

Guide

March 2015



Guide for Registered Auditors

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

Independent Regulatory Board for Auditors
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Johannesburg

This Guide for Registered Auditors: *Assurance Engagements on the Annual Financial Statements and Annual Statutory Returns of a Medical Scheme* was prepared by the Committee for Auditing Standards (CFAS) of the Independent Regulatory Board for Auditors (IRBA) and was approved for issue in March 2015.

The purpose of this 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.

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This 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. Guides do not impose requirements on auditors beyond those included in the International or South African Standard/s or South African regulatory requirements and 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 the requirements of the particular International or South African Standard/s to which the Guide relates, properly.

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.

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Introduction

Scope of this Guide

1. The purpose of this 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 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.¹
5. This 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 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

¹ Refer to the SAICA website, www.saica.co.za

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- d) Address reporting considerations, including:
 - (i) Forming an opinion on the financial statements; and
 - (ii) Reporting on the annual statutory returns.
- 8. This 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) *An ISA 700 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 700² report. The ISA 700 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)³.
 - c) *ISA 800 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 one that is used in the audit environment, as this may

² ISA 700, *Forming an Opinion and Reporting on Financial Statements*.

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

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imply absolute assurance, and reasonable assurance is appropriate in the context of the Act.

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 800⁴.

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 2410⁵.

This auditor report is therefore a combined:

- ISA 800 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 [Reporting on Parts 4 to 10 of the annual statutory return](#).

d) *An ISA 810 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 2013⁶. This is an ISA 810⁷ engagement.

⁴ ISA 800, *Special Considerations – Audits of Financial Statements Prepared in Accordance with Special Purpose Frameworks*.

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

⁶ Circular 6 of 2013, *Annual financial information provided to members*.

⁷ ISA 810, *Engagements to Report on Summary Financial Statements*.

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Effective date

10. This Guide is effective for engagements on accounting periods ending on or after 31 December 2015. Early adoption is encouraged.
11. The auditor reports included in this Guide are effective for reporting on engagements for periods ending on or after 31 December 2014. 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, *Quality Control 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 auditor. 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 complete the annual *Auditor Approval Questionnaire*⁸ issued by the Council within the prescribed deadlines.
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 is deemed to have been appointed by a 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 Code), the requirements of the International Standard on Quality Control 1, *Quality Control for Firms that Perform Audits and Reviews of Financial Statements and Other Assurance and Related Services Engagements* (ISQC 1) and the *International Standards on Auditing* (the ISAs) in the conduct of an audit of a medical scheme.
19. When a medical scheme utilises a service organisation, an auditor applies ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*, which

⁸ See Circular 25 of 2007, *Auditor Approval in Terms of Section 36(2) of the Medical Schemes Act*, for guidance on the revised auditor approval process from 2007 onwards. The *Auditor Approval Questionnaire* is available on the Council's website, www.medicalschemes.com.

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requires an auditor to assess, before accepting the engagement, whether sufficient appropriate audit evidence can be obtained from that service organisation, in order to complete the audit. In other words, if sufficient appropriate evidence cannot be obtained from that service organisation, this is not a scope limitation imposed as a result of the audit, but rather a scope limitation that should have been considered before the engagement was accepted, and appropriate responses 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 by that auditor setting out that auditor's understanding of the reason for the termination.

Planning of the engagement⁹

Fraud considerations

21. An auditor applies ISA 240, *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 [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.

⁹ 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 [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 which 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, 1969, as amended; and
 - k) Trust Property Control Act, 1988, as amended.

This list is not necessarily exhaustive, and has been compiled to the date that 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 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. 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 [Reporting on reportable irregularities](#).

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Risk assessment

29. An auditor applies ISA 315, *Identifying and Assessing the Risks of Material Misstatement through Understanding the Entity and Its Environment*.
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 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, reliance is placed almost entirely on the IT infrastructure, which poses risk of material misstatement and misappropriation of medical scheme assets if the IT control environment is not effective.
33. IT risks arise from manual and electronic interventions. An auditor considers the robustness of the IT environment 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 is appointed that is a service organisation, the relevant controls over the IT infrastructure are subject to the application by a medical scheme auditor of ISA 402¹⁰ and the service auditor of ISAE 3402¹¹ (when applicable). The service auditor's report serves as audit evidence to the medical scheme auditor. Also refer to the section [Service organisations](#).

Analytical reviews and key ratio analysis

36. An auditor applies ISA 520, *Analytical Procedures*.
37. A medical scheme monitors key ratios on an on-going basis. An auditor may use these to identify potential risks of material misstatement. The examples listed below are not exhaustive:¹²
 - 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.

¹⁰ ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.

¹¹ ISAE 3402 – *Assurance Reports on Controls at a Service Organization*.

¹² Calculated at scheme and at option level.

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- 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.
- 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 managed care management services per member per month.
- o) Average managed care management 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

Contributions are incomplete

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

Inaccurate contributions

39. Material misstatements may arise from:
- a) Contributions in respect of ancillary products raised and collected by a 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, 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) Contributions 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 where 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/under statement 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

40. 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

41. 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 contributions will be regarded as being in contravention of the Act, an auditor determines the event "becoming due", as specified in the Rules and may differ from scheme to scheme. Contributions in some schemes may become due at the beginning of a month whereas in other schemes contributions may become due at the end of a month. An auditor considers the scheme's approved credit policy in the circumstances and whether the policy has been implemented.

Contributions not paid directly into the scheme's bank account

42. Regulation 23 states that an administrator must deposit any medical scheme monies under administration, not later than the business day following the date of receipt of

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these monies, into a bank account opened in the name of the medical scheme. Regulation 23 also states that 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 in any bank account other than that of the medical scheme.

Savings contributions not paid over to the PMSA trust investment account within 7 days of receipt

43. Savings contributions received must be retained in a trust bank account, separate from any of a scheme's bank accounts. Circular 38 of 2011¹³ 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.

Arrear contribution receivable

44. A medical scheme's credit policy might not be applied correctly in respect of the suspension of benefits and termination of membership.
45. Misstatement of arrear contributions receivable may include inter alia:
- a) Inaccurate contributions, discussed in paragraph 39.
 - 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 it relates.
 - 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 scheme or group level only. This risk is mainly applicable to large open schemes.
 - g) Bad debts being written off, not in accordance with a 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.
46. Refer to [Appendix 11 – Contribution CAATS](#) for examples of CAATs used in the audit of a medical scheme.

