

**Recommendations by the Risk Equalisation Technical  
Advisory Panel**

**to the Council for Medical Schemes**

**Accounting and Financial  
Implications of the REF for Medical  
Schemes**

**RETAP Recommendations Report No. 3 of 2005**

**Approved at RETAP Meeting: 1 February 2005**

# **Risk Equalisation Technical Advisory Panel (RETAP)**

Following the approval of the Social Health Insurance (SHI) policy by the National Department of Health, the Minister of Health appointed a Ministerial Task Team (MTT) on Social Health Insurance to support the implementation of the SHI system in South Africa over the next five years. The MTT is made up of officials from the Department of Health, the Department of Social Development and the Council for Medical Schemes. In late January 2005 Cabinet approved the implementation of the Risk Equalisation Fund (REF) and placed the responsibility for implementation of the REF with the Council for Medical Schemes.

The Risk Equalisation Technical Advisory Panel (RETAP) was established on 20 October 2004 as a consultative group used to assist in the development of technical requirements for implementation of the REF. RETAPs role flows from some of the key recommendations made by the original Formula Consultative Task Team (FCTT). In particular, the panel must focus its attention on the practical requirements for the implementation of the REF formula. Its recommendations should enable an action plan to be developed for implementing the formula, taking into account all the practical and technical issues that will arise in the implementation phase.

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# 1. Introduction

## 1.1 Purpose of the Report

RETAP is required to advise on the practical and technical issues that will arise in the implementation of the Risk Equalisation Fund (REF). It is envisaged that prior to implementation there be a shadow year of operation of the REF. During the shadow period, medical schemes are to submit data and will receive notification of the amounts that would be payable from the REF, however no money will change hands.

The purpose of the shadow period is to ensure that medical schemes and the REF Authority are able to handle the technical and administrative requirements of the full implementation of the Risk Equalisation Fund. The REF Authority is the Council for Medical Schemes during this period.

The purpose of this report is to identify the accounting and reporting issues that will need to be considered by medical schemes in managing REF Contributions and accounting for the risk equalised package (the REF Package).

During the shadow period medical schemes will be notified of what these payments would be and it is advisable for trustees to ensure that shadow accounting is implemented to evaluate the likely impact on the medical scheme of the REF. Thus this report sets out standards for reporting that should be implemented during the shadow period of operation of the REF.

RETAP delegated the preparation of this report to Malcolm Brown of SAICA. In preparing this report the team has considered *inter-alia* proposals made by the Formula Consultative Task Team (FCTT), the Subsidy Consultative Task Team (SCTT) and the International Review Panel (IRP). Their recommendations relevant to the accounting for medical schemes were as follows:

### **FCTT Report Section 15.4 Liaison with Council for Medical Schemes, page 138:**

This report proposes that the Risk Equalisation Fund make use of the existing channels for data and communication with schemes that are well-established by the Council for Medical Schemes through the Office of the Registrar of Medical Schemes. If this principle is adopted, then collaboration with the Office will be the single most important element in bringing the REF to fruition.

Areas that require collaboration between the Council for Medical Schemes and the Risk Equalisation Fund include:

- Data definition for the quarterly and annual returns to the Registrar and for the REF Grid.
- The gathering and passing over of data for the REF processes.
- ...
- The amendment to scheme financial accounts to account for REF payments.
- The amendment to the solvency calculation for medical schemes to account for REF payments.
- The impact of the REF on options design and the monitoring of financial soundness of options.
- ...

The REF/REFTG needs to undertake the task of liaison with the Council for Medical Schemes on these issues.

**IRP Report Executive Summary, page 13:**

The C-M-S, together with the industry and the South African Institute of Chartered Accountants should elaborate a 'best practice' standard for reporting REF payments in the accounts of the schemes.

Consultations were held with the Council for Medical Schemes regarding their initial view on statutory return requirements regarding the REF Benefit Package (effectively PMB benefits) and option reporting.

SAICA technical department is aware of the future requirement for the audit of REF data but has not as yet been requested to comment on the document.

The document was discussed, amended and adopted by a meeting of RETAP on 1 February 2005. This report is thus the formal recommendations from RETAP from RETAP to the Council for Medical Schemes which is responsible for the implementation of the REF. The Council for Medical Schemes will need to satisfy itself as to the appropriateness of the recommendations.

This document was prepared as a discussion document and further recommendations are made at the end of Section 8 as to the process that should be followed to review and distribute this document.

## 2. Flow of Funds to Medical Schemes

### 2.1 Structure before REF

The diagram below indicates the flow of funds to medical schemes before the introduction of a Risk Equalisation Fund.

