SUREMED HEALTH
(Registration Number 1464)

REPORT OF THE BOARD OF TRUSTEES FOR THE YEAR ENDED 31 DECEMBER 2023

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The report and schedules set out below comprise the Report of the Board of Trustees presented to the members of Suremed Health.

Contents **Page**

SUREMED HEALTH
REGISTRATION NUMBER 1464

REPORT OF THE BOARD OF TRUSTEES
FOR THE YEAR ENDED 31 DECEMBER 2023

The Board of Trustees hereby presents its report for the year ended 31 December 2023.

1. DESCRIPTION OF THE MEDICAL SCHEME

1.1. Terms of registration

Suremed Health is a not for profit open medical scheme registered in terms of the Medical Schemes Act 131 of 1998 (the Act), as amended.

1.2 Benefit options with Suremed Health

The scheme offers 4 benefit plans to employers and members of the public.

These are:

- Challenger Option
- Navigator Option
- Shuttle Option
- Explorer Option

1.3 Personal medical savings account monies managed by the scheme on behalf of its members

In order to provide a facility for scheme members to set funds aside to meet future healthcare costs not covered in the benefit option, the Trustees have made the savings plan option available to meet this objective.

Members that belonged to the Navigator benefit option during the year under review paid an amount of approximately 20% of their gross contributions into a savings account so as to help pay day to day healthcare costs, up to a prescribed threshold.

Unexpended savings amounts are accumulated for the long-term benefit of the member and interest is paid on balances at a rate determined by the Board of Trustees.

The liability to the members in respect of the savings plan is reflected as a financial liability in the financial statements and is repayable in terms of Regulation 10 of the Act. In terms of the rules of the scheme, the scheme carries the risk.

Savings contributions are refundable when a member leaves the scheme or transfers to an option within the scheme which does not have a savings option. The money will be transferred to the member within six months of the date of the change.

SUREMED HEALTH
REGISTRATION NUMBER 1464

REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2023

2. MANAGEMENT

2.1 Board of Trustees in office during the year under review:

Mr. AB Vermeulen	Chairman (member elected)
Mr. JLO Fernandes	Trustee (member elected)
Dr. N. Louw	Trustee (employer nominated)

2.2 Principal Officer:

Mr. J Janse van Rensburg

Registered office address and postal address:

c/o Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.3 Registered office address and postal address during the year:

Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.4 Medical Scheme Administrators (Accreditation number Admin:22) during the year:

Momentum Thebe Ya Bophelo (Pty) Ltd
7 Lutman Street
Richmond Hill
Gqerberha
6001

P.O. Box 1672
Gqerberha
6000

2.5 Actuaries (Accreditation number: RSP016/2010) during the year:

Prognosys Actuaries and Consultants
27 Muir Road
Rondebosch
Cape Town
7700

2.6 Actuaries (used for calculation of risk adjustment factor) (Accreditation number: RSP029/2010):

Momentum Health Solutions (Pty) Ltd
201 Umhlanga Ridge Boulevard
Cornubia
4439

2.7 Auditors during the year:

PricewaterhouseCoopers Inc.
Ascot Office Park
Greenacres
Gqerberha
6045

3. INVESTMENT STRATEGY OF THE MEDICAL SCHEME

The Trustees continue to invest in line with the requirements of the Act. There has been no change in the policy during the current accounting period.

The scheme's investment objectives are to maximise the return on its investments on a long term basis at minimal risk. The investment strategy takes into consideration both constraints imposed by legislation and those imposed by the Board of Trustees. To achieve this, the funds are invested on short-term and longer-term deposits with major banking institutions.

4. MEDICAL INSURANCE RISK MANAGEMENT

The primary insurance activity carried out by the scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. These risks relate to the health of the scheme members; as such the scheme is exposed to the uncertainty surrounding the timing and severity of claims under the contract. The scheme also has exposure to market risk through its investment activities.

The scheme manages its insurance risk through benefit limits and sub-limits, approval procedures for transactions that involve pricing guidelines, pre-authorisation and case management, service provider profiling, centralised management of risk transfer arrangements and the monitoring of emerging issues.

