#DIFFERENCE MAKERS

MEDICAL SCHEMES ACCOUNTING GUIDE FOR THE YEAR-END 31 DECEMBER 2024

With suggested amendments and comments for the year-end 31 December 2024

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PREFACE

This guide has been prepared by the Medical Schemes Project Group of the South African Institute of Chartered Accountants (SAICA) in consultation with the Council for Medical Schemes (CMS) to provide guidance to SAICA members on the accounting requirements applicable to schemes that carry on the business of a medical scheme and auditors of medical schemes.

The guide assumes compliance with IFRS® Accounting Standards (IFRS Accounting Standards) and any additional requirements of CMS and addresses only the accounting and reporting issues that are generally applicable to schemes that carry on the business of a medical scheme. The guide is, therefore, not considered to be complete in all aspects. Readers are advised to read this guide in conjunction with applicable legislation, circulars from CMS, and IFRS Accounting Standards, where appropriate, and to consider specific facts and circumstances applicable to individual schemes to ensure that all areas are adequately covered in any work they undertake.

Every effort has been made to ensure that the references are correct when reference is made to quotes, extracts and paragraphs from IFRS Accounting Standards. The information contained in the guide is for information purposes only and is not prescriptive.

The guide does not address audit issues. The Independent Regulatory Board for Auditors (IRBA) issues separate guidance for auditors of medical schemes.

Every effort has been made to ensure that the advice given in this guide is correct. Nevertheless, the advice is provided purely as guidance to members of SAICA to assist them with particular problems relating to the subject matter of the guide, and SAICA will have no responsibility to any person for any claim of any nature whatsoever that may arise out of or be related to the contents of this guide. Members are cautioned against preparing their financial statements as per this Guide. Financial statements should be prepared in accordance with IFRS Accounting Standards and applicable legislation.

INTRODUCTION

1. A South African medical scheme is registered under section 24(1) of the Medical Schemes Act 131 of 1998, as amended, and the Regulations thereto (the Act). Medical schemes are classified as not-for-profit under the Act and are similar to mutual funds, as the scheme belongs to its members. However, this excludes healthcare insurance products provided by the Insurance Act (No. 18 of 2017) effective 1 July 2018.

2. Medical schemes do not have shareholders and do not issue equity instruments.

3. The CMS is the regulatory body tasked with regulating medical schemes in South Africa.

4. The CMS issues an annual circular providing guidance on the key considerations it will consider when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost industry increase assumptions for the respective benefit year.

5. The primary sources of business are employers who wish to arrange healthcare benefits for their employees and their employees' dependants and individuals who wish to cover themselves and their dependants. Some medical schemes are formed with the primary objective of supporting 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 or members of the public (i.e. open enrolment), which are referred to as "open medical schemes".

6. Medical schemes use two main administration models: self-administered or outsourced to a CMS-accredited medical scheme administrator. The extent of the outsourced administration is set out in the written administration agreement between a medical scheme and administrator.

7. Business is introduced to medical schemes by direct marketing or brokers accredited in terms of the Act. The Act also regulates the payment of commissions to brokers. Contracts are entered into between the members and the medical scheme in terms of the rules of the medical scheme. The period of the contract is from the date of admission to membership until the date on which the contract is terminated in terms of the rules of the medical scheme for reasons that include the following:

   (a) Failure to pay, within the time allowed in the medical scheme's rules, the membership contributions required;

   (b) Failure to repay any debt due to the medical scheme;

   (c) Death of member;

   (d) Committing any fraudulent act;

   (e) Prior termination of the contract, in terms of the rules, by either party;

(f) Non-disclosure of material information; and

(g) Liquidation of the medical scheme.

Medical schemes may, however, change their contributions and benefits at any time during the year, subject to a one-month notice period and the approval of the Registrar of Medical Schemes (Registrar).

8. In practice, an employer may negotiate certain terms and conditions in the membership contract with a medical scheme on behalf of its employees, such as eliminating the waiting period. Each member must still sign a separate contract with the medical scheme. Individuals may join any open medical scheme in their personal capacity, or a restricted medical scheme should they qualify for membership.

9. The Act enforces community rating and prohibits risk rating. Individual contracts may not be priced based on the specific risks associated with the individual or any other individual criteria. Medical scheme contributions can only be varied based on income or the number of dependents, or both the income and the number of dependents. As the scheme cannot price for specific individual risks, it results in cross-subsidisation in the scheme. An implicit principle accepted by members electing to join a medical scheme is the acceptance of risk by the medical scheme, the pooling of contributions for settlement of that individual member's benefits, other members' benefit and to support community rating in setting contributions for current and future members. Medical scheme reserves may be utilised to provide members with other economic benefits such as funding reductions in contributions or deferral of contribution increases.

10. Medical schemes shall not provide for any other grounds, including age, sex, past or present state of health of the applicant or one or more of the applicant's dependants, for varying the frequency of rendering relevant health services to an applicant or one or more of the applicant's dependants, other than for the provisions as prescribed, when determining contributions. All applicants must, therefore, be accepted by medical schemes without contribution loadings (albeit waiting periods might be applicable), irrespective of the risks posed. The risks faced by medical schemes are similar and may be managed together depending on the scheme's risk management strategy. The scheme will set a price that fully reflects their risk at a scheme or benefit level - depending on their risk management. More often than not, this is done at a scheme level. Medical schemes may provide for members' health requirements through benefit options that are approved by the CMS and cross-subsidise the level of contributions for sick members by using those of healthy members, which promotes community rating in setting contributions. This cross-subsidisation occurs not only within the benefit option but also across the scheme as a whole.

11. Healthcare benefits are prescribed in the rules of the medical scheme, which usually contain healthcare benefit limits and exclusion clauses in addition to the minimum benefits prescribed in the Act and Regulations. In terms of the Act, all benefit options must provide for prescribed minimum benefits. These are the minimum basket of benefits that all medical schemes are required to offer their members. Medical schemes are required to cover the costs related to the diagnosis, treatment, and care of:

(a) Any emergency medical condition;

(b) A limited set of approximately 270 medical conditions; and

(c) 25 chronic disease list conditions (CDLs) as well as other chronic diagnosis treatment pairs (DTPs) and chronic conditions (e.g. HIV and menopause).

These are known as “Prescribed Minimum Benefits” (PMBs), and members are entitled to these benefits regardless of the scheme option selected. PMB conditions encompass all aspects of care, including acute and chronic medicines, medical and surgical supplies, and both in-hospital and out-of-hospital care. Co-payments on PMBs will apply when the member has voluntarily not used the scheme’s designated service provider.

12. Healthcare benefit limits (no limits apply to 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. These healthcare benefit limits may be apportioned for 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 before 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 personal medical savings accounts.

13. Certain risks may be reinsured by the medical scheme, in terms of which another party underwrites certain risks for healthcare benefits. This risk transfer can take the form of a commercial reinsurance contract or a provider contract in terms of which the provider is paid a monthly sum or capitation fee to provide defined services during a specified period according to the needs of the members of a scheme.

(a) Provider: The provider carries both the risk of the number of incidents that occur during the specified period and the cost of providing the service. Entering a risk transfer arrangement does not reduce a scheme’s primary obligations to its members and their dependants. Premiums/fees and recoveries for claims relating to risk transfer arrangements are presented separately in respect of each risk transfer arrangement so that the financial extent of such arrangements may be clearly demonstrated.

(b) Commercial reinsurance: No medical scheme shall 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), where a medical scheme intends to enter into any commercial reinsurance contract or amendment of such contract, the Board of Trustees shall furnish the Registrar with a copy of the contract or the amendment and an evaluation of the need for the proposed commercial reinsurance contract, by a person who has the necessary expertise, and who has no direct or indirect financial interest in the contract.

14. A member also carries the risk for payment of sums charged by the provider of healthcare services in excess of the prescribed healthcare benefits provided by the medical scheme (i.e. scheme rate), which could be in the form of co-payments paid to the provider or a refund of sums paid, lent or

advanced by the medical scheme, in terms of the rules, on behalf of the member.

15. Some medical schemes provide for personal medical savings account facilities to assist members in managing cash flow to pay for healthcare services for which they are responsible. In accordance with the Act, a maximum of 25% of the total gross contribution made in respect of the member during the financial year concerned can be allocated to a personal medical savings account. These monies may only be used for healthcare services and are only refundable as provided for in Regulation 10. Personal medical savings account facilities may not be utilised to provide for the costs of PMBs (including benefits and co-payments).

16. The Constitutional court judgment in the matter between Genesis Medical Scheme and the Registrar of Medical Schemes and Another [2017] ZACC 16 (the judgment) heard on 6 June 2017, found that Personal medical savings accounts (PMSA) funds entered the scheme's bank account without being impressed by a trust or fiduciary relationship, and once paid into a scheme's bank account, become assets of the scheme, regardless of whether the scheme later allocates a proportion to a PMSA. Consequently, there is no distinction between scheme and PMSA assets. All assets must be invested in accordance with the Medical Schemes Act and Regulations. There is no statutory requirement for assets arising from any unspent PMSA allocation to be invested separately. The judgment found that as PMSAs are not trust assets, schemes may keep interest accruing from PMSAs in its bank account. Medical schemes may provide for the allocation of interest to be credited to the members' personal medical savings accounts in terms of the scheme's rules.

17. Should the medical scheme's rules state that the PMSA monies belong to members, a trust relationship is created. In this instance, personal medical savings accounts constitute trust money as defined in section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001 read with Regulation 10 to the Act. These personal medical savings must be invested separately from scheme funds, which are further clarified by section 4(5) of the Financial Institutions (Protection of Funds) Act 28 of 2001. Interest earned on these funds must also be credited to the members' personal medical savings accounts in terms of the scheme's rules, with no portion retained by medical schemes.