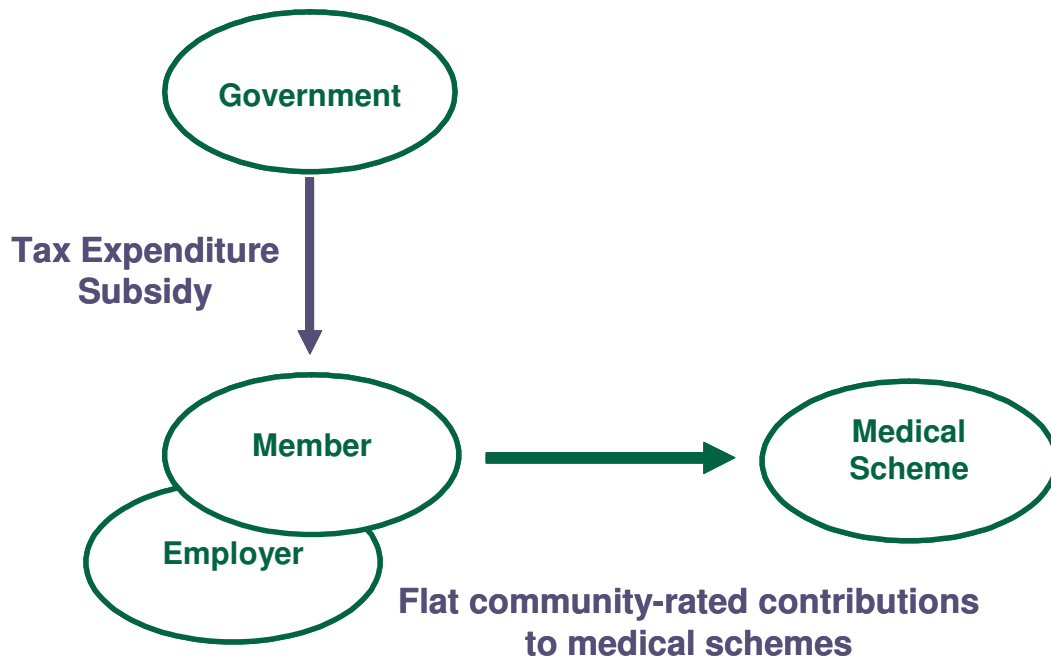


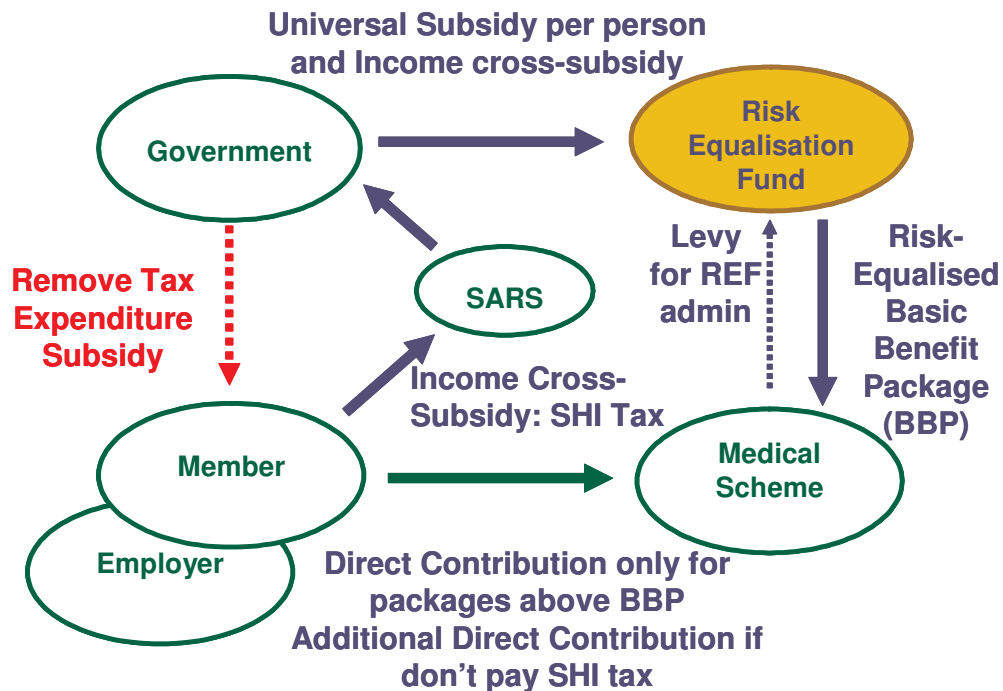
Figure 1: Flow of Funds to Medical Schemes Prior to Risk Equalisation and Before Tax Expenditure Subsidy Reform

### 2.2 Structure in the Full SHI Framework

In January 2004 the Minister of Health stated there were three issues on the unfinished reform agenda toward implementing Social Health Insurance:

- Risk-related cross-subsidies;
- Income-related cross-subsidies; and
- Mandatory cover.

The diagram below shows the possible structure of the full SHI framework incorporating both risk-based and income-based cross-subsidies.



**Figure 2: Flow of Funds to Medical Schemes under Social Health Insurance**

Note that while the full SHI framework is the policy of the Department of Health, as of 31 January 2005 it is not yet policy of the Government. The intention to implement income-based cross-subsidies in the medical schemes environment was part of the ANC Health Plan of 1994 and has been confirmed by several subsequent commissions of inquiry. In January 2005 Cabinet approved the implementation of the REF by the Council for Medical Schemes. However the full SHI framework with the income-cross-subsidies is still subject to approval by Cabinet.

The FCTT Report on the formula for risk-based cross-subsidies was developed independently of the income-cross subsidy reform but commented on the issue as given verbatim below.

**FCTT Report Section 15.6: Proceeding Independently of Subsidy Reform, page 139**

This report has showed that there is an overwhelming need for risk equalisation. To delay the implementation of the REF in order to finalise the more difficult subsidy reform would be fool-hardy.

The main impact of subsidy reform is on the revenue to be received by the REF and thus on the magnitude of the payments to and from the REF. The initial modelling work has shown the operation of the REF in the absence of subsidy reform. Any contribution subsidy will reduce the necessity for payments by schemes to the REF which can only make the operation of the Fund more simple.

The Formula Consultative Task Team strongly urges the Department of Health to process with the implementation of the Risk Equalisation Fund as soon as possible, independent of the outcome of the discussions on subsidy issues.

## 2.3 Advice of the International Review Panel

The IRP made substantial recommendations in regard to the flow of funds. They identified two modalities of flow for the REF and argued strongly for Modality 1 in order to prepare the ground for Social Health Insurance.

### **IRP Report Executive Summary: Flow of funds, page 8**

Two different options for the flow of funds into- and out of the REF are described in the preparatory reports: (i) Modality 1, under which the REF receives a contribution from beneficiaries, and pays the medical schemes. Under this modality, the medical schemes collect directly from their beneficiaries an additional contribution for components of benefits which are not equalized through the REF (for ease of reference we call these components 'PMB+'); and (ii) Modality 2, under which the REF received its income from the medical schemes, and pays out to the medical schemes. There is no direct contribution of the consumer to the REF. Under modality 2, it has been proposed to add a government subsidy through injection of funds into the REF.

The Panel observes that, with the exception of the government subsidy, the payments to and from each of the actors are essentially identical in both modalities. The differences are only in the flow of funds, yet the Panel identified significant advantages to modality 1. For one, the government wishes to move toward implementation of SHI. Therefore, the flow of funds determined now should be compatible with the implementation of SHI, without having to reform the operation of the REF later on. One of the desirable components of SHI is income rating. Even if this cannot be implemented now, such a measure could be implemented in the future only if reliable income data is available. Under modality 1, it is in the interest of the government to mandate the SARS to collect the REF contribution. SARS is better positioned than any other government agency to implement mandatory payment of contributions, and to apply income rating, when these measures are decided upon (SARS is the only agency that collects income data). Under modality 2, when consumers pay to the medical scheme both a community-rate for PMB and the contribution for PMB+, they are unable to distinguish between the cost of PMB and the added cost of PMB+. This situation of lesser transparency is currently the standard, and it can be remedied without any cost to beneficiaries, the schemes or the government, by choosing modality 1 for the flow of funds.

**IRP Report Section 2.5: REF related flow of funds, page 22**

Table 1 provides a compilation of the differences between modality 1 and modality 2. As can be seen, the indirect implications are quite far-reaching. The Panel considers modality 1 to be more compatible with the introduction, in the future, of mandatory membership in medical schemes and of the more progressive income-rating of the contribution.