The scheme uses several methods to assess and monitor insurance risk exposure both for individual types of risk insured and overall risks. These methods include internal risk measurement models, sensitivity analyses, scenario analyses and stress testing.

The theory of probability is applied to the pricing and provisioning for a portfolio of insurance contracts. The principal risk is that the frequency and severity of claims is greater than expected.

Medical insurance events are, by their nature random, and the actual number and size of events during any one year period may vary from those estimated using established statistical methods.

Experience shows that the larger the portfolio of similar insurance contracts, the smaller the relative variability around the expected outcome. In addition, a more diversified portfolio is less likely to be affected across the board by a change in any subset of the portfolio. The scheme has developed its insurance underwriting strategy to diversify the type of insurance risks accepted and within each of these categories, to achieve a sufficiently large population of risks and thereby reduce the variability of the expected outcome.

Prescribed Minimum Benefits (PMB's)

In terms of this regulation, a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions. Section 29 (1) (p) of the Act provides that the rules of a medical scheme may, in respect of any benefit option provide that the diagnosis, treatment and care costs of a prescribed minimum benefit condition will only be paid in full by the medical scheme if those services are obtained from a designated service provider in respect of that condition. Payment of these claims is potentially higher than the standard claims at the tariffs agreed by the Scheme.

Reinsurance contracts

Certain risks are mitigated by entering into risk transfer arrangements - these are in substance, the same as a non-proportional commercial reinsurance contract. In this regard the scheme specifically decided to transfer all risks relating to emergency and ambulance benefits to ER24 and primary care benefits of the Explorer and Shuttle members to Prime Cure Health (Pty) Ltd.

In terms of the risk transfer arrangements, the suppliers provide certain minimum benefits to all scheme members, as and when required by the members. The scheme does however remain liable to its members with respect to ceded insurance if the suppliers fail to meet the obligations they assume.

When selecting a supplier, the scheme considers its relative security. The security of the supplier is assessed from public rating information and from internal investigations such as capacity and appropriate resources.

5. SCHEME GOVERNANCE

Strategy Plan

The scheme's strategy is determined on an annual basis and approved by the Board of Trustees. Its purpose is to provide direction to the activities of the Principal Officer and management, and to provide a structure through which performance of these individuals can be monitored. It also ensures that the scheme operates effectively and efficiently. During the year under review the trustees gave attention to strategies covering the following:

- Member satisfaction;
- Marketing;
- Communication through website and social media;
- Broker management;
- Health risk management; and
- Risk evaluation and management.

Performance against the scheme strategies is measured by the Board of Trustees at each Board meeting to ensure that the business of the scheme is being managed within the vision and strategies of the scheme.

Risk Management Plan

The management of risk is the responsibility of the Board of Trustees. A risk register, which identifies the risks related to the scheme and the controls in place to address these risks, is approved by the Board of Trustees on an annual basis. The top risks identified for the scheme are:

- Council for Medical Scheme directives;
- Rising medical benefit costs;
- Not increasing membership numbers;
- Membership declining below sustainable levels;
- Fraud;
- Loss of going concern status;
- National Health Insurance implications;
- Hostile takeover; and
- Service provider delivery.

The risk management plan (RMP) includes appropriate mitigation steps and action plans to manage the risks. The RMP progress is reported on at all Audit Committee and Board of Trustee meetings.

Governance Program

The scheme is committed to following the principles of good corporate governance applicable to Medical Schemes. The scheme's vision, mission and values are reviewed annually by the Board of Trustees to ensure that the Board remains committed to building an ethical organisation. In 2023, these were as follows:

Vision
To be an ethical, sustainable, caring medical scheme providing affordable quality cover to all our members

Mission
To achieve sustainable growth and member loyalty through appropriate quality products, administration services, strong governance and operational excellence

Values
- Integrity;
- Quality services;
- Caring;
- Value for money; and
- Respect for, and loyalty towards, our stakeholders.

Performance of Scheme against Governance structures

The scheme performs an annual review of the King 4 principles, which is approved by the Board of the Trustees. This review sets out whether the scheme applies a specific principle and how this principle is applied. If a principle is not applied, it sets out why it is not applied. In the year under review, all applicable principles were adequately performed and reported.