¹³ Circular 38 of 2011, *Personal Medical Savings Accounts*.

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Healthcare benefits

47. 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.
48. In some cases a 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

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

Invalid claims

53. 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 scheme.

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- o) Level of care and level of stay per the pre-authorisation differ from claims submitted by the service provider, without explanation provided.

Claims not paid within 30 days of receipt

- 54. 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

- 55. The following may result in inaccurate claims 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 incorrect risk benefit or savings categories.
 - d) Prescribed minimum benefits (PMBs) not paid in full or from savings accounts.
- 56. 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 which could then be subject to 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.
- 57. The auditor obtains an understanding of the role that internal audit/forensic audit department play within the scheme in identifying fraudulent claims.

Managed care healthcare benefits

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

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- c) Completeness and accuracy of the disclosure of the managed care information in terms of IFRS 4¹⁴ and IFRS 7¹⁵ is at risk.
- d) The managed care 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 scheme being audited.
- g) Contract governing service not in place.

Risk transfer arrangements

59. 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 [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 4¹⁶ and IFRS 7¹⁷ 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 scheme being audited.
 - f) A contract governing 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)

60. Risks of material misstatements could include:
- a) Unauthorised adjustments are made to the IBNR provision in order to overstate the scheme's surplus/understate the 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.
 - c) Invalid IBNR models used or change in IBNR models used during the year.

¹⁴ IFRS 4, *Insurance Contracts*.

¹⁵ IFRS 7, *Financial Instruments: Disclosures*.

¹⁶ IFRS 4, *Insurance Contracts*.

¹⁷ IFRS 7, *Financial Instruments: Disclosures*.

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- 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.
61. 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 from the prior period are appropriate in the circumstances.
 - c) The quality of data that is used to calculate the IBNR provision.
62. Factors to be considered by an auditor in evaluating the computed provision include:
- a) The period elapsed between year-end and 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 some scheme Rules may allow for longer periods).¹⁸

The longer the period elapsed between year-end and 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 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 receipt of claims which 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.
 - e) Management controls.

An auditor considers any management controls over the computation including a consideration of significant changes between the current and prior year.
 - f) A medical scheme's authorisation process.

¹⁸ Refer to Regulation 6(4) which specifies the different time frames for invalid claims.

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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 [Auditor and management experts](#).

Non-healthcare expenditure – broker commissions

63. 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 scheme.
 - g) Broker commissions are paid by a medical scheme in respect of unaccredited brokers.
 - h) Broker commissions are not discontinued when the 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

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

Investments

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

Investments held not in compliance with the Act

66. Section 35(6) of the Act prohibits a scheme from:
- a) Encumbering its assets;

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- 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.

67. Section 35(8) of the Act precludes a scheme from holding investments (including the granting of loans to) in:
- a) A participating employer;
 - b) Any administrator or arrangement associated with the scheme;
 - c) Any other medical scheme;
 - d) Any administrator; and
 - e) Any person associated with the above-mentioned parties.
68. 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 scheme has not 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 and thus 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

69. 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.
70. Compliance is also 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

71. A risk exists that a 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 also commonly known as a wash-sale transaction. Assuming all other variables in the calculation being constant, realised gains would have a positive impact on the solvency calculation of a scheme. This is therefore an avenue through which schemes could manipulate their solvency ratio. Having regard for the derecognition criteria, such transactions would typically need to be reversed.

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Personal medical savings accounts (PMSAs)

Restrictions on PMSA contributions and claims

72. 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. While these savings belong to the member, they may only be used for healthcare services as provided for in the 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.
73. Accordingly the following risks of material misstatement may arise:
- a) Inaccurate member records impacting on the accuracy of savings account balances or claims being paid from savings account balances where the member in fact still has available benefits.
 - b) Savings account balances are not refunded to the intended recipient. This risk is exacerbated where the account relates to a member that 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) Savings accounts may be used for the payment of non-healthcare services.
 - e) PMBs and members' portions of PMBs are paid from the PMSAs.
 - f) Savings account 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."

Savings account balances written off

74. There is a risk that long outstanding savings account balances (credit balances) are written off thereby contravening Regulation 10(3) of the Act.
75. Old credit balances (longer than 5 years) must be paid over to the Guardian's Fund in terms of section 93 of the Administration of Estates Act 66 of 1965.¹⁹

Incorrect interest allocated to savings accounts

76. There is a risk that interest accrued on savings accounts to the credit of members may not be based on the effective interest method.

¹⁹ Cognisance should be taken of any guidance issued by the Council in this regard.

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77. There is a risk that interest may be charged on savings accounts funded by the trust monies in contravention of Circular 38 of 2011²⁰.

Overdrawn savings accounts

78. There is a risk that advances are made from savings plan monies and not from a scheme's funds in contravention of Circular 38 of 2011.

Savings plan monies not invested separately

79. There is a risk that PMSAs may not be invested separately from scheme assets as required in terms of the Protection of Funds Act.
80. There is a risk that there are mismatches between the PMSA assets and the related PMSA liability.
81. 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

82. There is a risk that the scheme does not adhere to the Circular 5 of 2012²¹ prescribed minimum disclosure requirements relating to PMSA trust investments and trust liabilities.

Auditor and management experts

83. 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*.
84. 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:
- a) Actuary:
- (i) An actuary *may* be used within a medical scheme environment to assist the scheme in assessing the adequacy of the IBNR provision.²²

²⁰ Circular 38 of 2011, *Personal Medical Savings Accounts*.

²¹ Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts*.

²² Per Circular 33 of 2013, *Guidance on benefit changes and contribution increases for 2014*, the 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

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- (ii) Refer to the section [Risk assessment](#) for risk assessment relating to the IBNR provision.
- b) Valuation specialists:
 - (i) Where the 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 scheme where an expert may be required, for example post-retirement benefit plans, investment property and property, plant and equipment.