Table 1: Comparison between the Flow of Funds under Modality 1 and Modality 2

Item:	Modality 1	Modality 2
Payment of the industry (national) community-rate for PMB (REF PMB)	Payable by consumers to the REF	Payable by consumer to the chosen medical scheme; the medical scheme then has to pay to the REF
Payment of the contribution for the benefits over and above the PMB (PMB+), plus/minus the difference between the REF PMB and the scheme-specific PMB-expenses.	Payable by consumers to the chosen medical scheme (Identical for both modalities)	
Payment from REF to the medical schemes	Equal to the ex-ante amount calculated on the basis of the national REF PMB, and payable to medical schemes according to their specific risk profile, as per the REF Contribution Table (Identical for both modalities)	
Net payments from REF to medical schemes	All medical schemes receive net payments according to the formula described above.	A medical scheme with an above-average risk profile on balance receives an amount out of the REF, while a medical scheme with a below-average risk profile will only pay the REF
“Winner-loser” nexus	All medical schemes receive payments from the REF; it is easy to explain the fairness of the system whereby schemes receive a low payment for a low-risk consumer and a high payment for a high-risk consumer.	Medical schemes may have the perception of being “winners” or “losers”, depending on whether the net balance of their payments into- and out of the REF is positive (zero or) negative. This “winner-loser” image might not be beneficial for the acceptance of the REF.
Mandatory payments to REF to prevent adverse selection	Easily implemented, a government agency is responsible for collection from all persons	More difficult to implement because medical schemes will collect only from their members

Item:	Modality 1	Modality 2
Implementing income-rating (as part of SHI)	Consumers' contribution can be income-based if collected through the SARS (the only agency entitled to obtain full income information). Income related cross-subsidies are reflected in consumers' payments into the REF.	It is not possible to calculate consumers' income-related payments because medical schemes do not know the consumers' income.
Volumes that flow through REF	The actual amount flowing into and out of the REF will be large, reflecting the full risk adjustment across the entire industry.	The actual payments are dependent on the risk profiles of the medical schemes. For example, when some schemes cover only above average-risk consumers and other schemes cover only below average-risk consumers, the flow of funds will be very large. But if all medical schemes have the same risk profile (as far as the REF-risk factors are concerned) net payments between the REF and the medical schemes will be zero.

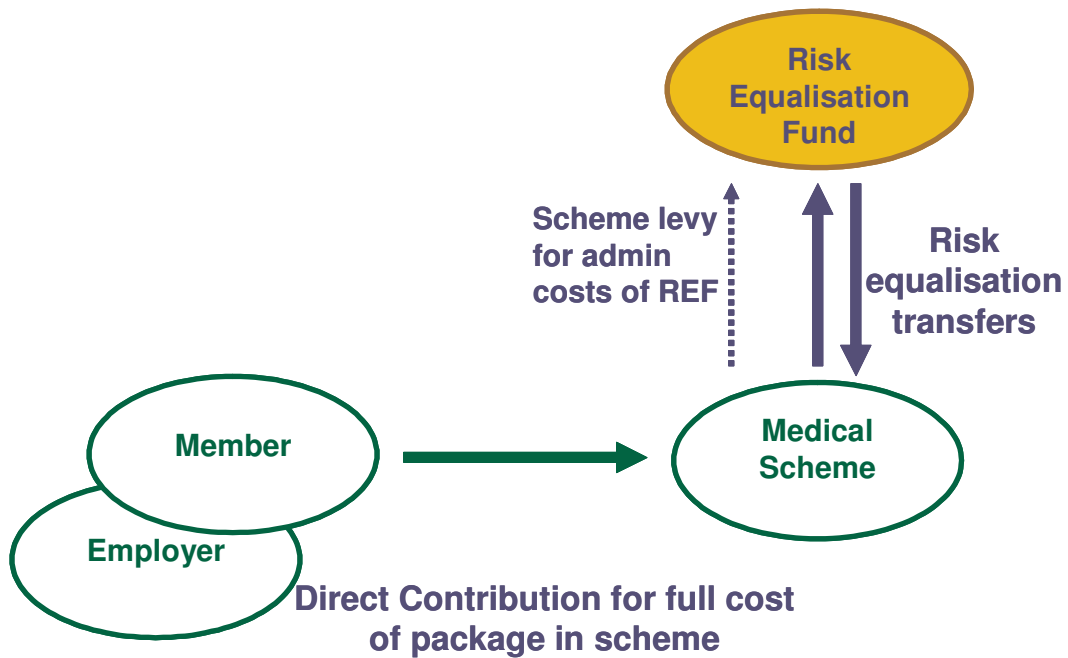
**Recommendation 5:**

Based on the differences discussed above, the Panel recommends that modality 1 be retained for the flow of funds into- and out of the REF from inception.

## 2.4 Structure in the Initial Shadow Period

As the full SHI framework (Modality 1 of the IRP) is not yet Government policy, it is necessary to proceed during the shadow period with the more restricted version of the REF, as shown in the diagram below. It is however strongly recommended by the Department of Health that the full framework for SHI be implemented and this may well occur prior to the live implementation of the REF.

The accounting and reporting issues discussed in this report pertain to the form of the Risk Equalisation Fund prior to the implementation of the full Social Health Insurance framework. In other words, no universal subsidy or income-based cross subsidy is received by the REF. Instead, the REF operates purely between medical schemes as shown below.



**Figure 3: Flow of Funds to Medical Schemes in the Initial Shadow Period of Operation of the REF**

The report is based on the supposition that REF Contributions will be received by medical schemes from the REF based on the REF Contribution Table. The REF will receive funds from the medical schemes based on the Industry REF Community Rate, as published in the REF Contribution Table.

The funds required by the REF regarding its costs of administration and solvency margin is assumed to be in the form of an REF Levy payable by the medical schemes to the REF.

In the event that the full framework for SHI is adopted, RETAP recommends that this document be amended accordingly.

## **3. Impact of REF on Income and Expenditure**

### **3.1 Medical Scheme Income**

Medical schemes will under the REF structure receive income as follows:

1. REF Contributions received directly from the REF in respect of the PMB Benefit Package. The REF Contributions will be determined according to the REF Contribution Table and the beneficiary profile of the particular medical scheme.
2. Direct contributions from members in respect of the particular option to which the member has elected to belong. These contributions will cover all medical scheme costs including taking into account the payments to and from the REF.
3. Direct contributions into member savings accounts. These savings are held on behalf of members to meet member health care services paid by the scheme which are not included in the Prescribed Minimum Benefits (PMB) for the option to which the member belongs.
4. Investment income.

### **3.2 Medical Scheme Expenditure**

Under the REF structure medical schemes will incur expenditure as follows:

1. Purchase of health care services from health care providers.
2. Payment of provider accounts on behalf of members from the member savings account balances.
3. Payments to the REF based on the Industry REF Community Rate per beneficiary.
4. Council for Medical Schemes levy.
5. The REF Levy. This could be incorporated with the levy payable to the Council for Medical Schemes as it has the same per beneficiary format for calculation. The decision on whether to have one or two levies depends on the governing legislation.
6. Administration costs.
7. Broker fees.
8. Managed health care costs: management services. (for administration of managed care. Capitation and other health care provision costs are included in purchase of health care services)
9. BHF or other industry membership fees..
10. Bad Debts.