18. Inherent in medical scheme operations is the fact that income, in the form of contributions, together with the minimum required reserve level to be maintained, provides cash reserves available for investment. The investment income from these cash reserves and other reserve funds plays an important part in the medical scheme's operations. 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 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.

19. A medical scheme is required to maintain minimum accumulated funds, which may not be less than 25% of gross annual contributions. 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.

20. Medical scheme reserves can be transferred from a medical scheme through voluntary dissolution or amalgamation. Members of the medical scheme are required to approve a voluntary dissolution or amalgamation by a majority vote at a general meeting. Medical scheme reserves can also be used to support lower contribution increases or to fund increases in member benefits.

21. Where a decision has been taken to wind up or dissolve a medical scheme, past practice has evidenced that any positive balance remaining in the medical scheme following the winding up or dissolution is paid out to members in cash. An example of this is the Gen-Health Medical Scheme, which had been liquidated on 12 October 2010, and members were paid from the remaining assets.

DEFINITIONS USED IN THE GUIDE

Accounting period – for the financial statements of medical schemes, is the 12-month period ending 31 December.

Accumulated funds, – in terms of Regulation 29 (1) of the Act, means the net asset value of a medical scheme, excluding funds set aside for specific purposes and unrealised non-distributable reserves.

Act – means the Medical Schemes Act No. 131 of 1998, as amended, and the Regulations thereto.

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

Administration expenses – means the costs incurred to administer a medical scheme in terms of the rules and the Act.

Administrator – means any legal person who has been accredited by CMS in terms of section 58 of the Act to administer medical schemes.

Amounts attributable to future members - liability attributable to policyholders with the most residual interest in the entity.

Auditor – means any registered auditor as defined in the Auditing Profession Act, No. 26 of 2005, appointed by the medical scheme and approved by CMS to act as auditor for a medical scheme.

Board of Trustees – means the board of trustees of a medical scheme charged with managing the affairs of a medical scheme, and which has been elected or appointed in terms of the rules of the medical scheme.

Beneficiary – means a member or a person admitted as a dependant of a member to a medical scheme.

Benefit option/plan – means 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 a medical scheme.

Business of a medical scheme – As defined by the Act and means the business of undertaking, in return for a premium or contribution, the liability associated with one or more of the following activities–

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

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

Commencement of cover – means the date on which the coverage of the health risk commences, in terms of the rules of a medical scheme, in respect of a beneficiary's health cover. This is the date the membership commences and does not take any waiting periods enforced into account.

Commercial reinsurance – means a contractual arrangement in terms of which some element of risk contained in the rules of a medical scheme is transferred to a registered reinsurer in return for some consideration.

Condition-specific waiting period – means 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 a membership application was made.

CMS – means the Council for Medical Schemes established by section 3 of the Act.

Co-payments/deductible – see the definition of member's portion.

Dependant – means the spouse or partner, dependent 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 that, under the rules of a medical scheme, is recognised as a dependant of such a member and is eligible for benefits under the rules of the medical scheme.

Designated service provider – 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.

Directly attributable expenses – expenses that are directly attributable to fulfilling the insurance cost, such as claims handling, fixed and variable overheads, etc.

Employer – means 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.

Fulfilment cashflow – fulfilment cash flows are defined as the best estimate of future cash flows within the boundary of a contract, plus a risk adjustment.

General waiting period – means a period in which a beneficiary is not entitled to claim any benefits.

Healthcare benefits – means the members' entitlement to healthcare services in terms of the rules of the medical scheme and the Act.

Insurance acquisition cash flow – cash flows arising from the costs of selling, underwriting and starting a group of insurance contracts (issued or expected to be issued) directly attributable to the portfolio of

insurance contracts to which the group belongs. Such cash flows include cash flows not directly attributable to individual contracts or groups of insurance contracts within the portfolio.

Insurance revenue – when an entity applies the premium allocation approach, insurance revenue for the period is the amount of expected premium receipts (excluding any investment component and adjusted to reflect the time value of money and the effect of financial risk, if applicable) allocated to the period. The entity shall allocate the expected premium receipts to each period of insurance contract services on the basis of the passage of time; unless the expected pattern of release of risk during the coverage period differs significantly from the passage of time, then on the basis of the expected timing of incurred insurance service expenses.

Insurance service expense - means expenditure incurred to fulfil a medical scheme's obligation in terms of the insurance contracts written and include:

- Incurred claims and benefits excluding investment components;
- Other incurred directly attributable insurance service expenses;
- Changes that relate to current and past service (i.e. changes in the fulfilment cashflows relating to the liability for incurred claims); and
- Changes that relate to future service (i.e. losses/reversals on onerous groups of contracts).

Insured event – an uncertain future event covered by an insurance contract that creates insurance risk.

Investment component – the amounts an insurance contract requires the entity to repay to a policyholder in all circumstances, regardless of whether an insured event occurs.

Investment income – includes interest (inclusive of interest received on investments, bank accounts and arrear balances), dividends, rental and policy income as well as net realised gains or losses on available-for-sale financial assets (applicable to medical schemes that elected to defer implementation of IFRS 9: Financial Instruments) and net gains or losses on financial assets at fair value through profit or loss.

Liability for incurred claims (LIC) – an entity's obligation to:

(a) investigate and pay valid claims for insured events that have already occurred, including events that have occurred but for which claims have not been reported and other incurred insurance expenses; and

(b) pay amounts that are not included in (a) and that relate to:

  i insurance contract services that have already been provided, or

  ii any investment components or other amounts that are not related to the provision of insurance contract services and that are not in the **liability for remaining coverage.**

Liability for remaining coverage (LRC) – an entity's obligation to:

(a) investigate and pay valid claims under existing insurance contracts for insured events that have not yet occurred (i.e. the obligation that relates to the unexpired portion of the insurance coverage); and

(b) pay amounts under existing insurance contracts that are not included in (a) and that relate to:

i insurance contract services not yet provided (i.e. the obligations that relate to future provision of insurance contract services); or

ii any investment components or other amounts that are not related to the provision of insurance contract services and that have not been transferred to the liability for incurred claims.

Linked policy – means a long-term policy of which the amount of the policy benefits is not guaranteed by the long-term insurer and is to be determined solely by reference to the value of particular assets or categories of assets, which are specified in the policy and are actually held by or on behalf of the insurer specifically for the purposes of the policy. [1]

Managed healthcare – means 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 programmers.

Medical scheme – means any medical scheme registered under section 24(1) of the Act.

Member – means a natural 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 and, in exchange for a contribution, is entitled to healthcare benefits.

Member's portion – means that part of the amount due to a supplier of healthcare services for which the member is responsible, in terms of the rules of the medical scheme.

Minimum accumulated funds (solvency ratio) – means the minimum accumulated funds to be maintained by a medical scheme per Regulation 29 of the Act and expressed as a percentage of gross annual contributions for the accounting period under review, which accumulated funds may not be less than 25% of the gross annual contributions. The minimum accumulated funds are also referred to as the "solvency ratio" or the "accumulated funds ratio" and are the minimum capital requirement that medical schemes are required to maintain. Circular 13 of 2001, issued by CMS, provides further information on what should be excluded from the amount of the accumulated funds, for purposes of calculating the minimum accumulated funds.

Net expenses from reinsurance contracts held – the net effect of reinsurance income less reinsurance expense.

[1] Insurance Act No. 18 of 2017

Non-attributable expenses – comprise non-directly attributable administration fees, other operating expenses incurred in operating a medical scheme, and impairment losses incurred in respect of financial instruments measured at amortised cost.

Onerous contracts – an insurance contract is onerous at the date of initial recognition if the fulfilment cash flows allocated to the contract, any previously recognised insurance acquisition cash flows and any cash flows arising from the contract at the date of initial recognition in total are a net outflow.

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 relevant health service.

Personal medical savings accounts (PMSA) – means the balance of allocated savings contributions available for the exclusive benefit of the member and his or her dependents for the payment of healthcare benefits that are for the member's account, in terms of the rules of the medical scheme.

Personal medical savings account claims – means healthcare benefits paid from a member's personal medical savings account in terms of the scheme's registered rules and Regulation 10 of the Act.

Personal medical savings account contributions – means 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.

Personal medical savings account trust investment – where a medical scheme's rules create a trust relationship by stating that the funds belong to the member: represents the amounts invested in respect of contributions received from members allocated 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 scheme on the members' behalf.

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

Prescribed minimum benefits – means the benefits contemplated in Section 29(1) (o) of the Act and consists of the provision of the diagnosis, treatment and care costs of –

- The 25 Chronic Disease List Conditions (CDLs), as well as the chronic Diagnosis and Treatment Pairs (DTPs) and chronic conditions (e.g. HIV and menopause) listed in Annexure A of the Act, subject to any limitations specified in Annexure A; and

- Any emergency medical condition.

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

Regulations – means the Regulations to the Medical Schemes Act No. 131 of 1998, as amended.

Reinsurance contracts – an insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts). This can take the form of either a risk-transfer arrangement or a commercial reinsurance arrangement which has been furnished to and reviewed by the Registrar as required by Sections 20 (3) and (4) of the Act.

Reinsurer – means an insurer licensed to conduct reinsurance business and licensed to conduct life or non-life insurance business or both.

Relevant health service – as defined by the Act and means any health care treatment of any person by a person registered in terms of any law, which treatment has as its object:

- The physical or mental examination of that person;
- The diagnosis, treatment or prevention of any physical or mental defect, illness or deficiency;
- The giving of advice in relation to any such defect, illness or deficiency;
- The giving of advice in relation to, or treatment of, any condition arising out of a pregnancy, including the termination thereof;
- The prescribing or supplying of any medicine, appliance or apparatus in relation to any such defect, illness or deficiency or a pregnancy, including the termination thereof; or
- Nursing or midwifery, and includes an ambulance service, and the supply of accommodation in an institution established or registered in terms of any law as a hospital, maternity home, nursing home or similar institution where nursing is practiced, or any other institution where surgical or other medical activities are performed, and such accommodation is necessitated by any physical or mental defect, illness or deficiency or by a pregnancy.

