist after the amalgamation) submitted its audited annual financial statements and its annual return for the period to the date of transfer to the Registrar.

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<sup>88</sup> Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts*.

## **Appendix 10 – Claims CAATs**

The examples of claims CAATs that may be typically performed in a medical scheme environment are set out below.

<b>CAAT name</b>	<b>Description</b>
Duplicate claims	This CAAT lists all the records from the medical claim file in which the claim reference number, claim line number and invoice amount have been duplicated. A table provides a listing of such records and their details.
Duplicate active member numbers	This CAAT lists all those cases in which the member numbers have been duplicated and their termination date is less than the date on which the CAAT is run or where the date field is blank. A table provides a listing of such records and their details.
Duplicate surname and dates of birth	This CAAT lists all members in the membership table with the same surnames and dates of birth. A table provides a listing of these records and their details.
Claims paid to a blank membership number	This CAAT lists all cases in which claims have been made but in which the membership number is blank. A table provides a listing of such transactions and their details, with the total amounts paid per processing date.
Claims paid to an invalid membership number	This CAAT extracts all cases in which claims have been made to members whose membership numbers do not exist on the members' master file. A table provides a listing of the details of such payments.
Claims paid exceeding scheme tariff	This CAAT lists claims paid that are greater than the scheme tariff amount.
Claims paid for treatment after end-date	This CAAT lists all claims that have been paid for treatments occurring after the member's termination date. A table that gives the details of such payments, including the termination date of members, is provided.

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<b>CAAT name</b>	<b>Description</b>
Stale claims	All claims where the claims received date is later than four months after the date of treatment, or longer period as determined by the Rules.
Claims paid later than 30 days	This CAAT lists the claims paid more than 30 days after the processed date. A table lists the details of these claims.
Negative claims	This CAAT checks for "negative benefits" that have been paid (i.e. reversals).
PMB claims paid from a savings account	This CAAT lists PMB claims paid from the member's savings account portion, in contravention of the Act.
Process dates prior to service dates	This CAAT performs a review of the service dates and capturing dates to ensure that no claim is captured prior to the service being rendered. The resulting table could indicate fraudulent claims or incorrectly manually-processed claims.

## **Appendix 11 – Contribution CAATs**

The examples of contribution CAATs that may be typically performed in a medical scheme environment are set out below.

<b>CAAT Name</b>	<b>Description</b>
Subscriptions with a negative value within subscriptions raised	This CAAT lists all the "invoices" being raised for subscriptions due that are "negative" and may indicate invalid journals.
Subscriptions with a "negative" value within subscriptions paid	This CAAT lists all the "invoices" being paid for subscriptions due that are "negative" and may indicate invalid cash reversals.
Test for subscriptions with zero values	This CAAT lists all contributions "invoiced" and "received" with no amounts. The resulting list will indicate possible option changes per member that need to be validated.
All membership codes are valid	This CAAT tests that subscriptions are only "invoiced" and "received" for individuals that are valid members of the scheme based on the membership master file. The resulting table lists possible invalid contributions received or receivable and should be considered for a possible overstatement of contribution income.

## Appendix 12 – List of Resources

Useful websites for further information:

### **Independent Regulatory Board for Auditors (IRBA)**

<https://www.irba.co.za/guidance-to-ras/technical-guidance-for-auditors/industry-specific-guides-and-regulatory-reports/medical-schemes-engagements>

### **South African Institute of Chartered Accountants (SAICA)**

<https://www.saica.co.za/TechnicalInformation/Assurance/Guides/tabid/538/language/en-ZA/Default.aspx>

### **Council for Medical Schemes (the Council)**

[www.medicalschemes.com](http://www.medicalschemes.com)

### **Financial Sector Conduct Authority (FSCA)**

<https://www.fsca.co.za/Pages/Default.aspx>