11. Investment losses.
12. Contribution to Reserves. (will need to be included in the calculation of the member contribution rates)

### 3.3 Determination of the Direct Contribution Rate

The following example explains how medical schemes will determine the sum to be paid by beneficiaries for the purchase of PMB Benefits:

Step to be taken	Medical Scheme A	Medical Scheme B
Actuarial valuation of the cost of providing PMB benefits based on history and projections per beneficiary	R200	R400
Payment to REF at Industry REF Community Rate per beneficiary	R150	R150
REF Contributions per beneficiary as calculated for the PMB Benefit package	-R50	-R250
Direct contribution per beneficiary per month to meet PMB benefits.	R300	R300

Note1 that figures are inserted for demonstration purposes only and do not represent any proposed REF rates

Note 2 that this example relates to the provision of PMB benefits only..

Note 3 that medical schemes will need to charge for non-healthcare costs and the build-up of solvency margins as part of their direct contribution rate. To the extent that a medical scheme is operating below the REF efficiency, it will need to raise the additional amount to cover the PMB benefit package in the form of higher direct contributions from its members.

### 3.4 Allocation of Income to Meet Expenditure

The following table indicates the allocation of medical scheme income to meet the medical scheme expenditure.

Expenditure item	REF Contributions	Direct member contributions	Savings	Investment income
REF payment at Industry REF Community Rate per beneficiary		*****		
PMB Benefit Package benefits	*****	**** to the extent that the scheme is operating below the REF efficiency, it will need to raise the additional amount to cover the PMB Benefit Package.		
Non PMB Benefit Package benefits		*****		
MSA payments			*****	
CMS Levy		*****		
REF Levy		*****		
Administration		*****		
Broker fees		*****		
Managed health care: management services		*****		
BHF and industry fees		*****		
Bad Debts	*****	*****		
Investment income and losses				*****
Contribution to reserves	***** (If Industry REF Community Rate exceeds or is less than PMB benefits there is a transfer to or from Reserves)	*****		*****

Each scheme will have a formula which is consistently applied to allocate the administration costs, broker fees, managed care costs, bad debts incurred and levies paid to the approved options. The formula may be according to beneficiary numbers, or percentage of contributions received, or benefits paid, or a combination of these according to the scheme's context. (In practice many of the costs are contracted on a per member per month basis such as admin fees, managed care fees and broker fees. The smaller costs of stationery, trustee fees, actuary fees and audit fees would be apportioned on a reasonable basis.)

## **4. Impact of REF on Management Reports**

Understanding the beneficiary profiles and claims profiles are fundamental to budgetary and scheme management processes. Medical scheme management therefore specify that the scheme administration systems provide benefits paid information by beneficiary and by option. This is used by management in determining the contribution rates and measuring claims expenditure against expectations for beneficiary category and for each option.

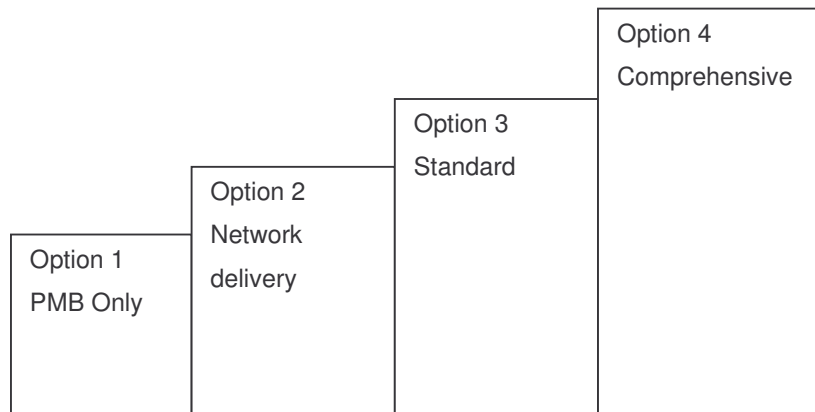
### **4.1 Management Reporting of PMBs**

The introduction of the concept of the REF equalised package, i.e. the PMB Benefit Package, may result in schemes splitting all benefit payments for which the scheme is responsible between PMB Benefit Package benefits and non- PMB Benefit Package benefits by option.

Prescribed Minimum Benefits have been in legislation since the Medical Schemes Act, No. 131 of 1998, and were implemented with effect from 1 January 2000. Whilst it has been a management decision as to whether to measure PMB costs against budget in the past it is now recommended that schemes prepare separate income statements in the future to facilitate best business practices. These practices will include, inter-alia, performance measurement, contribution determination, DSP negotiations and representations to the REF regarding REF contribution rates.

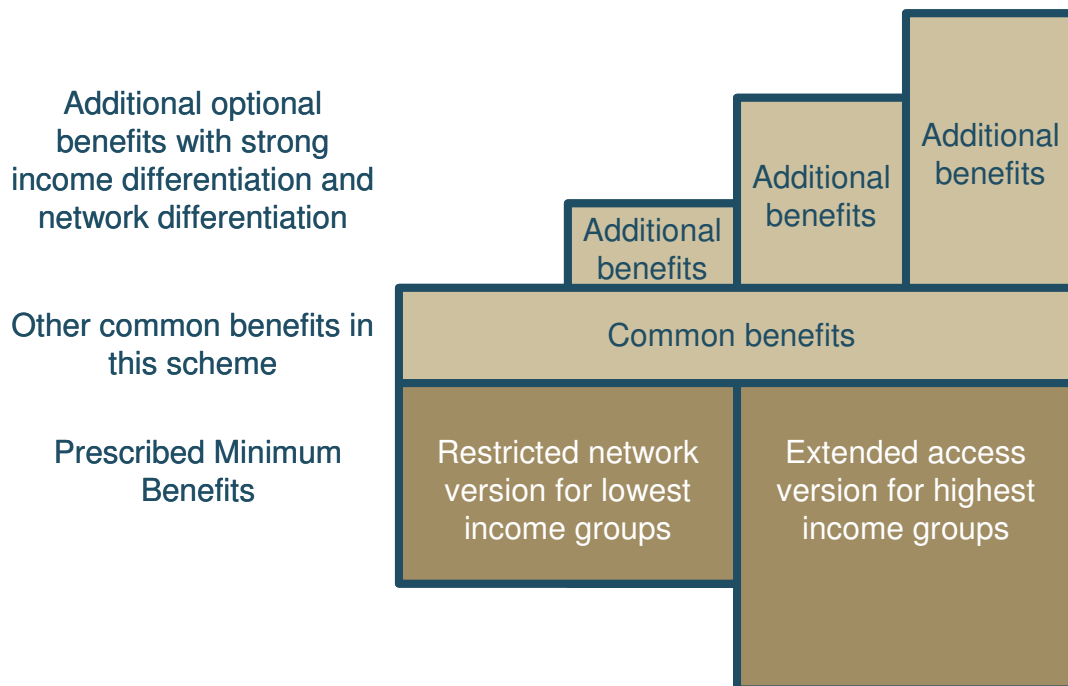
### **4.2 Legislated Option Structures**