Report of the Board of Trustees – is the annual report by the Board of Trustees, which oversees the activities of the medical scheme and are those persons with a fiduciary responsibility towards a medical scheme. The report shall deal with every matter which is material for the appreciation by members of the medical scheme of the state of affairs and the business of the medical scheme and the results thereof and contain relevant information indicating whether or not the resources of the medical scheme have been applied economically, efficiently and effectively.

For the purpose of this guide, the report will include reports by the Board of Trustees, management committee, audit committee, investment committee or any other persons with a fiduciary responsibility towards the medical scheme.

Restricted membership scheme – means a medical scheme whose rules restrict the eligibility for membership by reference to:

- Employment or former employment or both, in a profession, trading, industry of calling;

- Employment or former employment or both by a particular employer or by an employer included in a particular class of employers;

- Membership or former membership or both, of a particular profession, professional association or union; or

- Any other prescribed matter.

Risk adjustment for non-financial risk – the compensation an entity requires for bearing the uncertainty about the amount and timing of the cash flows that arise from non-financial risk as the entity fulfils insurance contracts.

Risk transfer arrangement – 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 dependents, 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.

Rules of the medical scheme – means the registered rules approved by the Registrar, constitutions and/or agreements in terms of which the member receives healthcare benefits and in terms of which the medical scheme is administered.

LEGISLATION

Medical Schemes Act 131 of 1998, as amended (the Act)

1. This Act consolidates the laws relating to registered medical schemes; provides for the establishment of the CMS as a juristic person; provides for the appointment of the Registrar of Medical Schemes (Registrar); makes provision for the registration and control of certain activities of medical schemes; protects the interests of members of medical schemes; provides for measures for the coordination of medical schemes and provides for incidental matters.

2. Section 20 of the Act requires that every entity that conducts a business as described above must apply to the Registrar for registration under the Act, which places a legal obligation on all organisations carrying on business as defined to register under the Act. Non-registration of such a business will constitute a material irregularity and is prohibited in terms of section 20 of the Act.

3. Section 24 gives the Registrar the power to register medical schemes, with the concurrence of the CMS, and to impose such terms and conditions that are deemed appropriate.

4. In terms of section 27 of the Act, the Registrar has the power to cancel or suspend the registration of a medical scheme if, after investigation, CMS is of the opinion that registration should be so cancelled or suspended.

5. 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.

6. 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.

7. Section 26(4) of the Act sets out the items that may be debited to a scheme's bank account.

8. Section 26(5) prohibits the payment of dividends, rebates and bonuses.

9. 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.

10. 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 becomes due.

11. Section 26(11) prohibits medical schemes from carrying on any business other than the business of a medical scheme.

12. Section 29 details the minimum matters for which the scheme's rules must provide. Section 29(1)(h) requires that the medical scheme rules shall, subject to the provisions of the Act, set out the manner

in which and the circumstances under which a medical scheme shall be terminated or dissolved. Section 29(1)(n) of the Act eliminates medical schemes' ability to underwrite individual policies and set contribution levels at a particular policyholder level that fully reflects the risks of that policy. In setting contribution levels, the Act only allows for contributions to be determined on the basis of income or the number of dependents, or both the income and the number of dependents. Section 30 continues to detail the general provisions that may be included in the scheme's rules. Sections 31 and 32 provide further information on the amendment of rules and the binding force of the rules. The rules need to be approved by the Registrar in terms of section 31 before it becomes binding.

13. Section 30(1)(e) and Regulation 10(1) of the Act deal with prescribed personal savings accounts (PMSAs) as part of the benefits of a medical scheme which may only be provided by registered medical schemes.

14. Section 29A of the Act stipulates the conditions under which a medical scheme may apply general and specific waiting periods:

(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)			
Break MORE than 90 days (??)	**Break LESS than 90 days (0 to 89 days)**		
Previous membership period			
Regardless of previous membership	**24 Months and longer**	**Shorter than 24 months (previous waiting periods may still be in place)**	**Regardless of previous membership** • Change of employment • Employer changing / terminating medical scheme • Plan movements
• General waiting period – 3 Months • Condition specific –12 months • Waiting period applies to PMB's	• General waiting period – 3 months • Waiting period **does not** apply to PMB's	• Condition specific - 12 months • Waiting period **does not** apply to PMB's	• No general or condition specific waiting periods may be imposed

15. Section 33(2) of the Act provides that the Registrar will not approve any benefit option unless satisfied that such benefit option:

(a) Includes the prescribed benefits;

(b) Shall be self-supporting in terms of membership and financial performance;

(c) Is financially sound; and

(d) Will not jeopardise the financial soundness of any existing benefit option within the medical scheme.

16. 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):

- Medical scheme shall maintain its business in a financially sound condition (sections 35(1) and 35(2));

- 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, CMS (section 35(6)); and

- 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, any administrator or any arrangement associated with the medical scheme, orany other above-mentioned (section 35(8)).

(b) The appointment of the auditor and the audit committee (section 36);

(c) Submission of the financial documentation and information to the Office of the Registrar within the prescribed deadlines (section 37):

- Section 37(1) requires the trustees to prepare the annual financial statements and to submit these together with the Report of the Board of Registrar by 30 April each year;

- Section 37(2) specifies what statements/reports are considered to form part of the annual financial statements;

- Section 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

- The disclosure of financial information in respect of every benefit option offered by the medical scheme is required in terms of section 37(4) (d). This is required to be audited in terms of Circular 4 of 2008.

17. In terms of section 44, the Registrar may order an inspection of a medical scheme:

    - If he/she is of the opinion that such an inspection will provide evidence of any irregularity or non-compliance with the Act; or

    - For purposes of routine monitoring of compliance with the Act by a medical scheme or any other person.

18. Section 44(8) provides the Registrar, with the concurrence of CMS, with the power to place restrictions on the administration costs of medical schemes in respect of any financial year and may, for this purpose, prescribe the basis on which such costs shall be calculated.

19. In terms of Section 51(1) of the Act, the Registrar may, with the consent of CMS, apply to the court for an order for judicial management, curatorship or winding up, in terms of the conditions laid down in the Act.

20. Section 57 of the Act provides that a medical scheme shall have a board of trustees consisting of persons who are fit and proper to manage the business contemplated by the medical scheme in accordance with the applicable laws and the rules of such medical scheme. This section also sets out the duties of the Board of Trustees to ensure good governance.

21. Section 59(2) of the Act and Regulation 6 set out the payment periods by the scheme to a member or a service supplier in the case where an account has been rendered. Section 61 of the Act speaks to undesirable business practices. The Registrar has issued Government Gazette No. 26516 in this respect. This Government Gazette addresses the alienation of assets at substantially less than its fair value, the awarding of an administration contract without following due process as well as where conflicts of interest exist.

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 affected. The scheme that makes the transfer is still responsible for submitting a full set of annual financial statements as well as an annual return for the period to the date of transfer.

23. Section 64 of the Act states that “In the event of the rules of a medical scheme providing for the dissolution or termination of such medical scheme upon the expiry of a period or upon the occurrence of an event, or upon a resolution by the members that such medical scheme shall be terminated, then upon the expiry of such period, or the occurrence of such event, or the passing of such resolution, such medical scheme shall, subject to the provisions of this section, be liquidated in the manner provided for by the rules of such medical scheme, and the assets of that medical scheme shall, subject to the provisions of this Act, be distributed in the manner provided for by the rules of the medical scheme”.

24. A medical scheme may only compensate a broker in accordance with section 65 of the Act and Regulation 28, for the introduction or admission of a member to the medical scheme, and the provision of ongoing service or advice to that member.

25. Section 66 contains details of offences and penalties.

26. As per Regulation 2(3) the minimum number of members required for the registration of a medical scheme is 6 000. This number should be admitted within a period of 3 months of registration.

27. Regulation 4(4) prohibits the ring-fencing of reserves.

28. Regulation 6A sets out the requirements for disclosure of trustees' remuneration.

29. Regulation 8 and Annexure A provide information on PMBs.

30. 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 a personal medical savings account.

31. Regulation 10 stipulates the requirements in respect of savings accounts.

    (a) Regulation 10(1) limits the total gross contribution that is allocated to the member's personal medical savings account to 25%.

    (b) Regulation 10(4) states that credit balances in a member's personal medical savings account shall be transferred to another medical scheme or benefit option with a personal medical savings account, as the case may be when such a 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 enrols in another medical scheme without a personal medical savings account provision or selects a benefit option without a personal medical savings account; and

    (d) Regulation 10(6) stipulates that personal medical savings account facilities may not be utilised to provide for benefits and co-payments that relate to PMBs.

32. Managed care agreements are regulated in terms of Chapter 5 of the Regulations. As defined in Regulation 15: "*Managed healthcare means clinical and financial risk assessment and management of health care, 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.*"

33. Administration of a medical scheme by a third party should comply with Chapter 6 of the Regulations."

34. Regulation 23 requires an administrator to deposit any medical scheme monies under administration, not later than the business day following the date of receipt of these monies, directly into a bank account opened in the name of the medical scheme. This does not apply to electronic funds

transfers, which must be deposited directly into the medical scheme's bank account.

35. Regulation 29 to Chapter 8 of the Regulations 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 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*". Funds set aside for meeting claims, such as HIV/AIDS reserves, should not form part of funds set aside for specific purposes.

36. 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.

37. Where a scheme's rules create a trust relationship in respect of PMSA monies by stating that a member is the owner of the funds, the personal medical savings investment are excluded from the calculation of the scheme's aggregate fair value of liabilities and minimum accumulated funds to measure the scheme's compliance to Annexure B. The personal medical savings accounts may only be invested in deposits held at call with banks and fixed deposits with banks or in accordance with the scheme's rules.