Service organisations

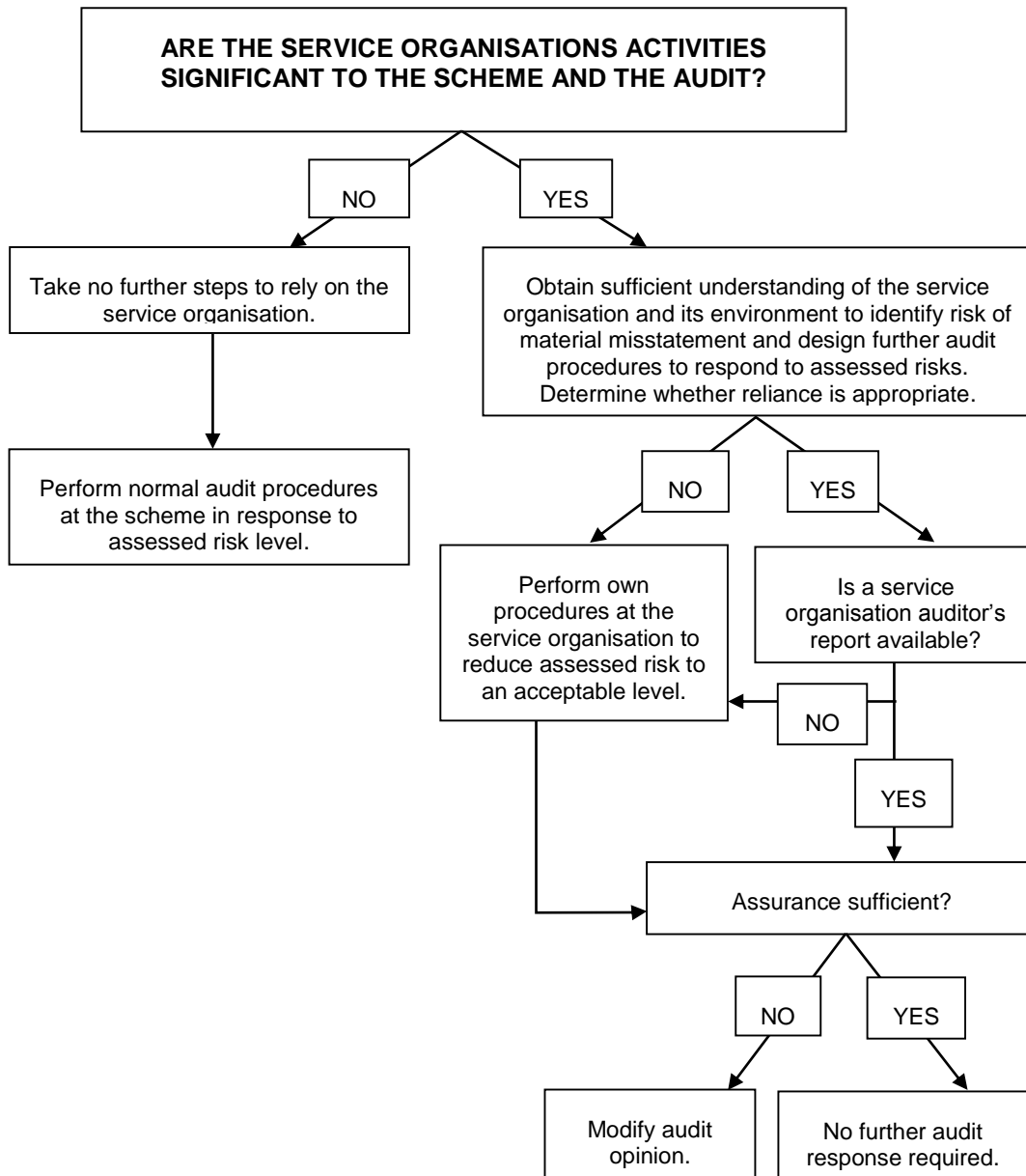
- 85. An auditor applies ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.
- 86. The obligation for obtaining of the audit evidence is that of a medical scheme. It would be helpful to an auditor if a contract between a medical scheme and a service organisation provides for a requirement for an independent report (preferably in compliance with ISAE 3402²³) by the service organisation on its control environment.
- 87. An auditor refers to ISA 402. The auditor applies judgement and documents considerations regarding the audit of service organisations.
- 88. The decision tree below illustrates the aspects an auditor considers when reliance on a service organisation is required:

-
- 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.

²³ ISAE 3402, *Assurance Reports on Controls at a Service Organization*.

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Related parties

89. An auditor applies ISA 550, *Related Parties*.
90. The SAICA *Medical Schemes Accounting Guide*²⁴ provides guidance in Appendix IV on identification of related parties and the disclosures required.
91. 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 24²⁵.

Sundry considerations

Statutory solvency requirements

92. 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%.
93. Regulation 29(3A) further indicates that a medical scheme which is registered for the first time after the coming into operation of the Regulations must maintain accumulated funds, expressed as a percentage of gross annual contributions, of not less than:
 - a) 10% during the first year after the 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 scheme be registered in June 2009, the scheme only needs to obtain a 10% solvency level at 31 December 2010.

94. Circular 13 of 2001²⁶, 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-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.

95. Consolidated results should also be excluded from solvency calculations as it is deemed not to be realised for scheme-purposes.

²⁴ Refer to the SAICA website, www.saica.co.za.

²⁵ International Accounting Standard 24, *Related Party Disclosures*.

²⁶ Circular 13 of 2001, *Non-Distributable Reserves in Solvency Calculation*.

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96. Where a medical scheme fails to comply with the requirements of these Regulations, for a period of 90 days, they 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 scheme's performance versus the approved requirements.

Exemptions in terms of section 8(h)

97. The Council may under exceptional circumstances grant exemption from the requirements of the Act, in the form of a directive.
98. The directive given by Council relating to the exemption request sets certain new compliance Rules that the 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 scheme has understood the new compliance Rules and whether the 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 scheme or an auditor to report on the primary non-compliance with the Act).

Allocation of income and expenses between different benefit options

99. 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.
100. Circular 4 of 2008²⁷, 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.
101. 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.

²⁷ Circular 4 of 2008, *Inclusion of Benefit Options Results in the Annual Financial Statements*.

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Auditor reporting

Schedule of reporting responsibilities

102. The schedules are a summary of reporting responsibilities of an auditor of a medical scheme and a board of trustees²⁸:

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

²⁸ 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 is 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 which has been reported in the report of the board of trustees; and
- c) For the sake of completeness.