5. SCHEME GOVERNANCE - continued

Use of Governance structures going forward

The scheme will continue to apply and review the Governance principles and strategies it currently has in place, and will monitor any new developments with a view to implement these, where appropriate and applicable to the scheme.

Future prospects for the scheme

The Board is of the opinion that there is no reason why Suremed Health should not be financially and otherwise sustainable as a going concern in the forthcoming 12 months.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES

6.1 Operational statistics per benefit option

	2023				
	Challenger	**Navigator**	**Shuttle**	**Explorer**	**Total**
Average number of members during the accounting period	136	435	231	235	1 036
Number of members at the end of the accounting period	134	426	261	260	1 081
Average number of beneficiaries during the accounting period	286	928	349	321	1 885
Number of beneficiaries at 31 December	278	904	391	339	1 912
Number of dependants at 31 December	144	478	130	79	831
Average number of dependants	151	493	118	86	848
Dependant ratio at 31 December	1.07	1.12	0.50	0.30	0.77
Net insurance revenue per average beneficiary per month (R)	4,252.72	2,374.35	1,502.41	1,206.87	2,299.26
Insurance service expenses per average beneficiary per month (R) *	4,754.82	2,476.27	1,269.83	1,631.06	2,454.87
Other expenses per average beneficiary per month (R)	243.39	157.34	85.49	73.02	142.73
Insurance service expenses as a percentage of insurance revenue *	111.81%	104.29%	84.52%	135.15%	106.77%
Other expenses as a percentage of insurance revenue	5.72%	6.63%	5.69%	6.05%	6.21%
Average age per beneficiary	50.17	42.95	30.47	33.86	39.84
Pensioner ratio at 31 December (percentage of beneficiaries > 65 years)	32.38	18.75	5.06	13.82	17.06
Average insurance contract liability to future members per member at 31 December (R)	-	-	-	-	57 134
Return on investments as a percentage of investments	-	-	-	-	8.94%

* Insurance service expenses exclude amounts attributable to future members

SUREMED HEALTH
REGISTRATION NUMBER 1464

REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2023

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES - continued

6.1 Operational statistics per benefit option - continued

	Restated 2022				
	Challenger	**Navigator**	**Shuttle**	**Explorer**	**Total**
Average number of members during the accounting period	144	454	179	227	1 003
Number of members at the end of the accounting period	141	445	195	213	994
Average number of beneficiaries during the accounting period	308	979	280	330	1 898
Number of beneficiaries at 31 December	300	960	306	308	1 874
Number of dependants at 31 December	159	515	111	95	880
Average number of dependants	165	526	101	104	895
Dependant ratio at 31 December	1.13	1.16	0.57	0.45	0.89
Net insurance revenue per average beneficiary per month (R)	3,937.24	2,188.52	1,320.83	1,173.23	2,167.92
Insurance service expenses per average beneficiary per month (R) *	3,605.71	2,269.75	1,144.51	1,529.92	2,192.07
Other expenses per average beneficiary per month (R)	220.30	141.95	73.49	67.78	131.67
Insurance service expenses as a percentage of insurance revenue *	91.58%	103.71%	86.65%	130.40%	101.11%
Other expenses as a percentage of insurance revenue	5.60%	6.49%	5.56%	5.78%	6.07%
Average age per beneficiary	49.30	41.62	30.88	35.91	40.15
Pensioner ratio at 31 December (percentage of beneficiaries > 65 years)	32.67	16.56	4.90	16.88	17.29
Average insurance contract liability to future members per member at 31 December (R)	-	-	-	-	62 930
Return on investments as a percentage of investments	-	-	-	-	5.78%

* Insurance service expenses exclude amounts attributable to future members

6.2 Results of operations

The results of the scheme are set out in the Annual Financial Statements. During 2023 the Challenger option saw 18 high cost cases, the Navigator option 19 high cost cases and the Explorer option 5 high cost cases. These cases are not the norm. The Trustees believe that no further clarification is required.