Financial Institutions (Protection of Funds) Act 28 of 2001

38. In instances where a trust relationship had been created by the medical scheme rules, the funds standing to the credit of the personal medical savings accounts of the members constitute trust money as defined in section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001:

    - Section 1 of the Protection of Funds Act[2] includes medical schemes as a supervised entity that is subject to the requirements of this Act as far as trust property is concerned; and

    - Section 1 defines trust property as any asset administered by or kept in safe custody by a supervised entity.

    - Sections 4(4) and (5) state that a supervised entity must keep trust property separate from assets belonging to that institution (scheme) and under no circumstances may that trust property form part of the assets or funds of the supervised entity.

39. Sections 4(4) and (5) state that a supervised entity must keep trust property separate from assets belonging to that institution (scheme) and under no circumstances may that trust property form part of the assets or funds of the supervised entity.

[2] Financial Institution changed to supervised entity as amended by the Financial Sector Regulation Act, 2017

Income Tax Act 58 of 1962, as amended

40. In terms of section 10(1) (d) of the Income Tax Act 58 of 1962, as amended, receipts and accruals of a benefit fund are exempt from normal tax. A medical scheme is included in the definition of a benefit fund and is consequently exempt from income tax.

Circulars and other relevant legislation

41. The Minister of Health publishes Regulations, and the Registrar occasionally publishes directives and circulars that govern the operation of medical schemes.

The following circulars are of importance to note:

- 6/2025: General concerns noted during the analysis of the 2023 Annual Financial Statements (AFS) and Annual Statutory returns (ASR)
- 43/2024: Standard guidelines on the format of business plans submitted to the Council for Medical Schemes
- 38/2024: Authorisation of Auditors and IFRS Advisors 2024
- 32/2024: Analysis of industry responses to the AQI publication
- 20/2024: Updated operational statistics for reporting
- 15/2024: IFRS Foundation trademark impact on auditor report templates
- 11/2024: Categorisation of assets in terms of Annexure B to the Regulations of the Medical Schemes Act
- 49/2023: IRBA PIE Definition and Enhanced Auditor Reporting
- 41/2023: International Financial Reporting Standard (IFRS)17 – Statement of financial position
- 29/2023: IFRS17 - Direct attributable expenditure
- 28/2023: IAS1 impact on ISA700 auditor report template
- 34/2022: General concerns noted during the analysis of the 2021 Annual Financial Statements (AFS) and Annual Statutory returns (ASR)
- 26/2022: Brokers earning commission on own policies
- 19/2022: Adjustment on fees payable to brokers March 2022
- 18/2022: Statement of Cash Flows

- 52/2021: Prescribed format of the Statement of Cash Flows
- 41/2021: General concerns noted during the analysis of the 2020 AFS
- 31/2021: Section 61 declaration for DSPs
- 63/2020: Prescribed auditor report templates
- 60/2020: Reportable Irregularities – CMS contact details
- 46/2020: General concerns noted during the analysis of the 2019 Annual Financial Statements and Statutory Returns
- 39/2020: Payment of commission to brokers and brokerages
- 36/2020: Virtual AGMs
- 28/2020: Covid-19 Medical Schemes Industry Guidelines
- 77/2019: Classification of and reporting on administration services – Accredited vs other administration services
- 41/2019: General concerns noted during the analysis of the 2018 Annual Financial Statements and Statutory Returns
- 45/2018: International Travel Benefit
- 28/2018: General concerns noted during the analysis of the 2017 Annual Financial Statements (AFS)
- 27/2018: Audit tenure
- 7/2018: Categorisation of assets in terms of Annexure B to the Regulations
- 2/2018: Personal Medical Savings Accounts and Scheme Rules
- 57/2017: Non-compliance with Laws and Regulations (NOCLAR)
- 56/2017: Personal medical savings accounts
- 40/2017: General concerns noted during the analysis of the 2016 Annual Financial Statements (AFS)
- 49/2016: Prescribed auditor report templates
- 35/2016: General concerns noted during the analysis of the 2015 Annual Financial Statements (AFS)

- 65/2015: Auditor's report – Key Audit Matters
- 56/2015: Accounting for accredited managed care services
- 43/2015: General concerns noted during the analysis of the 2014 Annual Financial Statement and Statutory Returns
- 13/2015: Categorisation of assets in terms of Annexure B to the Regulations
- 51/2014: Managed healthcare agreements – unwarranted performance or profit-sharing incentives
- 48/2014: Classification and disclosure of administration costs included in the contracted third-party administration fees.
- 10/2013: Funding of PMBs from personal medical savings accounts when members are discharged from hospital
- 6/2013: Annual financial information provided to members
- 41/2012: Prescribed format for the Statement of Comprehensive Income (and disclosures requirement in respect of PMSA monies where a trust relationship had been created in the scheme's rules)
- 23/2012: Explanatory Note 2 of Annexure B
- 5/2012: Clarification of Circular 38 of 2011 regarding personal medical savings accounts
- 44/2011: Revised Managed Care Standards
- 38/2011: Personal Medical Savings Accounts
- 52/2010: Granting of loans by medical schemes to members must stop
- 5/2010: Audit reports to the Annual Statutory Returns
- 23/2009: Annual financial statements
- 21/2009: Issues encountered during the evaluation of medical scheme administrators regarding the auditing of medical schemes
- 4/2008: Inclusion of benefit options results in the annual financial statements
- 49/2007: Financial reporting by managed care organisations
- 41/2006: 2006 audited financial statements:

- Reporting of non-compliance
- Prescription of unclaimed savings balances
- 11/2006: Issues in audited financial statements:
- Reporting of non-compliance matters
- Fair value of assets for Annexure B
- 33/2005: Pre-funded post-retirement funds – notice for removal of pre-funding reserves or funds
- 13/2001: Non-distributable reserves in solvency calculation

42. This section of the guide provides a selection of important sections contained in the Act and does not constitute a complete or comprehensive list. The relevant legislation and Regulations can be accessed from the CMS website. Any other relevant legislation should be considered, including the following:

- Auditing Profession Act, 2005;
- Collective Investment Schemes Control Act, 2002;
- Companies Act, 2008;
- Consumer Protection Act, 2008;
- Financial Advisory and Intermediary Services Act, 2002, as amended;
- Financial Institutions (Protection of Funds) Act, 2001;
- National Credit Act, 2014, as amended;
- Prescription Act, 1969, as amended;
- Trust Property Control Act, 1988, as amended; and
- Protection of Personal Information Act, No. 4 of 2013, promulgated into law on 26 November 2013. The Act will be effective on a date to be determined by the President.

ACCOUNTING GUIDE

Objectives

1. The financial statements of a medical scheme are prepared in accordance with IFRS Accounting Standards and in the manner required by the Act and Regulations thereto. The objective of this guide is to clarify certain financial reporting issues specific to the medical schemes industry.

2. The overall objective of financial reporting is to achieve fair presentation. Refer to International Accounting Standards (IAS) 1 *Presentation of Financial Statements* for some general guidance that should be taken into account in drafting the financial statements. IAS 1 also contains certain specific presentations and disclosure requirements regarding the various components of financial statements, including the significant accounting policies and other explanatory notes.

3. Examples of illustrative disclosures required in terms of IFRS Accounting Standards that are particularly relevant for medical schemes are included in the appendices to the guide. The illustrative disclosure examples are not intended to address all possible alternatives or to provide specific accounting, business, financial, investment, legal, tax or other professional advice or services.

Format of financial statements

4. Circular 23 of 2008 clarifies that the manner in which the annual financial statements are distributed to members is dealt with in the scheme's rules. Scheme rules further prescribe the format of the annual financial statements to be distributed. The format of the annual financial statements distributed to members generally takes one of three forms:

    - Full set of annual financial statements;
    - Summarised set of annual financial statements; or
    - Highlights document.

5. As per Section 37(4) the full set of financial statements needs to be prepared in accordance with IFRS Accounting Standards; and in the manner required by the Act. The financial statements have to be audited in terms of Section 37(3). Annual financial statements include the financial statements and report of the board of trustees.

6. As per Circular 6 of 2013, schemes whose rules require them to distribute summarised annual financial statements to their members should ensure that such financial statements:

    - Are prepared in accordance with the recognition and measurement requirements of IFRS Accounting Standards;
    - Are prepared in the manner required by the Act;
    - As a minimum, adhere to the presentation and disclosure requirements of IAS 34 Interim

financial reporting; and

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

These summarised annual financial statements would then be subject to an audit conducted in terms of International Standard of Auditing (ISA) 810 Engagements to report on Summary Financial Statements.

A trustees' report must be included as part of the summarised financial statements, as required for a full set of annual financial statements.

7. Circular 6 of 2013 also prescribed the content of the *Highlights* document issued to members.

The following is the minimum information required to be included in this document :

- By means of figures and a description report, set out and explain any matter or information that is material to the affairs of the medical scheme;
- Contain relevant information indicating whether or not the resources of the medical scheme have been applied economically, efficiently and effectively;
- Contain relevant information on how the scheme managed personal medical savings account trust monies on behalf of its members; and
- Contain a statement that the financial information in the *Highlights* document has been extracted from and is in agreement with the audited financial statements.

8. The Registrar requires a full set of the medical scheme's annual financial statements to be submitted in terms of section 37. Medical schemes should be aware that the information provided in the annual financial statements should be reconcilable to the information in the annual statutory return.

9. The Registrar determined in Circular 4 of 2008 that benefit options results are included in medical scheme's annual financial statements.

Statement of comprehensive income

10. The implementation of IFRS 17 – *Insurance Contracts* results in changes to the presentation of the Statement of Comprehensive Income with illustrative disclosures provided in Appendix II.

11. To date, the CMS has not issued circulars prescribing the format of the Statement of Comprehensive Income under IFRS Accounting Standards.