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Auditor				
Requirement in legislation	Reporting on:	Type of auditor report	Section in guide below	Appendix
Section 37(2)	Annual financial statements	ISA 700	Reporting on the annual financial statements	5
Sections 36(8), 37(3) read in conjunction with 37(2)	Parts 4 to 10 of the annual statutory return	ISA 800 and ISRE 2410	Reporting on Parts 4 to 10 of the annual statutory return	6
Sections 36(5)(b) and 36(8)	Compliance with sections 36(5)(b) and 36(8) of the Act	ISAE 3000 (Revised)	Report on Compliance with Sections 36(5)(b) and 36(8) of the Act	7
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 report – compliance reporting	Reporting on non-compliance by both an auditor and a board of trustees of a medical scheme: Report on Other Legal and Regulatory Requirements	5
Circular 6 of 2013	Summary financial statements	ISA 810	Report on summary financial statements	8
Section 36(5)(a)	Reportable irregularities	“Report on Other Legal and Regulatory Requirements” section of the ISA 700 report	Reporting on reportable irregularities	5
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.			Other reporting responsibilities to the Council	
Communication with <i>those charged with governance</i>			Communication with those charged with governance	

Preparing of the annual financial statements by the board of trustees

103. 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, and 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.

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104. 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, which includes the annual statutory return.
105. The annual financial statements must in terms of Section 37(4)(d) also include the benefit options' financial results, including its membership. These results are required to be audited in terms of Circular 4 of 2008.
106. 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.
107. 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*²⁹ 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 prescribed by the Council in terms of Circular 41 of 2012³⁰, for use by medical schemes.
108. 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.

²⁹ Refer to the SAICA website, www.saica.co.za.

³⁰ 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

109. 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, and contain relevant information indicating whether or not the resources of a medical scheme have been applied economically, efficiently and effectively.
110. 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 720³¹ in relation to other information in documents containing audited financial statements.

Reporting on the annual financial statements

111. 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.
112. An auditor performs an ISA 700³² 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.
113. Refer to [Appendix 5 – Report on the Financial Statements \(ISA 700 Report\)](#) for the template report.³³

Reporting on Parts 4 to 10 of the annual statutory return

114. 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 one that is used in the audit environment, as this may imply absolute assurance, and reasonable assurance is appropriate in the context of the Act.
115. 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.

³¹ ISA 720, *The Auditor's Responsibilities Relating to Other Information in Documents Containing Audited Financial Statements*.

³² ISA 700, *Forming an Opinion and Reporting on Financial Statements*.

³³ Refer also to ISA 705, *Modifications to the Opinion in the Independent Auditor's Report* and ISA 706, *Emphasis of Matter Paragraphs and Other Matter Paragraphs in the Independent Auditor's Report*.

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116. Section 39(3) of the Act elaborates that a medical scheme would be deemed not 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.
117. 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.
118. 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. 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.
119. Part 6.2 of the annual statutory return is the “Monthly Statement of Net Healthcare Result” which contains monthly financial information that would not be audited as part of the audit of the financial statements.
120. 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.
121. This auditor report is therefore a combined:
- a) ISA 800³⁴ 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 2410³⁵ review report on Part 6.2 of the annual statutory return, providing a limited assurance conclusion.
122. Refer to [Appendix 6 – Report on Parts 4 to 10 of the Annual Statutory Return \(combined ISA 800 and ISRE 2410 Report\)](#) for the template report.

³⁴ ISA 800, *Special Considerations – Audits of Financial Statements Prepared in Accordance with Special Purpose Frameworks*.

³⁵ 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

123. To provide further guidance, the Council issued Circular 11 of 2006³⁶ 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 on in the *auditor's ISA 700 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.
124. The board of trustees are required to disclose the following information in regard 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.
125. 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.
126. 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.
127. In determining what non-compliance matters to report an auditor considers:
- 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

³⁶ Circular 11 of 2006, *Issues to be Addressed in the Audited Financial Statements of Medical Schemes*.

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- b) Non-compliance with laws and regulations that do not have a direct effect on the determination of the amounts and disclosures in the financial statements, but compliance with which may be fundamental to a scheme's ability to continue its business or to avoid material penalties which may have a material effect on the financial statements.
128. 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.
129. 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](#).
130. *The legislation is correct to the date that this Guide was issued. For legislative changes after the date of issue of this Guide, refer to the websites of the relevant regulators.*
131. 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

132. 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).
133. 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), 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.
134. The Registrar therefore requires an auditor to perform a limited assurance engagement in terms of ISAE 3000 (Revised)³⁷, to conclude on whether the scheme complied with the criteria identified in the limited assurance report.
135. An auditor concludes whether anything has come to the auditor's attention that causes the auditor to believe that the Scheme has not complied, *in all material respects*, with the specified Sections of the Act and related Regulations. Materiality is however set as

³⁷ ISAE 3000 (Revised), *Assurance Engagements Other Than Audits or Reviews of Historical Financial Information*.

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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.

136. The ISAE 3000 (Revised) report (which is submitted as part of the annual statutory return) is the auditor report which 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”) which an auditor reports on. These criteria are limited to the financial aspects of the Act which an auditor will include in the auditor’s normal audit procedures.
137. 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 statements³⁸

138. 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 2013³⁹. 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 reports on the summary financial statements after having completed the financial statement audit and issuing an auditor’s report on the financial statements. An auditor complies with ISA 810⁴⁰. Refer to [Appendix 8 – Report on the Summary Financial Statements \(ISA 810 Report\)](#) for the template report.
139. As per the requirements of this circular, 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 34⁴¹; and

³⁸ Circular 6 of 2013 refers to a highlights document which 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, *The Auditor’s Responsibilities Relating to Other Information in Documents Containing Audited Financial Statements*. An auditor may read the highlights document “as a courtesy”.

³⁹ Circular 6 of 2013, *Annual financial information provided to members*.

⁴⁰ ISA 810, *Engagements to Report on Summary Financial Statements*.

⁴¹ 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

140. 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, 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.⁴²
141. An auditor considers the impact of the reportable irregularity on the audit opinion, and discloses the reportable irregularity in the ISA 700 report under “Report on Other Legal and Regulatory Requirements”, if applicable.

Other reporting responsibilities to the Council

Reasons for termination

142. Section 36(5)(a) 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 resignation) of the auditor.

Auditor Approval Questionnaire including declaration on application regarding internal control weaknesses

143. An auditor is required to complete the annual *Auditor Approval Questionnaire*⁴³ issued by the Council.
144. The Council requires an auditor to sign a declaration⁴⁴ upon application for the appointment of an auditor of a medical scheme, in which an auditor undertakes to report to the Registrar any material internal control weaknesses identified during the performance of the audit, which have remained unresolved for more than one audit period.