6. REVIEW OF THE ACCOUNTING PERIOD'S ACTIVITIES - continued

6.3 Solvency ratio

	2023 R		2022 R
The solvency ratio is calculated on the following basis:			
Insurance contract liabilities to future members	61 512 361		62 552 074
Insurance contract liabilities to future members excluding unrealised gains	61 512 361		62 552 074
Gross contributions	56 083 095		53 371 363
Ratio of insurance contract liabilities (future members) to gross annual contribution income	109.68%		117.20%
NOTE: There are no adjustments required to the reserves as per the Statement of Financial Position in order to arrive at the reserves as per Regulation 29.			

The scheme is above the statutory requirement of 25%.

7. EVENTS AFTER THE REPORTING PERIOD

There were no significant events after the reporting period that require disclosure, other than those already addressed.

8. ACTUARIAL SERVICES

The scheme's actuaries have been consulted in the determination of the contribution and benefit levels.

9. MARKETING AND DISTRIBUTION SERVICES

Marketing and distribution services are managed directly by the scheme in conjunction with the Administrators.

10. RELATED PARTY TRANSACTIONS

Refer to related parties disclosure in note 24 to the annual financial statements.

11. INVESTMENTS IN AND LOANS TO PARTICIPATING EMPLOYERS OF MEMBERS OF THE MEDICAL SCHEME AND TO OTHER RELATED PARTIES

The scheme holds no investments in participating employers of medical scheme members, or other related parties.

12. NON-COMPLIANCE MATTERS

Section 33 (2)

Each benefit option should be financially sound and self supporting. In respect of this scheme the Challenger, Navigator and Explorer options incurred net insurance deficits. Non-compliance results in benefit options making a surplus subsidising benefit options making a deficit.

The Challenger option saw 18 high cost cases during the year, Navigator option 19 high cost cases during the year and the Explorer option 5 such cases. These cases are not the norm. Appropriate adjustments have been made to the Challenger, Navigator and Explorer options for 2024.

Regulation 5(F)

In terms of this regulation diagnostic and such other code numbers that relate to relevant health services, need to be stated on all accounts. Non-compliance results in the scheme not complying with the Act. Certain accounts received from members who do not reside in South Africa do not have diagnostic and such other code numbers that relate to relevant health services. The administrator applies suitable codes where applicable.

Section 26 (7)

In terms of this section all contributions are to be received within 3 days of becoming due. Non-compliance could result in possible cash flow strain and have an impact on interest income. Late payments of contributions by members are not within the scheme's control, however a credit control policy is in place to address this matter and late payments are followed up by the administrator.

Section 59 (2)

Certain claims were paid in excess of 30 days after receipt by the administrator as a result of queries to be investigated/audited in relation thereto. Non-compliance could impact on the relationship with members and providers. Procedures and policies are in place to manage late payment of claims, including a weekly report of claims held for investigation which is checked and signed by management to ensure that the 30 day limit is not exceeded. This practice ensures accurate claims processing and is in the interest of the risk management of the scheme

The Trustees do not consider that these non-compliance matters have had a significant impact on the operations of the scheme or on the Financial Statements.

SUREMED HEALTH
REGISTRATION NUMBER 1464

REPORT OF THE BOARD OF TRUSTEES - continued
FOR THE YEAR ENDED 31 DECEMBER 2023

13. MEETING ATTENDANCE AND REMUNERATION

The following schedule sets out the attendance at meetings of the Board of Trustees and remuneration received.

	BOARD MEETINGS		AUDIT COMMITTEE MEETINGS		OTHER MEETINGS		FEES	EXPENSES	
NAME	A	B	A	B	A	B	R	R	
AB Vermeulen (BoT Chairman)	6	6	3	3	1	1	569 420	19 520	C
J Janse van Rensburg (Principal Officer)	6	6	3	3	1	1	724 500	19 109	
JLO Fernandes (BoT Trustee)	6	6	3	3	1	1	327 860	6 181	
N Louw (BoT Trustee)	6	6	-	-	1	1	328 160	-	
Total	24	24	9	9	4	4	1 949 940	44 810	

A = Total possible number of meetings that could have been attended
B = Actual number of meetings attended.
C = This amount includes expenses paid by the Chairman on behalf of the scheme

14. AUDIT COMMITTEE

Please refer to the attached report of the Audit Committee which summarises the roles, responsibilities and activities of the committee.

AB Vermeulen
Chairman

Date:

www.suremed.co.za

041 - 395 4400