Previous circulars issued by the CMS relating to the Statement of Comprehensive Income are referenced below (par 12 to 14):

12. Circular 56 of 2015 – *Accounting for accredited managed care services based on comments received from industry*, stated that the CMS has reviewed the classification of managed care services

(as defined in the Act) and concluded that all accredited managed care services (as specified in Circular 13 of 2014) should be included as part of healthcare expenditure as they directly impact on the delivery of cost-effective and appropriate (evidence-based medicine) healthcare benefits to beneficiaries of medical schemes. Healthcare expenditure will form part of fulfilment cash flow to determine the insurance liability.

13. The change in the treatment of accredited managed care services per Circular 56 of 2015 results in these fees being included as part of relevant healthcare expenditure, updating the disclosure set out in Circular 41 of 2012. Healthcare expenditure will form part of fulfilment cash flow to determine the insurance liability.

14. The prescribed format of the statement of comprehensive income was updated in Circular 46 of 2020 (Annexure A) to reflect the reclassification of accredited managed care as required by Circular 56 of 2015 and the disclosure changes brought forth by IFRS 9 (the disclosure requirements for IFRS 9 are included in IFRS 7).

15. Medical schemes should consider IAS 1 and IFRS 17 when preparing a statement of comprehensive income.

Statement of financial position

16. Medical schemes should refer to IAS 1 and IFRS 17 when preparing a statement of financial position.

Statement of changes in funds and reserves

17. Medical schemes should refer to IAS 1 when preparing a statement of changes in funds and reserves (if there is any in the scheme). There will be a statement of changes of funds and reserves if a scheme has financial assets through other comprehensive income (OCI) (IAS 1.106). If no statement of changes in funds and reserves is presented, it is recommended that a footnote is included in the basis of preparation paragraph.

Statement of cash flows

18. Medical schemes should refer to IAS 7 *Statement of Cash Flows* in preparing a statement of cash flows.

Amalgamations - impact of IFRS 3 Business Combinations

19. IFRS 3 defines a business combination as a transaction or other event in which an acquirer obtains control of one or more businesses. Business combinations that involve two or more mutual entities are included in the scope of IFRS 3.

Acquisition method

20. Paragraph 5 of IFRS 3 requires the use of the acquisition method to account for business combinations.

21. The acquisition method involves the following steps:

- Identifying the acquirer (being the entity that obtains control of another entity (as defined in IFRS 10 paragraph 18);
- Determining the acquisition date;
- Recognising and measuring the identifiable assets acquired, the liabilities assumed and any non-controlling interest (if applicable) in the acquiree; and
- Recognising and measuring goodwill or a gain from a bargain purchase (this step includes measuring the consideration transferred at fair value).

22. For accounting purposes, medical schemes meet the definition of a mutual entity in IFRS 3. A mutual entity is defined in Appendix A to IFRS 3 as "an entity, other than an investor-owned entity, which provides dividends, lower costs or other economic benefits directly to its owners, members or participants. For example, a mutual insurance company, a credit union and a co-operative entity are all mutual entities." As medical schemes are not investor-owned and provide medical benefits to members, they meet the definition of mutual entities. As "mutual entities" are within the scope of IFRS 3, medical schemes have to apply the requirements of IFRS 3.

23. IFRS 3 paragraph 37 states that the consideration transferred in a business combination shall be measured at fair value, which shall be calculated as the sum of the acquisition-date fair values of the assets transferred by the acquirer, the liabilities incurred by the acquirer to former owners of the acquiree and the equity interests issued by the acquirer.

24. Goodwill should be measured as the sum of:

- Consideration paid for the acquisition of the acquiree;
- Less: the net acquisition-date amounts recognised for acquired assets and liabilities.

Goodwill will most likely represent employees, and the synergies obtained. In a business combination achieved without the transfer of consideration, the acquirer must substitute the acquisition-date fair value of its interest in the acquiree for the acquisition-date fair value of the consideration transferred to measure the goodwill or a gain on a bargain purchase (IFRS 3 paragraph B46).

Amalgamation of medical schemes

25. The fair value of the member interests in the acquiree (or the fair value of the acquiree) may be more reliably measurable than the fair value of the member interests transferred by the acquirer. In this instance, paragraph 33 of IFRS 3 requires the acquirer to determine the amount of goodwill by using the acquisition-date fair value of the acquirer's member interests instead of the acquisition-date fair value of the acquirer's member interests transferred as consideration.

26. In addition, the acquirer, in a combination of mutual entities, shall recognise the acquiree's net assets as a direct addition to capital or equity in its statement of financial position, not as an addition to retained earnings (IFRS 3 paragraph B47). Therefore, the addition should not be added to accumulated funds but rather to a separate reserve. It should be noted that this separate reserve is available to all members of the amalgamated entity. However, it should be noted that as the scheme are mutual entities, any residual interest in the scheme is reflected as a liability to future members.

27. Paragraph BC73 of IFRS 3 clarifies that with the amalgamation of mutual entities, the entire amount of the acquiree's net assets may not be accounted for as a gain on a bargain purchase.

Winding-down costs

28. The winding-down costs of the amalgamated scheme (for instance, the cost of processing run-down claims and handling member queries in respect of the period before the amalgamation) should not be provided for as part of the liabilities on the amalgamation date, as no past event occurred that would lead to the recognition of a provision. The delivery of the services during the winding-down period would result in the recognition of an expense.

Example – Amalgamation of two medical schemes

29. With effect from 1 January 20xx, medical scheme B is to be amalgamated with medical scheme A. Both entities are mutual entities. In terms of the contract of amalgamation, the following factors are identified:

    - Based on the current profile of medical scheme B, reserves of R25 million will be required to maintain the level of the reserves post the amalgamation (from a statutory point of view). For accounting purposes, Medical scheme B recognised a liability to members and therefore had no equity.

    - The reserves of medical scheme B equal R50 million (from a statutory point of view). This amount covers the R25 million reserve requirement, and the additional R25 million reserve will compensate medical scheme A for the higher risk profile of the additional members (originally medical scheme B members). For accounting purposes, medical scheme A recognised a liability to members and therefore had no equity.

    - The current trustees of medical scheme A will have control over the amalgamated scheme.

30. In this example, medical scheme A is identified as the acquirer. It controls the amalgamated scheme through its current trustees.

31. Members of medical scheme B have effectively exchanged their interest in that scheme for a member's interest in medical scheme A.

32. In this example, the fair value of medical scheme B's members' interests is more reliably measurable than the fair value of the member interests of medical scheme A being transferred.

33. If we assume that the net asset value of medical scheme B represents the fair value of its equity interests at the date of amalgamation, there should be no goodwill (or goodwill bargain purchase gain), as the consideration transferred equals the net fair value of assets and liabilities acquired.

The impact of IFRS 17 Insurance Contracts

34. In May 2017, the International Accounting Standards Board (IASB) completed its project on insurance contracts with the issuance of IFRS 17 *Insurance Contracts*. IFRS 17 replaces IFRS 4 and sets out principles for the recognition, measurement, presentation, and disclosure of insurance contracts within the scope of IFRS 17. IFRS 17 became effective for year-ends commencing on or after 01 January 2023.

35. The objective of IFRS 17 is to ensure that relevant information is provided that faithfully represents the insurance contracts issued. This information gives users of financial statements a basis to assess the effect that insurance contracts have on the entity's financial position, financial performance, and cash flows.

36. The key principles of the standard are that an entity:

- Identify contracts that are in the scope of the IFRS 17.
- Separate any specified embedded derivatives, distinct investment components and distinct performance obligations from the insurance contract.
- Divide the insurance contract into portfolios and then groups it will recognise and measure.
- Measure the contracts in scope of IFRS 17 based on the applicable measurement model.
- Presents insurance revenue, insurance service expenses and insurance finance income or expenses separately.

37. IFRS 17 shall be applied to:

- Insurance contracts issued;
- Reinsurance contracts held and/or issued; and
- Investment contracts with discretionary participation feature issued, provided the entity also issues insurance contracts.

IFRS 17 has three measurement models:

- The general measurement model (GMM)
- The premium allocation approach (PAA)
- The variable fee approach (VFA)

The definition of an insurance contract

38. It is important to note that the definition of an insurance contract in IFRS 17 is not a legalistic definition and that it addresses the agreement's substance with a policyholder and not its legal form. For this reason, a contract that is not an insurance contract from a legal perspective could be an insurance contract from an accounting perspective.

39. A medical benefit plan or contract entered into with a member is an insurance contract as defined by IFRS 17, to the extent that:

- It transfers significant insurance risk, other than financial risk, to the scheme (i.e., the risk that the member may seek medical treatment);
- There is a specified uncertain future event, i.e. there is no certainty as to whether the member will seek medical treatment, when the member will seek medical treatment, or how much the medical scheme will need to pay if the member seeks medical treatment; and
- The member (i.e. policyholder) is adversely affected by the insured event (i.e. loss arising from the occurrence of a health event), and the medical scheme agrees to compensate the member for these costs.

40. IFRS 17 defines a reinsurance contract as an insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts).

41. Within a medical scheme context, this definition needs to be considered in respect of commercial reinsurance contracts and capitation agreements where the medical scheme has transferred significant risk to a third-party medical service provider. Therefore, a contract held by a medical scheme will meet the definition of a risk transfer arrangement and should be accounted for in terms of IFRS 17 if:

- The contract meets the definition of an insurance contract, and
- The reinsurer/service provider compensates the medical scheme for claims arising from one or more insurance contracts issued to members.

42. A medical scheme shall apply IFRS 17 to all medical benefit plans/ contracts that meet the definition of insurance contracts, as defined by IFRS 17. In applying IFRS 17, the medical scheme will be viewed as the insurer in respect of insurance contracts that it issues and as the cedant in respect of risk transfer arrangements that it holds.