⁴² Available on the IRBA website www.irba.co.za.

⁴³ See Circular 25 of 2007, *Auditor Approval in Terms of Section 36(2) of the Medical Schemes Act*, for guidance on the revised auditor approval process from 2007 onwards. The *Auditor Approval Questionnaire* is available on the Council’s website, www.medicalschemes.com.

⁴⁴ Refer to the declaration in the *Auditor Approval Questionnaire* issued by the Council.

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Management report

145. An auditor's management report which 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 scheme or the Council.⁴⁵

Other duties provided for in the Act

146. 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

147. An auditor is required to report on housekeeping matters to management as well as audit matters communicated to those charged with governance. In determining what matters should be reported to the Registrar, an auditor considers the guidance in ISA 260⁴⁶ and ISA 265⁴⁷.

⁴⁵ Refer to Circular 23 of 2011, *General Concerns noted during the Analysis of the 2010 Annual Financial Statements and Statutory Returns*.

⁴⁶ ISA 260, *Communication of Audit Matters with Those Charged with Governance*.

⁴⁷ ISA 265, *Communicating Deficiencies in Internal Control to those Charged with Governance and Management*.

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Appendix 1 – Definitions

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

For purposes 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.

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.

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

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.

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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 service or advice in respect of the introduction or admission of members to a medical scheme; or
- The ongoing provision of 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

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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.

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 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 submitting 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

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be either an auditor's internal expert (who is a partner⁴⁸ or staff, including temporary staff, of the auditor's firm or a network firm), or an auditor's external expert.⁴⁹

- *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.⁵⁰

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 managed care: healthcare services. Gross claims also include own facility costs for services rendered to members.

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.

⁴⁸ "Partner" and "firm" should be read as referring to their public sector equivalents where relevant.

⁴⁹ ISA 620, *Using the Work of an Auditor's Expert*.

⁵⁰ ISA 500, *Audit Evidence*.

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Investment manager – An investment manager is responsible for managing a 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. This process can be categorised into the following expenditure classifications:

- *Managed care: management services* – The cost of managing healthcare expenditure, such as bill review, specialist and hospital referrals, case management, disease management (excluding healthcare benefits that are included in the contract), peer review, claims audits and statistical analysis, but does not include the cost of any relevant healthcare services; and
- *Managed care: healthcare services* – The cost of healthcare services under payment systems, such as capitation fees, in terms of contracts not classified as risk transfer arrangements (healthcare services purchased) and disease management (healthcare benefits that are included in the contract). It excludes the administration thereof, which is regarded as Managed care: management services.

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".

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

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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 2001⁵¹ 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 managed care: management services, broker service fees, administration fees and other operating expenses incurred in operating a medical scheme, 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 trust 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 schemes that the member belongs to. PMSAs are savings contributions held in trust on behalf of members 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

⁵¹ Circular 13 of 2001, *Non-distributable reserves in solvency calculation*.

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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.

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.

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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 practised, 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.

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 – Means 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.

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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 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 4⁵². 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 the carrying on of 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 and include:

- 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 which may be granted by and the contributions which 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, and efficiency of, healthcare services, procedures or settings, on the basis of which appropriate managed healthcare interventions are made.

⁵² IFRS 4, *Insurance Contracts*.

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

Savings contributions – The amount allocated to a member’s personal medical savings account in terms of the 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 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 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 “Minimum accumulated funds (solvency ratio)” definition.

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 twelve-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, a general waiting period might be imposed;

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- If the previous membership was shorter than 24 months (previous waiting periods may still be in place), a condition-specific waiting period may be imposed; and
- Regardless of previous membership, if the member changed schemes due to a change in employment or the employer changing or terminating a scheme, 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.

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Appendix 2

Appendix 2 – Understanding the business of a medical scheme⁵³

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, *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.
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 that 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 scheme. In terms of section 24(3) of the Act, the Registrar approves the Rules of a medical scheme upon initial registration of such scheme. This approval is evidenced by a stamp on each page of the Rules. Any amendments to the Rules are required to be similarly approved by the Registrar (section 31(2)) and registered in accordance with section 31(3) of the Act. The medical scheme may annually revise its contribution tables and benefits. The

⁵³ ISA 315, *Identifying and Assessing the Risks of Material Misstatement through Understanding the Entity and Its Environment*.

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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 3 months and/or condition-specific waiting periods of up to 12 months, as well as late joiner penalties, on new members and dependants upon meeting 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 are limited and even prohibited in certain instances. For example, no waiting period may be imposed by a 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 schemes may apply when admitting new members:

<i>(Uncovered period – time period 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</i> <i>*Employer changing / terminating medical scheme</i>
<ul style="list-style-type: none"> ▪ General waiting period – 3 months ▪ Condition specific – 12 months ▪ Waiting period applies to PMBs 	<ul style="list-style-type: none"> ▪ General waiting period – 3 months ▪ Waiting period does not apply to PMBs 	<ul style="list-style-type: none"> ▪ Condition specific – 2 months ▪ Waiting period does not apply to PMBs 	<ul style="list-style-type: none"> ▪ No general or condition specific waiting periods may be imposed

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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 for a break of less than 3 months) with any medical scheme since 1 April 2001. Such late joiner penalties 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 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 scheme. A member may belong to only one benefit option in one 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 that member is defaulted to the existing benefit option for the following year. Dependent 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.

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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 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 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.

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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 scheme's DSP, where a DSP has been identified in a scheme Rules. However, co-payments may not be levied for emergencies. Co-payments on PMBs may not be funded from PMSA monies.
25. A member of a medical scheme has four months, or such longer period as per the Rules of that scheme, from the date of service to submit claims to that scheme.
26. The audit of claims takes cognisance of the manner in which claims are received by a scheme and the supporting documentation provided. Most 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 managed care organisation.
- Entering into a risk transfer arrangement does not reduce a 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 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, which 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 managed care 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 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.