Medical scheme options are under discussion. Currently each option must be financially sound in terms of the Medical Schemes Act, meaning that each option is in effect a “silo”. The member will elect their preferred option and contributions and benefits will be as specified for that option. The current option structure is for example:



**Figure 4: Example of Current Option Design**

Alternate option structures have been under discussion for some time in various industry forums. For example, there appears to be emerging consensus, as reported in the FCTT Report, that under the REF there be a PMB pool across all options. The diagram below is a possibility for the structuring of options in future that has been discussed in the Financial Soundness Focus Group and the FCTT with industry stakeholders.



**Figure 5: Emerging Consensus for Option Design**  
 Source: Financial Soundness Focus Group of the Council for Medical Schemes

Historically only one reserve was maintained by medical schemes. The introduction of an options structure such as the one above will provide an opportunity to require schemes to keep an earmarked reserve for REF funding. This could be applied only to the purchase of the REF equalised package or to other defined purposes. RETAP recommends that this form part of the reassessment of options structures by the Council for Medical Schemes.

However for the purposes of this report to the COUNCIL FOR MEDICAL SCHEMES we need to work within the existing legislative framework of “silo” options. Should there be a change to the Medical Schemes Act and Regulations in this regard, then RETAP recommends that these accounting recommendations be revisited. See also the discussion in Section 5.1.

### 4.3 Management Reporting by Option

Medical scheme management currently prepares separate income statements for each option. Systems are designed so that all entries pertaining to a particular beneficiary are allocated to the option to which the member has elected to belong.

RETAP recommends that each claim paid be sorted according to ICD-10 and CPT-4 codes and allocated between PMB Benefit Package benefits and non- PMB Benefit Package benefits within each option.

The REF Contributions and member contributions would be allocated to options according to a predetermined formula based on the factors used in arriving at the contribution tables.

Assuming the current option structure the following income statements by option component would be prepared for management purposes. The sources of the information are indicated in the income statement “blocks”. (Note that a split has been made between PMB benefits for which REF contributions are received from non PMB benefits for each option. This is to demonstrate reporting where scheme elects to measure the 2 components for each option)

<b>Income Statement Item</b>	<b>Option 1 PMB benefits</b>	<b>Option 1 Non-PMB benefits</b>	<b>Option 2 PMB benefits</b>	<b>Option 2 Non-PMB benefits</b>	<b>Option 3 PMB benefits</b>	<b>Option 3 Non-PMB benefits</b>
Direct member contributions	Contributions received for persons who elected this option	Contributions received for persons who elected this option	Contributions received for persons who elected this option	Contributions received for persons who elected this option	Contributions received for persons who elected this option	Contributions received for persons who elected this option
Savings contributions		Portion of contributions allocated to this option		Portion of contributions allocated to this option		Portion of contributions allocated to this option

<b>Income Statement Item</b>	<b>Option 1 PMB benefits</b>	<b>Option 1 Non-PMB benefits</b>	<b>Option 2 PMB benefits</b>	<b>Option 2 Non-PMB benefits</b>	<b>Option 3 PMB benefits</b>	<b>Option 3 Non-PMB benefits</b>
Less Savings contributions		Portion of contributions allocated to savings in this option		Portion of contributions allocated to savings in this option		Portion of contributions allocated to savings in this option
Direct Contributions net of savings	Sum of the above	Sum of the above	Sum of the above	Sum of the above	Sum of the above	Sum of the above
REF Contributions	REF Contributions received for persons who elected this option		REF Contributions received for persons who elected this option		REF Contributions received for persons who elected this option	
Less payments to REF	Industry REF Community Rate per beneficiary		Industry REF Community Rate per beneficiary		Industry REF Community Rate per beneficiary	
Transfer of amount raised as part of the direct contribution from members to meet PMB benefit costs that are estimated to be in excess of Industry REF Community rate received by schemes	Transfer in as allocated in calculation of direct member contribution	Transfer out as allocated in calculation of direct member contribution	Transfer in as allocated in calculation of direct member contribution	Transfer out as allocated in calculation of direct member contribution	Transfer in as allocated in calculation of direct member contribution	Transfer out as allocated in calculation of direct member contribution
Net Contributions	Net contributions to meet scheme risks	Net contributions to meet scheme risks	Net contributions to meet scheme risks	Net contributions to meet scheme risks	Net contributions to meet scheme risks	Net contributions to meet scheme risks
Net Claims Incurred (net of co-payments payable by members from savings or otherwise as per the rules)	PMB Claims incurred by beneficiaries electing this option	Non-PMB Claims incurred by beneficiaries electing this option	PMB Claims incurred by beneficiaries electing this option	Non-PMB Claims incurred by beneficiaries electing this option	PMB Claims incurred by beneficiaries electing this option	Non-PMB Claims incurred by beneficiaries electing this option
Gross Underwriting Surplus	Contributions less claims	Contributions less claims	Contributions less claims	Contributions less claims	Contributions less claims	Contributions less claims
Administration expenses	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula
Brokers fees	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula
Managed care: management services	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula	Allocation according to formula