Assessment as to whether a medical scheme is a mutual entity

43. A medical scheme is not legally defined as a mutual entity and the assessment as to whether a medical scheme is a mutual entity is done based on the principles set out in IFRS Accounting Standards.

44. IFRS 17 does not define a “mutual entity” but provides a key characteristic of a mutual entity in the Basis for Conclusions to the standard. BC265 explains that “a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder.”

45. The Act is not explicit that members (i.e. policyholders) hold a residual interest or are entitled to the residual interest upon liquidating the medical scheme. Section 64 of the Act requires the medical scheme rules to be followed in the event of liquidation.

46. Generally, the rules of medical schemes do not contain specific guidance on how the scheme's assets should be distributed on liquidation. The Act prohibits the disposal of assets of a medical scheme except in limited, listed circumstances, one of them being the liquidation of the scheme. Members can opt for voluntary liquidation and can distribute the scheme’s remaining assets amongst themselves.

47. As medical schemes do not have shareholders, the current members will access the reserves through economic benefits such as funding reductions in contributions or deferral of contribution increases.

48. Although the rules do not generally specify how the assets should be distributed on liquidation, IFRS 17 states that “contracts can be written, oral or implied by an entity's customary business practices. Contractual terms include all terms in a contract, explicit or implied, but an entity shall disregard terms that have no commercial substance (i.e. no discernible effect on the economics of the contract). Implied terms in a contract include those imposed by law or regulation” (IFRS 7.2).

49. Therefore, based on customary business practices, the remaining assets of a scheme should be distributed to the members on liquidation if there are any and if the scheme does not amalgamate with another scheme. Even if the assets are distributed by a regulator or by the policyholders to an independent third party, e.g. another medical scheme, an administrator or a charity, the important aspect is that the choice resides with the members or the regulator acting on behalf of the members, not with an equity holder.

50. The substance of the legal framework issued regarding insurance contracts and observed practice is that once a contribution is paid to the medical scheme, the contribution is used to provide benefits to members. The benefits are provided by the medical scheme (or amalgamated schemes) through insurance coverage, reduced contributions, or payment to members on liquidation (based on members’ votes).

51. It is therefore expected that the remaining assets of the scheme will be used to pay current and future members. Based on the above, a medical scheme is a mutual entity.

52. Determining whether a particular medical scheme is a mutual entity is an area of judgment and medical schemes should consider their own facts and circumstances in arriving at a decision. Current legislation and medical scheme rules are not necessarily clear regarding the mutual entity status of a medical scheme.

Separating components from an insurance contract

53. Medical schemes generally do not have any contracts with specified embedded derivatives. Certain types of contracts with members contain a PMSA, which, under IFRS 4, met the criteria for unbundling and was separated from the insurance contract and accounted for as a financial instrument.

54. The PMSA meets the definition of an investment component in IFRS 17 as it requires the medical scheme to repay a member in all circumstances, even if an insured event has not occurred. It needs to be assessed based on IFRS 17 whether the PMSA meets the definition of a distinct investment component and should be separated and accounted for as a financial instrument.

55. Firstly, to determine whether the investment component is distinct or not, the medical scheme has to assess per IFRS 17 whether the investment component and the insurance component are highly interrelated:

- The investment component and the insurance component are highly interrelated, where one component cannot be measured without considering the other.

  Under certain benefit plan options, a risk component becomes available once the PMSA has been exhausted and certain conditions are met. This indicates that the level of certain risk benefits available under the insurance contract varies according to the value of the PMSA. The value of risk benefits cannot be measured without considering the PMSA, resulting in the two components being highly interrelated.

- The second indication that the two components are highly interrelated is that the policyholder cannot benefit from one component unless the other component is also present.

If a member elects a benefit plan with a PMSA, he/she has no option but to take both the PMSA and risk component. Also, the lapse of one component will cause the lapse of the other. Based on the above, the risk component and the PMSA are highly interrelated which indicates the PMSA is a non-distinct investment component.

The second condition that must be met in order to separate components is that a contract with equivalent terms is sold or could be sold separately in the same market or jurisdiction.

The PMSA cannot be sold separately and does not exist without the active medical scheme policy. Where the contract is cancelled, both the risk and PMSA components are cancelled. This means the condition ‘that a contract with equivalent terms is sold or could be sold separately in the same market or jurisdiction’ is not met.

It appears that the conditions to separate the PMSA, an investment component, from the insurance component (risk portion) are not met. Therefore, PMSAs should not be separated from the insurance component, and IFRS 17 should also be applied to them.

The PMSA is thus accounted for as a non-distinct investment component with the balances included

in either insurance contract assets or liabilities in the statement of financial position. While the cash inflow relating to the PMSA is not recorded in the statement of comprehensive income (i.e. excluded from insurance revenue), it is considered in assessing onerous contracts.

Level of aggregation

56. The level of aggregation significantly impacts the measurement of insurance contracts. Aggregation of insurance contracts is done to prevent offsetting or cross subsidisation of contracts so that onerous contracts are identified correctly.

57. A portfolio comprises contracts subject to similar risks and managed together. Contracts within a product line would be expected to have similar risks and, hence, could be expected to be in the same portfolio if they are managed together. The identification of the portfolio of insurance contracts impacts the identification of groups of insurance contracts and the unit of account to which the requirements of IFRS 17 are applied for medical schemes.

58. The only product line offered by medical schemes is that of insurance cover against the cost of a health event. Medical schemes may offer various benefit options, but ultimately the same risk covered is the health event, with similar types of benefits provided across the different options. The requirement of PMBs ensures that similar benefits across benefit options are offered. However, the extent of the benefit levels across the different options may vary. These benefit options are also managed together on a scheme level. A medical scheme may consider the results, financial position, and cash flows at a lower level than at the overall scheme level. In such instances, the portfolio of insurance contracts could be at a lower level. Medical schemes should apply judgment when determining the portfolios of insurance contracts.

59. Medical schemes set out their pricing and valuation assumptions in submissions supporting the annual pricing and budget submissions to the CMS during September and October of each year. This would record a medical scheme's approach to the overall management of the scheme, including different benefit options. In general, contracts issued by medical schemes are subject to similar risks, managed together and fall into the same portfolio.

60. In terms of IFRS 17 par 16, for measurement purpose, an entity is required to divide a portfolio of insurance contracts issued into a minimum of:

    (a) A group of contracts that are onerous at initial recognition, if any;

    (b) A group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and

    (c) A group of the remaining contracts in the portfolio, if any.

61. Paragraph 20 of IFRS 17 states that if contracts within a portfolio would fall into different groups only because law or regulation specifically constrains the entity's practical ability to set a different price or level of benefits for policyholders with different characteristics, the entity may include those contracts in the same group. This approach should be applied consistently.

62. Section 29(1)(n) of the Act limits a medical scheme's ability to set a price that reflects the risk, and medical schemes cannot set a price that reflects the risk at policyholder level. The inability to set a price at the policyholder level results in the requirement of cross-subsidisation across different policyholders and different benefit options to ensure that a medical scheme remains affordable to members while remaining sustainable.

63. Based on the above, it should be considered whether the portfolio(s) consist of one or more groups of insurance contracts. Because of section 29(1)(n) of the Act, the exemption in paragraph 20 of IFRS 17 may apply.

Recognition

64. Insurance contracts issued shall be recognised from the earliest of the following:

    (a) The beginning of the coverage period;

    (b) The date when the first payment from a policyholder becomes due or when it is actually received in the instance when there is no contractual due date; and

    (c) For onerous contracts, when the contracts become onerous (IFRS 17.25).

65. Section 1 of the Act sets the financial year end for all medical schemes as 31 December each year. Medical scheme contracts are generally recognised on 1 January, the beginning of the coverage period. The member application forms include the billing and payment arrangements for contributions. Contributions may be billed in advance or arrears and are due within three days from the due date. Contributions received in December that are due in January (i.e. contributions received in advance) would result in such contracts relating to the following financial year /coverage period being required to be recognised in the current reporting period as:

    - a liability for remaining coverage or

    - a separate financial liability (in terms of IFRS 9)– derecognise when the related member contract is recognised (for example in January of the particular year) (IFRS 17.B66A).

    As IFRS 17 is not clear on this, the medical scheme should document in its accounting policies which of the above treatments was followed by the scheme.

66. In most instances, contracts issued by medical schemes are in line with its financial year, and no contracts will be issued for a financial year after the end of that specific financial year.

67. As the coverage period generally aligns with the reporting period (financial year), insurance contracts will be recognised from 1 January or from the inception of cover should the member join the medical scheme after 1 January. Regulation 4(3) to the Act provides that a medical scheme may, in its rules, provide that a member may only change to any benefit option at the beginning of the month of January each year and by giving written notice of at least three months before such change is made.

68. An exception to this would be where the medical scheme as a whole is priced for a deficit position, which may trigger onerous contracts. Where the contracts are assessed as onerous, an onerous contract liability should be recognised when the contracts become onerous. As pricing for medical schemes is done in September/October for the following year, the onerous contract test would be assessed at this time, with the following year's loss being recognised in the current financial year. The impact of medical schemes being defined as mutual entities need to be considered in assessing onerous contracts. However, below, we will discuss the measurement of liability to future members and its impact on the recognition of onerous contracts.

Reinsurance contracts held

69. A medical scheme shall divide portfolios of reinsurance contracts held applying paragraphs 56 – 63, except that the reference to onerous contracts shall be replaced with reference to contracts on which there is a net gain on initial recognition. For some reinsurance contracts held, applying paragraphs 56 – 63 will result in a group that comprises a single contract. Generally, in the case of medical schemes, each reinsurance contract (i.e. risk transfer arrangement) will represent one portfolio and one group. The reinsurance contracts are not subject to similar risks and are not managed together and therefore they are not combined with other reinsurance contracts for measurement purposes.