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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:
 - a) Managed care: management services;
 - b) Managed care: healthcare services with no transfer of risk; and
 - c) Managed care: healthcare services with risk transfer.
31. Managed care: management services expenditure is administrative in nature and represents the cost of managing healthcare expenditure. This may include services such as bill review, specialist and hospital referrals, case management, disease management, peer review, claims audits and statistical analysis. It is important to note that it does not include the cost of any relevant healthcare services. Managed care: management services expenditure forms part of the scheme's non-healthcare expenditure incurred.
32. Managed care: healthcare services with no transfer of risk may only be provided by accredited managed care organisations. This expenditure normally represents the provision of fee-for-service healthcare benefits included in managed care contracts. An example of this is disease management (e.g. diabetes) where the actual healthcare services provided as per the contract would be included in the managed care: healthcare services with no transfer of risk expenditure; the management of the disease would be classified as managed care: management services (see above).
33. Managed care: healthcare services with risk transfer may be provided by either an accredited managed care organisation or a provider. Such provider would normally be the DSP for the related healthcare benefit. These arrangements are capitation agreements, in which the managed care 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, managed care: management services (refer paragraph 31), broker costs, commercial reinsurance results (refer 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.

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36. Broker costs consist of regulated broker commissions as well as distribution fees which are incurred in managing broker networks. A medical scheme may not directly or indirectly (i.e. via the distribution networks) compensate brokers other than 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. While these savings belong to a member, they may only be used for healthcare services as provided for in the scheme's Rules and are only refundable as provided for in Regulation 10. PMSAs may not be utilised to provide for benefits and members' portions relating to PMBs.
38. PMSAs constitute trust money as defined in section 1 of the Protection of Funds Acts 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 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.
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 which are a deposit component of the insurance contracts.

Investments

40. 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.
41. Trustees of a medical scheme may choose to have some or all of a scheme's assets invested in a range of products, for example, deposits, securities, immovable properties, unit trusts, linked policies etc.
42. These investments may either be through direct ownership (where the scheme invests directly with the investee or makes investments through a broker) or through indirect ownership (where the scheme invests through an asset manager in linked policies).

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43. In terms of the Protection of Funds Act, PMSA monies should be separately invested from scheme assets. Circular 38 of 2011⁵⁴ clarified 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

44. 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 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 organisations⁵⁵

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

⁵⁴ Circular 38 of 2011, *Personal Medical Savings Accounts*.

⁵⁵ ISA 402, *Audit Considerations Relating to an Entity Using a Service Organization*.

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Appendix 3 – Extracts from and commentary on the Medical Schemes Act and related Regulations

The legislation is correct to the date that this Guide was issued. For legislative changes after the date of issue of this Guide, refer to the website of the Council.

This appendix contains a summary of and therefore highlights 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 carrying on 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 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 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.

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10. Section 26(11) prohibits medical schemes from carrying on any business other than the business of a medical scheme.
11. Section 29 details the minimum matters for which the scheme's Rules must provide. Section 30 continues to detail the general provisions which may be included in the 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 above mentioned (section 35(8)).
 - b) Auditor and audit committee
 - (i) The appointment of the auditor and the audit committee (section 36).⁵⁶
 - 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

⁵⁶ Refer to paragraph 13 of this Guide for further detail 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 2008⁵⁷.
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) For purposes of routine monitoring of 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 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 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 on-going service or advice to that member.⁵⁸
24. Section 66 contains details on offences and penalties.

⁵⁷ Circular 4 of 2008, *Inclusion of Benefit Options Results in the Annual Financial Statements*.

⁵⁸ 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.

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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, not later than the business day following the date of receipt of these monies, into a bank account opened in the name of the medical scheme. 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”.⁵⁹

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. As was clarified in Circular 5 of 2012⁶⁰, due to the nature of PMSAs (i.e. these do not form part of scheme assets), the limitations imposed by Regulation 30 and Annexure B are not applicable to these trust monies. Circular 38 of 2011⁶¹ provided clarity as to the type of instruments these trust monies may be invested in.
38. 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.

⁵⁹ Refer to paragraphs 78 to 82 for more detail on the items which should be taken into account for solvency purposes..

⁶⁰ Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts*.

⁶¹ Circular 38 of 2011, *Personal Medical Savings Accounts*.

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Appendix 4

Appendix 4 – Circulars relevant to financial statements

This list is complete to the date 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
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
25 of 2014	Adjustment of statutory fees payable to brokers
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
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
25 of 2012	Adjustment of statutory fees payable to brokers
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

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Circular number	Subject
5 of 2010	Audit reports to the Annual Statutory Returns
2 of 2010	Categorisation of assets in terms of Annexure B to the Regulations
38 of 2009	Increase in fees payable to brokers with effect from 1 January 2009 <ul style="list-style-type: none"> • Date later amended to 1 January 2010
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"> • Extension for compliance has been granted in Circular 7 of 2010
23 of 2009	Annual Financial Statements
21 of 2009	Issues encountered during the evaluation of medical scheme administrators regarding the auditing of medical schemes
18 of 2009	Format of Statement of Comprehensive Income
4 of 2008	Inclusion of benefit options results in the Annual Financial Statements
49 of 2007	Financial reporting by managed care organisations
38 of 2007	Summarised Financial Statements
25 of 2007	Auditor approval applications
41 of 2006	2006 audited financial statements: <ul style="list-style-type: none"> • Reporting of non-compliance • Prescription of unclaimed savings balances
11 of 2006	Issues in audited financial statements: <ul style="list-style-type: none"> • Reporting of non-compliance matters • Fair value of assets for Annexure B
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

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Appendix 5

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

Report on the Financial Statements (ISA 700 Report)

The auditor reports are effective for reporting on engagements for periods ending on or after 31 December 2014.

Circumstances

- *The financial statements are prepared in accordance with International Financial Reporting Standards and the requirements of the Medical Schemes Act of South Africa.*
- *Unmodified opinion.*
- *Report on non-compliance with the Medical Schemes Act of South Africa and, where applicable, reportable irregularities in accordance with the Auditing Profession Act, 2005.*

Independent Auditor's Report

To the Members of <name of scheme>

Report on the Financial Statements

We have audited the financial statements of <name of scheme>, as set out on pages <xx> to <xx> which comprise the statement of financial position at <date of period end>, and the statements of comprehensive income, changes in funds and reserves and cash flows for the <year/period> then ended, and the notes, comprising a summary of significant accounting policies and other explanatory information.

Trustees' Responsibility for the Financial Statements

The scheme's trustees are responsible for the preparation and fair presentation of these 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 trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

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An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, these financial statements present fairly, in all material respects, the financial position of <name of scheme> at <insert date of 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.

Report on Other Legal and Regulatory Requirements ⁶²

Non-compliance with the Medical Schemes Act of South Africa⁶³

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

<Report in accordance with the Auditing Profession Act, 2005 – section 45: 'Duty to report on irregularities'>.