<b>Income Statement Item</b>	<b>Option 1 PMB benefits</b>	<b>Option 1 Non-PMB benefits</b>	<b>Option 2 PMB benefits</b>	<b>Option 2 Non-PMB benefits</b>	<b>Option 3 PMB benefits</b>	<b>Option 3 Non-PMB benefits</b>
Net underwriting surplus	_____ Gross underwriting less direct costs	_____ Gross underwriting less direct costs	_____ Gross underwriting less direct costs	_____ Gross underwriting less direct costs	_____ Gross underwriting less direct costs	_____ Gross underwriting less direct costs
Bad debts	Actual bad debts incurred plus provision for bad debts allocated to this option	Actual bad debts incurred plus provision for bad debts allocated to this option	Actual bad debts incurred plus provision for bad debts allocated to this option	Actual bad debts incurred plus provision for bad debts allocated to this option	Actual bad debts incurred plus provision for bad debts allocated to this option	Actual bad debts incurred plus provision for bad debts allocated to this option
Surplus from operations	_____ Net underwriting surplus less bad debts	_____ Net underwriting surplus less bad debts	_____ Net underwriting surplus less bad debts	_____ Net underwriting surplus less bad debts	_____ Net underwriting surplus less bad debts	_____ Net underwriting surplus less bad debts
Investment income	Actual investment income allocated to this option	Actual investment income allocated to this option	Actual investment income allocated to this option	Actual investment income allocated to this option	Actual investment income allocated to this option	Actual investment income allocated to this option
Net realized and unrealized investment gains	Actual movement in value of assets sold and/or revalued allocated to this option	Actual movement in value of assets sold and/or revalued allocated to this option	Actual movement in value of assets sold and/or revalued allocated to this option	Actual movement in value of assets sold and/or revalued allocated to this option	Actual movement in value of assets sold and/or revalued allocated to this option	Actual movement in value of assets sold and/or revalued allocated to this option
Net surplus Transferred to reserves	_____ Surplus from operations plus investment income =====	_____ Surplus from operations plus investment income =====	_____ Surplus from operations plus investment income =====	_____ Surplus from operations plus investment income =====	_____ Surplus from operations plus investment income =====	_____ Surplus from operations plus investment income =====

Note that the individual schemes may not elect to allocate investment income and profits on sale or revaluation of investments to the option accounts but treat these transactions as scheme transactions i.e. the “option” income statements stop at the “Surplus from operations” line. This counters the criticism as to whether these items can effectively be allocated between the options as in the example.

## 4.4 Example of a Management Report

Based on Section 4.3 the following is an example of a management report:

(Note that a split has been made between PMB benefits for which REF contributions are received from non PMB benefits for each option. This is to demonstrate reporting where scheme elects to measure the 2 components for each option)

Income Statement Item	Option 1 PMB benefits	Option 1 Non-PMB benefits	Option 2 PMB benefits	Option 2 Non-PMB benefits	Option 3 PMB benefits	Option 3 Non-PMB benefits
Direct member contributions	R900	R600	R900	R700	R900	R800
Savings contributions		R00		R225		R225
Less Savings contributions		R00		-R225		-R225
Direct Contributions net of savings	<u>R900</u>	<u>R600</u>	<u>R900</u>	<u>R700</u>	<u>R900</u>	<u>R800</u>
REF Contributions	R50		R250		R250	
Less payments to REF for equalization of PMB benefits	-R150		-R150		-R150	
Transfer of any amount to meet PMB benefit costs in excess of Industry REF Community rate	R00	R00	R00	R00	R50	-R50
Net Contributions	<u>R800</u>	<u>R600</u>	<u>R1000e</u>	<u>R700</u>	<u>R1050</u>	<u>R750</u>
Net Claims Incurred	R740	R350	R940	R450	R970	R500
Gross Underwriting Surplus	<u>R60</u>	<u>R250</u>	<u>R60</u>	<u>R250</u>	<u>R80</u>	<u>R250</u>
Administration expenses	R00	R150	R00	R160	R00	R170
Brokers fees	R00	R45	R00	R48	R00	R51
Managed care: management services	R60	R50	R60	R50	R60	R50
Net underwriting surplus	<u>R00</u>	<u>R5</u>	<u>R00</u>	<u>-R8</u>	<u>R20</u>	<u>-R21</u>

Income Statement Item	Option 1 PMB benefits	Option 1 Non-PMB benefits	Option 2 PMB benefits	Option 2 Non-PMB benefits	Option 3 PMB benefits	Option 3 Non-PMB benefits
Bad debts	R00	R4	R00	R5	R4	R5
Surplus from operations	R00	R1	R00	-R13	R16	-R26
Investment income	R00	R5	R00	R8	R00	R12
Net realized and unrealized investment gains	R00	R2	R00	R10	R00	R12
Net surplus	R00	R8	R00	R5	R16	-R2
Transferred to reserves	=====	=====	=====	=====	=====	=====

## 4.5 Purpose of Management Reports

Currently medical scheme management reports are prepared to include income statements for each option and for the scheme as a whole. This is also required for CMS statutory returns. Management needs to measure the performance of each option to follow trends and make decisions resulting from those trends. These decisions relate to cost control and contribution determination.

The introduction of REF and the PMB Benefit Package does not change the position in any way and the monthly, quarterly and annual reports will still need to be prepared by option. In order to manage the PMB risk the scheme management will require information regarding REF income and PMB expenditure be split from non-PMB income and non-PMB expenditure for each option. Thus we can expect the management reports to not only measure performance by option but also to measure PMB performance to determine whether the beneficiary claims profile differs materially from the REF profile. Importantly, the format should allow for the efficiency of healthcare delivery in the scheme to be compared to the efficiency assumed in the REF Contributions.

Effective management decision making is important as any shortfall will need to be recovered by way of direct contributions. For open schemes this will impact on their competitive position.

## 4.6 Solvency Calculation

This report clarifies the accounting treatment of the REF payments. It might initially seem that solvency could be calculated from these elements in a straight-forward manner, taking into account the REF payments to schemes as an additional source of contributions..

However there are philosophical issues which need to be addressed by the Ministerial Task Team. The question of the degree of solidarity and the degree of equalisation of the price of the PMB package for all beneficiaries need to be clarified. For example, if the equalised end price to the consumer is to include the contribution for the solvency margin, then a different treatment of the REF payments for solvency purposes needs to be adopted. This is the subject of a separate report and set of recommendations from RETAP..

## 5. Reports to Council for Medical Schemes

### 5.1 Reporting to the Council for Medical Schemes

The following are principles which need to be considered in the discussion:

- The CMS statutory return requires financial information by option.
- The REF would require financial information for PMB expenditure.
- The CMS statutory return and the REF returns would need to be reconciled.
- Therefore the information to be maintained by the schemes must be able to meet these requirements.

Section 33 of the Act regarding financial soundness by option would still have to be complied with. The definition of PMB benefits and non-PMB benefits would need to be clear. The expected improvement in the ability of medical schemes to identify PMBs is explored in Section 5.2 below.

Cross subsidisation of one option by another is inevitable, even though not planned or budgeted. The regulator will examine the cross subsidisation that occurs within a scheme to ensure that any such subsidisation takes place from the non-PMB portion of any option to the PMB portion of the option.

This underscores the point that we need to think carefully about the future structure of options – does it make more sense to have a single PMB pool across all options or a PMB pool per option? There are positives and negatives for both. In considering this issue we need to consider whether in principle it will be permitted for schemes to have different benefit provision criteria for the different options e.g. public hospitals in one option and private hospitals in another option or capitated primary care in one option and member selection of a GP in another option.