Recognition

70. Instead of applying paragraph 64, a medical scheme shall recognise a group of reinsurance contracts held from the earlier of the following:

    (a) The beginning of the coverage period of the group of reinsurance contracts held; and

    (b) The date the medical scheme recognises an onerous group of underlying reinsurance contracts applying paragraph 64 (c), if the scheme entered into the related reinsurance contract held in the group of reinsurance contracts held at or before that date.

71. Notwithstanding paragraph 70 (a), a scheme shall delay the recognition of a group of reinsurance contracts held that provide proportionate coverage until the date that any underlying insurance contract is initially recognised, if that date is later than the beginning of the coverage period of the group of a reinsurance contract held.

Premium allocation approach (PAA)

72. For contracts issued to which the medical scheme applies the PAA, it is assumed that no contracts in the portfolio are onerous at initial recognition unless facts and circumstances indicate otherwise. The medical scheme shall assess whether contracts (or the portfolio as discussed above) that are not onerous at initial recognition have no significant possibility of becoming onerous subsequently by assessing the likelihood of changes in applicable facts and circumstances.

73. A key principle in determining the cash flows to be included in the insurance contracts issued is the contract boundary. Cash flows are within the boundary of an insurance contract if they arise from

substantive rights and obligations that exist during the reporting period in which a medical scheme can compel a member to pay the contributions or in which the medical scheme has a substantive obligation to provide a member with services. The service under contracts issued by medical schemes is the indemnification against the cost arising from a health event covered in terms of the rules of the medical scheme.

74. A substantive obligation to provide services ends when:

- The medical scheme has the practical ability to reassess the risks of the particular member and, as a result, can set a price or level of benefits that fully reflects those risks; or
- Both of the following criteria are satisfied:
    - i The medical scheme has the practical ability to reassess the risks of the portfolio of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflect the risks of that portfolio; and
    - ii The pricing of the contributions for coverage up to the date when the risks are reassessed does not take into account the risks that relate to periods after the reassessment date.

75. The limitations imposed on a medical scheme by the Act restrict a medical scheme's practical ability to assess the risks of a particular member and set a price or level of benefits that fully reflect the risks of an individual member. Medical schemes are prohibited from setting a price or level of benefits that fully reflects those risks. As a result of these legislative requirements, when assessing the risk and pricing for the health events covered, risk is assessed, and a price is set after considering the risks covered at the total medical scheme level.

76. The Act and the medical scheme rules align the benefit year for insurance contracts issued with the medical scheme financial year. Multi-year scenarios are prepared to provide a view of the possible future impact and position of a medical scheme; however, the risks from these future periods are not taken into account in setting the pricing level for a specific benefit year.

77. Contribution level and benefit changes require CMS approval before implementation. These are generally done and only considered annually, with interim increases (changes during the course of a financial year) or changes only considered in exceptional cases and rarely approved. The CMS requires changes to contributions and benefits to be submitted in September and October for the following year, with approval being provided around December for the next financial year.

78. The medical scheme regulatory environment results in medical schemes only having the practical ability to reassess the risks and set a price that fully reflects the risks at a scheme level and that the changes can only be made annually, effective from the beginning of the financial/benefit year (i.e. January). As the CMS generally only considers and approves changes annually, these changes are generally effective for the full 12-month benefit year.

79. Some medical schemes apply contribution increases on a date other than 1 January, typically in March or July. For most of these medical schemes, although contributions are increased during the

financial year, benefits are increased from 1 January, and contribution increases are set to reflect the risk over the 12-month period to December – the benefit year, which aligns with the financial year.

80. Existing medical scheme members elect their benefit option for the following benefit year on an annual basis (generally by December of the current year), which will be effective from 1 January of the following year. This results in the coverage period being one year or less, as a new contract will be entered into and will be effective from 1 January each year.

81. This impacts the contract boundary for contracts issued, which does not exceed 12 months and is generally aligned with a medical scheme's financial year.

82. The coverage period for medical scheme contracts in the portfolio is one year or less. This is supported by the benefit cycle and medical schemes' setting of contribution levels. This takes place annually, with the benefit cycle commencing on 1 January each year and ending on 31 December.

83. IFRS 17 allows for the simplification of the measurement of a group of insurance contracts using the PAA set out in IFRS 17 paragraphs 55–59 if, and only if, at the inception of the group, the following criteria is applicable:

    (a) There is a reasonable expectation that the simplification would produce a measurement of the liability for remaining coverage for the group that would not differ materially from the one that would be produced by applying the requirements in IFRS 17 paragraphs 32–52 (the GMM). This is not met if, at the inception of the group, there is an expectation of significant variability in the fulfilment cash flows that would affect the measurement of the liability for remaining coverage during the period before a claim is incurred.; or

    (b) The coverage period of each contract in the group (including insurance contract services arising from all premiums within the contract boundary determined at that date applying IFRS 17 paragraph 34) is one year or less.

84. Each medical scheme contract has a coverage period of one year or less. This allows medical schemes to simplify the measurement of their insurance contract portfolio by using the PAA.

85. The classification of medical schemes as mutual entities does not impact the extent of insurance cover/ insurance contract services to be provided by the medical scheme in terms of the member contracts, and therefore, the PAA is still applicable.

86. In applying the PAA, the medical scheme:

    (a) may recognise any insurance acquisition cash flows as expenses when it incurs those costs.

    (b) shall measure the liability for incurred claims for the group of insurance contracts at the fulfilment cash flows relating to incurred claims. The future cash flows are not required to be adjusted for the time value of money and the effect of financial risk, as these cash flows are expected to be paid in one year or less from the date the claims are incurred.

87. The costs of selling the insurance contracts (mainly broker fees) may only be paid once contributions have been received and, therefore, only after the insurance contract has been recognised. As part of the underwriting process, there may be instances where medical opinion fees are paid to assess the new application. As the coverage period of the contracts does not exceed one year, it is expected that the accounting policy to be adopted by medical schemes would be to recognise these fees as an expense when incurred. As a result of this process, no asset or liability is recognised for insurance acquisition cash flows.

88. The insurance liability to be recognised by the scheme will consist of a liability for remaining coverage and a liability for incurred claims.

Liability for remaining coverage

89. Using the PAA, on initial recognition, a medical scheme shall measure the liability for remaining coverage as follows (IFRS 17.55(a)):

The premiums, if any, received at initial recognition;
minus any insurance acquisition cash flows at that date unless the entity chooses to recognise the payments as an expense;
plus or minus any amount arising from the derecognition at that date of:
• any asset for insurance acquisition cash flows; and
• any other asset or liability previously recognised for cash flows related to the contracts (this could include contributions received in advance if scheme elected to account for the contributions received in advance as a separate financial liability before the related contract was recognised).

90. Using the PAA, on subsequent measurement, the medical scheme should measure the liability for remaining coverage as follows (IFRS17.55(b)):

The carrying amount of the liability at the start of the reporting period
Plus the premiums received in the period;
minus insurance acquisition cash flows unless the entity chooses to recognise the payments as an expense;
plus any amounts relating to the amortisation of insurance acquisition cash flows recognised as an expense in the reporting period unless the entity chooses to recognise insurance acquisition cash flows as an expense;
plus any adjustment to a financing component (if the scheme if the scheme is required to account for the time value of money on premiums received);
minus the amount recognised as insurance revenue for services provided in that period and
minus any investment component paid or transferred to the liability for incurred claims (see par 91 below).

91. As the coverage period and the financial year for a medical scheme are the same, there would generally be no liability for remaining coverage at the year-end reporting date, assuming that the actual cash collected for contributions equals the contributions recognised. There may be an amount in the liability for remaining coverage:

    - If an accounting policy choice was made to account for the *investment component (PMSA)* in the liability for remaining coverage until it becomes payable in cash to the member (see below).

- The scheme received contributions in advance *(see par 89 above).*

An accounting policy should be documented as to when the PMSA is transferred to the liability for incurred claims. This transfer could be done when an amount becomes payable in cash to the member (for example when the member exists the scheme). Only at the point when the amount becomes payable to the member, the relevant portion of the PMSA is transferred to the liability for incurred claims.

Alternatively, the scheme should document in its accounting policies that all amounts relating to PMSA are transferred from the liability for remaining coverage to the liability for incurred claims at the end of each financial year as the underlying medical contract with the member then comes to an end.

It should be noted that the liability for incurred claims includes the PMSA used by members (transferred from the liability for remaining coverage).

Liability for incurred claims

92. Medical scheme rules require claims to be submitted within four months after the service was rendered. The rules provide medical schemes discretion to extend the four-month period to a maximum of six months. This means that at the reporting date, medical schemes would need to recognise a liability for incurred claims, comprising the fulfilment cash flows related to past service.

93. The liability for incurred claims is measured at the fulfilment cash flows related to past service, for cash flows within the contract boundary.

94. The estimate of future cash flows shall:

    (a) in an unbiased way, incorporate all reasonable and supportable information available without undue cost or effort regarding the amount, timing, and uncertainty of those future cash flows. To do this, the probability-weighted mean of the full range of possible outcomes shall be estimated;

    (b) reflect the perspective of the medical scheme, provided that the estimates of any relevant market variables are consistent with observable market prices for those variables;

    (c) be current – the estimates shall reflect conditions existing at the measurement date, including assumptions at that date about the future; and

    (d) be explicit – the medical scheme shall estimate the risk adjustment for non-financial risk separately from the other estimates.

95. Insurance service expenses for the following changes in the carrying amount of the liability for incurred claims shall be recognised:

(a) For the increase in the liability because of claims and expenses incurred in the period, excluding any investment components; and

(b) For any subsequent changes in fulfilment cash flows relating to incurred claims and incurred expenses.

96. The estimate of the future cash flows for the liability for incurred claims shall be adjusted to reflect the compensation that the medical scheme requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk. This risk adjustment for non-financial risk also reflects the degree of diversification benefit the entity includes when determining the compensation required for bearing that risk, and both favourable and unfavourable outcomes, in a way that reflects the medical scheme's degree of risk aversion.