⁶² ISA 700 paragraphs 38 and 39.

⁶³ Delete the paragraph that is not applicable.

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Auditor's Signature

Name of individual registered auditor

Registered Auditor

Date of auditor's report

Auditor's address

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Appendix 6

**Appendix 6 – Report on Parts 4 to 10 of the Annual Statutory Return
(combined ISA 800 and ISRE 2410 Report)**

The auditor reports are effective for reporting on engagements for periods ending on or after 31 December 2014.

Circumstances:

- *The auditor of this engagement is the auditor of the Scheme.*
- *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 and 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), 37(3) read in conjunction with 37(2), and 39(3);*
- *The auditor’s opinion on the financial statements for the current year/ period is unmodified;*
- *The use of the auditor’s report is restricted to the Registrar;*
- *The auditor has not identified a Reportable Irregularity in terms of the Auditing Profession Act, 2005; and*
- *Where a modified opinion has been expressed on the financial statements, the auditor must consider the implications for the opinion to be expressed in the auditor’s report on Parts 4 to 6.1 and 6.3 to 10 of the annual statutory return.*

Independent Auditor’s Report⁶⁴

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

We have audited Parts 4 to 6.1 and 6.3 to 10 and reviewed Part 6.2 of the annual statutory return (the Return) of <Name of Scheme> (the Scheme) 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.

⁶⁴ The Office of the Registrar requires auditors to submit this report on the auditor’s letterhead.

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Trustees' Responsibility for the Return

The trustees are responsible for the preparation of Parts 4 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, 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 they determine is necessary to enable the preparation of Parts 4 to 10 of the Return that is free from material misstatement, whether due to fraud or error.

Audit Report on Parts 4 to 6.1 and 6.3 to 10 of the Return

Auditor's Responsibility

Our responsibility is to express an opinion on Parts 4 to 6.1 and 6.3 to 10 of the Return based on our audit. We conducted our audit in accordance with International Standards on Auditing. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether Parts 4 to 6.1 and 6.3 to 10 of the Return are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in Parts 4 to 6.1 and 6.3 to 10 of the Return. The procedures selected depend on the auditor's judgement, including the assessment of 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. In making those risk assessments, the auditor considers internal control relevant to the Scheme's preparation of Parts 4 to 6.1 and 6.3 to 10 of the Return 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. An audit also includes evaluating the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of Parts 4 to 6.1 and 6.3 to 10 of the Return.

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

Opinion on Part 4 to 6.1 and 6.3 to 10 of the Return

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 and related Regulations.

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Review Report on Part 6.2 of the Return

Auditor's Responsibility

Our responsibility in terms of Section 36(8), 37(3) read in conjunction with 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 management 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.

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 opinion or our conclusion, we emphasise that Parts 4 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. As a result, parts 4 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), 37(3) read in conjunction with Sections 37(2) and 39(3) of the Medical Schemes Act No. 131 of 1998 and is not to be used for any other purpose. Our report is provided solely for the information of the Registrar.

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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 audit of Parts 4 to 6.1 and 6.3 to 10 and our review of Part 6.2 of the Return we considered evidence obtained during our audit of the financial statements of the Scheme.

Auditor's Signature

Name of individual registered auditor

Registered Auditor

Date of auditor's report

Auditor's address

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Appendix 7

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

The auditor reports are effective for reporting on engagements for periods ending on or after 31 December 2014.

Circumstances:

- *The auditor of this engagement is the auditor of the Scheme.*
- *The engagement is an ISAE 3000 (Revised) engagement where limited assurance is obtained.*
- *The auditor's opinion on the financial statements for the current year/ period is unmodified.*
- *The auditor has not identified a Reportable Irregularity in terms of the Auditing Profession Act, 2005.*
- *Based on the procedures performed and the evidence obtained, the auditor reports all instances of non-compliance that have come to his attention.*
- *Materiality is 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.*

Independent Assurance Report of the Independent Auditor⁶⁵

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 obtain 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;

⁶⁵ The Office of the Registrar requires auditors to submit this report on the auditor's letterhead.

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3. Sections 26(4) relating to the restriction of payments made from the scheme's bank account; and 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;
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 Medical Council;
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 insurance⁶⁶;
11. Sections 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 Scheme 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 4(1), 4(2), 4(4) and 4(5) of the Financial Institutions (Protection of Funds) Act 28 of 2001 relating to the investment of personal medical savings account monies and

⁶⁶ In terms of this section, instances of non-compliance that may be identified may include that the Scheme either failed to take out 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.

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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;

16. Regulations 15 relating to the provision of managed health care; 18 relating to provisions to be included in administration agreements; and 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), 28(5) relating to compensation of brokers by a Scheme and 28B relating to requirements for accreditation of brokers by the Medical Council; 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 and related Regulations.

Our Independence and Quality Control

We have complied with the Code of Professional Conduct for Registered Auditors issued by the Independent Regulatory Board for Auditors, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

In accordance with International Standard on Quality Control 1, *<name of audit firm>* maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Auditor's Responsibility

Our responsibility is to express a limited assurance conclusion on whether the Scheme has complied with the specified Sections of the Act and related Regulations based on the procedures we have performed and the evidence we have obtained. We conducted our limited assurance engagement in accordance with the International Standard on Assurance Engagements (ISAE) 3000 (Revised), *Assurance Engagements Other Than Audits or Reviews of Historic Financial Information*. That standard requires us to plan and perform our assurance engagement in order to obtain limited assurance on whether the Scheme has complied with the specified Sections of the Act and related Regulations.

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

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issued an *<unmodified/modified>*⁶⁷ 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 which included:

- Making inquiries of the Scheme's management primarily responsible for financial and accounting matters and regulatory compliance;
- Re-performance of calculations, 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 and consequently, the level of assurance obtained in a limited assurance engagement is substantially lower than the assurance that would have been obtained had a reasonable assurance engagement been performed. Accordingly, we do not express a reasonable assurance opinion about whether the Scheme has complied with the specified Sections of the Act and related Regulations.

Basis for Qualified Conclusion

*< List all instances of non-compliance >*⁶⁸.

Qualified Conclusion⁶⁹

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.

⁶⁷ 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.

⁶⁸ Refer to paragraph A182 of ISAE 3000 Revised. Delete this paragraph if the conclusion is unmodified.