It is attractive to have one PMB pool per scheme because this ensures that PMBs are fully community-rated. If PMBs are equalized between schemes and we allow a PMB pool per option, then community-rating breaks down at option level – some people will pay more or less for PMBs because the option they join has certain characteristics. However, one single pool for PMBs has a negative effect in that the lowest claiming members (the lowest income options with currently predominantly African/Black members) will pay more for PMBs than before. We need to carefully work through the consequences of this on affordability. Once the full SHI framework is in place, this problem is lessened. RETAP recommends a separate report on the consequences of possible future option structures.

There will need to be a mechanism to cross reference the CMS statutory returns with the REF returns to ensure consistency in reporting by the regulatory authorities. However as the REF Authority will be the Council for Medical Schemes in the initial period, the harmonisation of reporting will be simplified.

RETAP recommends that wherever possible the statutory returns to the Registrar of Medical Schemes be used in order to reduce the burden on data submission. Where the REF Authority needs similar information but perhaps with a different definition, the desired outcome will be to harmonise the statutory returns with the REF returns. A good example of this is the age profile of medical scheme beneficiaries. REF has a need for a particular definition and age band structure which is driven from risk considerations. The statutory returns age profile is used for information and research. In this instance it would be preferable for the statutory return to draw from the REF age profile data.

## **5.2 Improved Definition of PMBs**

In the second half of 2004 the Council for Medical Schemes rapidly published a series of draft cross-walks of ICD-10 codes for each chapter of the PMB-DTPs. Industry feedback was requested and the finalised list of ICD-10 codes was released as a 132 page document on 30 December 2004. The Council for Medical Schemes website cautions:

These codes serve as guidelines to interpretation of the prescribed minimum benefits set out in Annexure A of the General Regulations, made in terms of the Medical Schemes Act, 131 of 1998. These guidelines, however, have no legal status. Accordingly, if there is a conflict of interpretation between these guidelines and the definition of conditions set out in Annexure A to the regulations, the definition of conditions contained in the regulations will prevail.

Circular 58 of 2004, dated 17 December 2004, from the Registrar of Medical Schemes states:

The process of coding of PMB has been completed... The coded PMB will serve as a guideline during the first half of 2005. During this time any additional comments, with motivations will be considered.

The Council for Medical Schemes has worked extensively with the Department of Health, industry stakeholders and healthcare providers in particular on the issue of a common diagnosis code. Late in 2004 this process was brought to fruition with the announcement that ICD-10 codes would begin to be compulsorily implemented from January 2005.

Circular 58 of 2004, dated 17 December 2004, from the Registrar of Medical Schemes states:

The implementation of ICD-10 in the medical scheme environment takes effect on 1 January 2005. All health service providers are encouraged to begin submission of ICD-10 diagnosis codes in their accounts for administrative and statistical purposes.

The implementation process will entail a phase-in period of 6 months, to allow stakeholders to finalise their preparations for the implementation of ICD-10. During this period, no outright rejection of accounts without ICD-10 codes will be permitted. However regular monthly meetings will be held in order to monitor and review the implementation process.

Submission of ICD-10 codes will be compulsory from 1 July 2005. All health service providers will be required to include ICD-10 codes in their accounts to medical schemes in compliance with legislation. Any claim that is submitted without ICD-10 codes will be liable for rejection from 1 July 2005.

There can thus be expected to be a substantial improvement during 2005 in the ability of medical schemes to differentiate between PMB and non-PMB benefits.

### **5.3 Data for Submission to the REF Authority**

REF audited returns will set out the number of beneficiaries in each cell of the REF Grid. This will mean that the systems will need to classify each beneficiary according to age, most expensive chronic condition according to the REF Contribution Table, number of chronic conditions, whether registered for HIV/AIDS treatment and whether a child was born during the reporting period.

The systems will need to support the demands of the auditor to confirm the classification of each beneficiary. This will mean a review of the system to ensure that accurate information is retained at all times, controls would be sufficient to prevent manipulation of data, birth dates are confirmed, HIV/AIDS and chronic disease classifications are supported by clinical evidence, births are confirmed, the system correctly allocates beneficiary with multiple chronic conditions to the most expensive chronic condition and the count of multiple chronic conditions is accurate.

The systems will need to allocate all income and expenditure items into the correct income or expenditure account so that management will be in a position to accurately extract management reports, statutory returns and financial statements and the auditors will receive adequate audit evidence in carrying out their responsibilities.

Suppliers of health care services will be required to classify/code each claim submitted to the medical scheme so that the medical scheme system will be able to allocate each claim to the correct accounts in the system. For example each claim will reflect patient name, patient membership number, ICD-10 code and/or NAPPI code, chronic condition and CPT-4 procedure followed.

Registration of chronic conditions is not compulsory but many medical schemes require registration to facilitate beneficiary disease management as well as cost management. This process may have to be extended by the medical schemes to manage the reporting requirements of the REF Authority, CMS and scheme management.

## 6. Accounting Process for REF Transactions

Medical schemes will be:

1. accounting and reporting internally on a monthly basis
2. submitting the statutory return to the CMS on a quarterly basis
3. reporting to the REF regulator on a quarterly basis (to be confirmed)
4. paying the Industry REF Community Rate on a quarterly basis – possibly 8-10 weeks after the quarter end (4 weeks to submit the return, 4 weeks for REF to check the return and 2 weeks for the REF to communicate with the scheme and to receive payment) (timing to be confirmed )
5. receiving the REF Contribution on a quarterly basis – possibly 10-12 weeks after the quarter end (timing to be confirmed )
6. providing for the REF Community Rate and the REF Contribution on a monthly basis
7. making adjustments to the accounting records on confirmation of the REF Community Rate and the REF Contribution
8. recording the adjustments in the next internal monthly management report
9. recording the adjustments in the next CMS quarterly statutory return

The following are the journal entries in the books of the medical scheme for REF entries:

(Note these entries are as though there is 1 beneficiary per option for illustrative purposes)

Description	Debit R	Credit R
Members	5250.00	
Members Option 1	R1500	
Members Option 2	R1825	
Members Option 3	R1925	
To Income accounts:		
Option 1 PMB contributions		900.00
Option 1 non-PMB contributions		600.00
Option 2 PMB contributions		900.00
Option 2 non-PMB contributions		700.00
Option 2 Member savings accounts		225.00
Option 3 PMB contributions		900.00
Option 3 non-PMB contributions		800.00
Option 3 Member savings accounts		225.00
Being raising of contributions payable by members for the month of.!!! (This entry is based on actual recorded membership as at the date of the entry and will be adjusted by way of adjusting entries as and when membership lists for the month are corrected by way of terminations and additions)		