⁶⁹ Delete this paragraph if the conclusion is unmodified

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OR

Conclusion⁷⁰

Based on the procedures performed and the evidence obtained 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.

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 may not be suitable for another purpose. Our report is presented solely for the information of the Registrar.

Auditor's Signature

Name of individual registered auditor

Registered Auditor

Date of auditor's report

Auditor's address

⁷⁰ Delete this paragraph if the conclusion is modified.

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Appendix 8

Appendix 8 – Report on the Summary Financial Statements (ISA 810 Report)⁷¹

The auditor reports are effective for reporting on engagements for periods ending on or after 31 December 2014.

Circumstances:

- *The auditor performed the main audit of the scheme (ISA 700 report) which resulted in an unmodified/modified report.*
- *The auditor's report on the summary financial statements is dated the same as the audit report on the financial statements.*

Report of the Independent Auditor on the Summary Financial Statements

To the Members of the <name of scheme>

The summary financial statements of <name of scheme>, as set out on pages <xx> to <xx>, which comprise the summary statement of financial position at <date of period end>, and the summary statements of comprehensive income, changes in funds and reserves and cash flows for the <year/period> then ended, and related notes, are derived from the audited financial statements of <name of scheme> for the <year/period> ended <date of period end>. We expressed an unmodified audit opinion on those financial statements in our report dated <xxxxx>.

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, therefore, is not a substitute for reading the audited financial statements of <name of scheme>.

Trustees' Responsibility for the Summary Financial Statements

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

⁷¹ In terms of Circular 6 of 2013, *Summarised Financial Statements*.

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Auditor's Responsibility

Our responsibility is to express an opinion on the summary financial statements based on our procedures, which were conducted in accordance International Standards on Auditing (ISA) 810, *Engagements to Report on Summary Financial Statements*.

Opinion

In our opinion, the summary financial statements derived from the audited financial statements of *<name of scheme>* for the *<year/period>* ended *<date of period end>* are consistent, in all material respects, with those financial statements, in accordance with the content and disclosure requirements of Circular 6 of 2013 issued by the Council for Medical Schemes.

Auditor's Signature

Name of individual registered auditor

Registered Auditor

Date of auditor's report

Auditor's address

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Appendix 9 – Non-compliance matters

The legislation is correct to the date that this Guide was issued. For legislative changes after the date of issue of this Guide, refer to the website of the Council.

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 \(ISA 700 Report\)](#)); 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 minuted 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 of which at least two are members of the board of trustees and of which the majority are not officers of the medical scheme or the third party administrator, the controlling company of the administrator or any subsidiary of its

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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 it 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 adheres to the requirements of Board Notice 73 of 2004;

Managed care agreements (managed care/healthcare services and managed care management services)

- All managed care agreements adhered to the provisions imposed by Regulation 15;

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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, not later than the business day following the date of receipt of these monies, into a bank account opened in the name of the medical scheme. 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 (sections 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);

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Trustee remuneration

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

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 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 above mentioned (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;
- PMSA trust monies were separately invested from the scheme's assets in terms of the requirements imposed by the Financial Institutions (Protection of Funds) Act 28 of 2001. These monies were only invested in the instruments allowed for in Circular 38 of 2011⁷², 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), into which shall be paid every amount:

⁷² Circular 38 of 2011, *Personal Medical Savings Accounts*.

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- 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 sections 26(4), including;
 - The payment of benefits in terms of the scheme's Rules;
 - Costs incurred in the carrying on of the business as a medical scheme; and
 - Amounts invested by the board of trustees in accordance with section 35(7).
- No dividends, rebates or bonuses⁷³ were paid (section 26(5));
- In terms of the Financial Institutions (Protection of Funds) Act 28 of 2001, PMSA monies must be kept separately from scheme assets. Circular 38 of 2011⁷⁴ 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, not later than the business day following the date of receipt thereof, into a bank account opened in the name of the medical scheme.
 - 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 in 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 as well as the accounting for or disclosure thereof, as appropriate.

⁷³ This does not relate to bonuses paid to the scheme's employees in terms of employment contracts.

⁷⁴ Circular 38 of 2011, *Personal Medical Savings Accounts*.

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- 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 approval and withdrawal of benefit options, subsection (3) stipulates that the Registrar may demand from the principal officer such financial guarantees as 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 medical scheme such financial guarantees and guarantee deposits as 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) schemes 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

- PMSAs must be kept separately from scheme funds in terms of section 4(5) of the Financial Institutions (Protection of Funds) Act 28 of 2001. Interest earned on these funds must be credited to a member's individual PMSA. Circular 38 of 2011⁷⁵ also clarified that no advances may be made out of these trust 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));

⁷⁵ Circular 38 of 2011, *Personal Medical Savings Accounts*.

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- 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 enrolling in another medical scheme without a PMSA provision or selected a benefit option without a savings plan (Regulation 10(5));
- Circular 5 of 2012⁷⁶ clarified 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;
- Savings plan account facilities were not utilised to provide for benefits and co-payments relating to PMBs (Regulation 10(6));
- The scheme adhered to the minimum disclosure requirements relating to PMSA trust investments and trust liabilities imposed by Circular 5 of 2012.

Solvency

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

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.

⁷⁶ Circular 5 of 2012, *Clarification of Circular 38 of 2011 regarding personal medical savings accounts.*

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Appendix 10

Appendix 10 – Claims CAATS

The examples of claims CAATS which may be typically performed in a medical scheme environment are set out below:

CAAT name	Description
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 blank membership number	This CAAT lists all cases in which claims have been made but in which the membership number is blank. Table provides a listing of such transactions and their details, with the total amounts paid per processing date.
Claims paid to invalid membership number	This CAAT extracts all cases in which claims have been made to members whose membership number does 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 is provided that gives the details of such payments, including the termination date of members.

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CAAT name	Description
Stale claims	All claims where the claims received date is later than 4 months after 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 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 savings account	This CAAT lists PMB claims paid from the member's savings account portion which is 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.

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Appendix 11

Appendix 11 – Contribution CAATS

The examples of contribution CAATS which may be typically performed in a medical scheme environment are set out below:

CAAT name	Description
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 possible over statement of contribution income.

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Appendix 12

Appendix 12 – List of resources

Useful websites for further information:

Independent Regulatory Board for Auditor (IRBA)

<http://www.irba.co.za/index.php/regulated-industries-functions-74/98?task=view>

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

Financial Services Board (FSB)

www.fsb.co.za