Description	Debit R	Credit R
Expense account - Industry REF Community Rate Option 1 Option 2 Option 3 To REF provision - Industry REF Community Rate Being provision for Industry REF Community Rate for the month of !!!! based on number of beneficiaries	150.00 150.00 150.00	450.00
REF provision– REF Contribution To Income Account - REF Contribution Option 1 Option 2 Option 3 Being provision for REF Contributions for the month of !!!! based on the estimated beneficiary numbers for the REF Contribution table.	550.00	50.00 250.00 250.00
Transfer account non PMB contributions Option 3 To Transfer acct PMB contributions Option 3 Being transfer of allocated non-PMB contribution to PMB contribution for the month of !!!! based on the number of beneficiaries	50.00	50.00
REF provision - Industry REF Community To Expense account - Industry REF Community Rate Option 1 Option 2 Option 3 Being reversal of provision for Industry REF Community Rate for the month of !!!! (Full amount reversed and actual amount raised in next journal entry)	450.00	150.00 150.00 150.00
Expense account Industry REF Community Rate Option 1 Option 2 Option 3 TO REF creditor- Industry REF Community Rate Being raising of creditor for sum due to REF for- Industry REF Community Rate for month of !!! (based on actual approved rate per REF communication)	150.00 150.00 150.00	450.00



## 7. Impact of REF on Auditing of Medical Schemes

The International Review Panel and the FCTT made initial recommendations with regard to the auditing of data sent to the REF Authority.

### **IRP Report Section 2.16.3.1 Auditing of transactions between medical schemes and the REF, page 40:**

**Recommendation 35:** The existing external auditors of medical schemes should carry out the auditing requirements for REF. However, the C-M-S should be empowered to validate the audit, including requesting additional information. Because the audited returns will determine the amount that each scheme is entitled to from REF, the Panel suggests that the margin of materiality for audit of the REF payments should be lower than that fixed for general financial audit (e.g. a materiality level of 1%, compared to the traditional level of 10% applies to financial audits). The Council should consult the industry and the Auditor's trade association on the level of materiality to be determined.

### **FCTT Report Section 15.3 Liaison with SAICA on Audit of REF Grid Data, page 137:**

No formal discussion has yet taken place with the South Africa Institute of Chartered Accountants (SAICA). The following principles are suggested by the Formula Consultative Task Team:

- All data forwarded to the REF will be subject to an annual audit.
- This will form part of the annual audit of the medical scheme.
- SAICA will need to draft guidelines to assist the auditors with the process of auditing the clinical and demographic data forwarded to the REF.

The REF/REFTG needs to undertake the task of liaison with SAICA on this issue.

With regard to the IRP recommendation 35, in South Africa the external auditor decides on materiality according to his professional judgement and would take exception to being told what levels of materiality he/she should follow in undertaking an audit. The 10% norm is not one would find in the RSA audit environment.

Auditors are obliged to follow SAAS 800 and SAAS 920 standards relating to "special purpose audit engagements" and "Engagements to perform agreed-upon procedures regarding financial information" respectively.

The suggestion is that SAICA in co-operation with the REF Authority prepares a guideline for use by the auditor in carrying out the function of auditing data submitted to the REF. The MSPG of SAICA, which includes CMS representation, would be responsible for drafting the guideline for approval by SAICA management.

The REF Authority will need to recommend whether the audit is required for each quarter or annually. RETAP recommends an annual audit of the data submitted to the REF in order to coincide with the annual audit of the medical scheme.

## 8. Summary of Recommendations to Council for Medical Schemes

- (A) The accounting and reporting issues discussed in this report pertain to the form of the Risk Equalisation Fund prior to the implementation of the full Social Health Insurance framework. In other words, no universal subsidy or income-based cross subsidy is received by the REF. Instead, the REF operates purely between medical schemes. In the event that the full framework for SHI is adopted, RETAP recommends that this document be amended accordingly.
- (B) For the purposes of this report to the Council for Medical Schemes we need to work within the existing legislative framework of “silo” options. Should there be a change to the Medical Schemes Act and Regulations in this regard, then RETAP recommends that the accounting standards be revisited.
- (C) RETAP recommends a separate report on the consequences of possible future option structures.
- (D) Historically only one reserve was maintained by medical schemes. The introduction of an options structure with one or more common pools for PMBs will provide an opportunity to require schemes to keep an earmarked reserve for REF funding. This could be applied only to the purchase of the REF equalised package or to other defined purposes. RETAP recommends that this form part of the reassessment of options structures by the Council for Medical Schemes.
- (E) The introduction of the concept of the REF equalised package, i.e. the PMB Benefit Package, will force schemes to split all benefit payments for which the scheme is responsible between PMB Benefit Package benefits and non- PMB Benefit Package benefits by option. Whilst it has been a management decision as to whether to measure PMB costs against budget in the past it is now recommended that schemes prepare separate income statements in the future to facilitate best business practices. These practices will include, inter-alia, performance measurement, contribution determination, DSP negotiations and representations to the REF regarding REF contribution rates.
- (F) RETAP recommends that each claim paid be sorted according to ICD-10 and CPT-4 codes and allocated between PMB Benefit Package benefits and non- PMB Benefit Package benefits within each option. The REF Contributions and member contributions would be allocated to options according to a predetermined formula based on the factors used in arriving at the contribution tables.

- (G) RETAP recommends that wherever possible the statutory returns to the Registrar of Medical Schemes be used in order to reduce the burden on data submission. Where the REF Authority needs similar information but perhaps with a different definition, the desired outcome will be to harmonise the statutory returns with the REF returns.
- (H) The suggestion is that SAICA in co-operation with the REF Authority prepares a guideline for use by the auditor in carrying out the function of auditing data submitted to the REF. The MSPG of SAICA, which includes CMS representation, would be responsible for drafting the guideline for approval by SAICA management.
- (I) The REF Authority will need to recommend whether the audit is required for each quarter or annually. RETAP recommends an annual audit of the data submitted to the REF in order to coincide with the annual audit of the medical scheme.
- (J) This document was prepared as a discussion document and we recommend that the document be submitted to SAICA for comment before distribution to medical schemes. We further recommend that SAICA be invited to prepare a guideline for the medical scheme external auditor to follow in carrying out the audit of data submitted to the REF for which audit certificates are required.
- (K) We recommend that this Report be issued by the REF Authority as a guideline to Medical Schemes for their administration of REF transactions and preparation of reports both internally and externally to the REF and to the CMS.
- (L) We recommend that the CMS review and comment on this report before finalisation to ensure compatibility with their statutory requirements.

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South African Institute of Chartered Accountants (2004) **Audit and Accounting Guide on Medical Funds**, November 2004. Available on SAICA website <http://www.saica.co.za>. The CMS circular 55 of 2004 requires medical schemes to comply with this guideline.

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