97. The objective of the risk adjustment for non-financial risk is to reflect the medical scheme's perception of the economic burden of its non-financial risks. The non-financial risks covered by the risk adjustment are insurance and other non-financial risks such as lapse and expense risks. It shall not reflect the risks that do not arise from the insurance contracts, such as general operational risk.

98. Where the medical scheme's benefit year, financial year, and contract boundary align, all contracts entered into during the reporting period would have expired. The only area of uncertainty is related to the liability for incurred claims, which would require the risk adjustment.

99. IFRS 17 does not specify the estimation technique(s) used to determine the risk adjustment for non-financial risk. However, to reflect the compensation the medical scheme would require for bearing the non-financial risk, the risk adjustment for non-financial risk shall have the following characteristics:

(a) Risks with low frequency and high severity will result in higher risk adjustments for non-financial risk than risks with high frequency and low severity;

(b) Risks with a wider probability distribution will result in higher risk adjustments for non-financial risk than risks with a narrower distribution;

(c) The less that is known about the current estimate and its trend, the higher will be the risk adjustment for non-financial risk; and

(d) To the extent that emerging experience reduces uncertainty about the amount and timing of cash flows, risk adjustments for non-financial risk will decrease and vice versa.

100. The medical scheme shall apply judgment when determining an appropriate estimation technique for the risk adjustment for non-financial risk and consider whether the technique will enable concise and informative disclosure so that users of financial statements can benchmark the performance against the performance of other medical schemes.

101. Paragraph 119 requires an entity that uses a technique other than the confidence level technique to determine the risk adjustment for non-financial risk to disclose the technique used and the

confidence level corresponding to its results. The historical claims experience and IBNR run-off are key inputs in setting the risk adjustment expected to be used by medical schemes.

102. There is no requirement to adjust future cash flows for the time value of money and the effect of financial risk, as these cash flows are expected to be paid within one year or less from the date the claims are incurred. For medical schemes, the majority of claims are settled within four months from the date of service.

Mutual entity measurement considerations

103. IFRS 17.B71 states, "After all insurance contract services have been provided to the contracts in a group, the fulfilment cash flows may still include payments expected to be made to current policyholders in other groups or future policyholders. An entity is not required to continue to allocate such fulfilment cash flows to specific groups but can instead recognise and measure a liability for such fulfilment cash flows arising from all groups".

104. Based on this paragraph, it is expected that the remaining assets of the scheme will be used to pay current and future policyholders.

105. The scheme should recognise a liability in terms of IFRS 17.B71 in its statement of financial position to provide coverage to future members ("liability to future members"). This is on the basis that the scheme is in a surplus position. If the scheme is in a deficit position, there is no residual to draw on to raise a liability. It could also be argued that it is a liability to members, and not only future members. However, for IFRS 17 purposes, at the end of each financial year, the contract with a member comes to an end. Therefore, for the purpose of this guide, we have referred to it as a liability to future members. Each scheme to decide what is the most appropriate wording for its financial statements.

106. The liability to future members is, in essence, incurred because by "signing" the contract with the member, the scheme is obliged to:

- provide coverage to that member;
- pay incurred claims of that member; or
- provide coverage to future members (IFRS 17.B71 liability).

107. The liability to future members could be presented separately to the liability for incurred claims and the liability for remaining coverage. This is supported by IFRS 17.BC 269 "… an insurer that is a mutual entity can distinguish:

(a) In the statement of financial position, the liability attributable to policyholders in their capacity as policyholders from the liability attributable to policyholders with the most residual interest in the entity; and

(b) In the statement(s) of financial performance, the income or expenses attributable to policyholders in their capacity as policyholders before determination of the amounts attributable to policyholders with the most residual interest in the entity."

108. On the measurement of the liability to future members, the fulfilment cash flows are measured at the current value.

109. There may be accounting mismatches between the measurement of the liability to future members and the measurement of the other net assets of the scheme. This liability should be measured incorporating information about the fair value of the other assets and liabilities of the scheme. Many of these other assets and liabilities are not required to be measured at fair value in applying IFRS Accounting Standards, for example, amortised cost financial assets and pension scheme surpluses and deficits. Furthermore, the carrying amounts of assets that are not measured at fair value are more likely to be measured at a value lower rather than higher than fair value because of requirements to recognise impairments (IFRS 17.BC 266).

110. The liability to future members may be greater than recognised assets in the financial statements, even though the schemes are solvent for regulatory purposes, but IFRS will have no equity (or negative equity) and no net comprehensive income for the accounting period (IFRS 17.BC 265, 267).

Onerous contract assessment

111. IFRS 17.57 states that "if at any time during the coverage period, facts and circumstances indicate that a group of insurance contracts is onerous, an entity shall calculate the difference between:

(a) The carrying amount of the liability for remaining coverage determined applying the PAA; and

(b) The fulfilment cash flows that relate to the remaining coverage of the group, applying the GMM. If the entity does not adjust the liability for incurred claims for the effect of the time value of money or financial risk, it shall not include these adjustments in the fulfilment cash flows."

112. We would, therefore, expect all the cash flows within the contract boundary to be included in the onerous contract assessment.

113. The net residual of the scheme is already disclosed as a liability to future members. Therefore, no further liabilities should be recognised. IFRS 17.57 requires an additional liability to be recognised when comparing the liability for remaining coverage under the PAA with the liability for remaining coverage in terms of the GMM. IFRS 17.57(b) includes a reference to B71, under which an additional liability is recognised.

114. Where the following year's deficit exceeds the value attributable to members – the most residual interest – the contracts written would be onerous and an onerous contract liability should be raised. Where the amounts attributable to members exceed the following year's deficit the contracts would not be determined as onerous, and no onerous contract liability is raised as a liability to future members is already recognised.

Measurement: Cash flows

115. The cash flows to fulfil an insurance contract include:

- Contributions (including contribution adjustments) from a member and any additional cash flows that result from those contributions.
- Payments to (or on behalf of) a member, including claims that have already been reported but not been paid, claims incurred but not yet reported and all future claims for which the medical scheme has a substantive obligation.
- Insurance acquisition cash flows attributable to the portfolio to which the contract belongs.
- Claim handling costs (i.e. the costs the medical scheme will incur in investigating, processing and resolving claims under existing insurance contracts, including legal and loss adjusters' fees and internal costs of investigating claims and processing claims payments)
- Costs the medical scheme will incur in providing contractual benefits paid in kind.
- Policy administration and maintenance costs, such as costs of contribution billing and handling policy changes
- Potential cash inflows from recoveries on past claims, such as those from third party recoveries
- Any other costs specifically chargeable to the member under the terms of the contract – these would generally be co-payments / deductibles due by members.

116. Cash flows that are not incurred to fulfil insurance contracts are not included in the boundary of an insurance contract and are measured and presented separately. These include:

- Investment returns (on financial assets) – these are recognised, measured and presented separately.
- Cash flows (payments or receipts) that arise under reinsurance contracts held
- Cash flows that may arise from future insurance contracts, i.e. cash flows outside the boundary of existing contracts.
- Cash flows that cannot be directly attributed to the portfolio of insurance contracts containing the contracts, such as some product development and training costs. Such costs are recognised in profit or loss when incurred.
- Cash flows that arise from abnormal amounts of wasted labour or other resources used to fulfil the contract - such costs are recognised in profit or loss when incurred.
- Cash flows arising from components separated from the insurance contract and accounted for

using other applicable standards.

Disclosures for insurance contracts

117. A scheme is required to disclose information in the notes that, together with the information provided in the statement of financial position, statement(s) of financial performance and statement of cash flows, gives a basis for users of financial statements to assess the effect that contracts within the scope of IFRS 17 have on the scheme's financial position, financial performance and cash flows.

118. To achieve that objective, an entity shall disclose qualitative and quantitative information about:

    (a) The amounts recognised in its financial statements for contracts within the scope of IFRS 17 (refer to IFRS 17 paragraphs 97–116);

    (b) The significant judgements, and changes in those judgements, made when applying IFRS 17 (refer to IFRS 17 paragraphs 117–120); and

    (c) The nature and extent of the risks from contracts within the scope of IFRS 17 (refer to IFRS 17 paragraphs 121–132).

119. Of the disclosures required by IFRS 17 paragraphs 98–109A, only the following paragraphs apply to contracts under the PAA.

IFRS 17	**Requirements**
Paragraph 98	A scheme shall disclose reconciliations that show how the net carrying amounts of contracts within the scope of IFRS 17 changed during the period because of cash flows and income and expenses recognised in the statement of financial performance. Separate reconciliations shall be disclosed for insurance contracts issued and reinsurance contracts held. An entity shall adapt the requirements of paragraphs 100–109 to reflect the features of reinsurance contracts held that differ from insurance contracts issued, for example, the generation of expenses or reduction in expenses rather than revenue.
Paragraph 99	A scheme shall provide enough information in the reconciliations to enable users of financial statements to identify changes from cash flows and amounts recognised in the statement of financial performance. To comply with this requirement, an entity shall: (a) disclose, in a table, the reconciliations set out in paragraphs 100–105; and (b) for each reconciliation, present the net carrying amounts at the beginning and at the end of the period, disaggregated into a total for groups of contracts that are assets and a total for groups of contracts that are liabilities, that equal the amounts presented in the statement of financial position applying paragraph 78.
Paragraph 100	A scheme shall disclose reconciliations from the opening to the closing balances separately for each of: (a) the net liabilities (or assets) for the remaining coverage component, excluding any loss component. (b) any loss component (see paragraphs 47–52 and 57–58).

	(c) the liabilities for incurred claims. For insurance contracts to which the PAA described in paragraphs 53–59 or 69–70 has been applied, an entity shall disclose separate reconciliations for: i the estimates of the present value of the future cash flows; and ii the risk adjustment for non-financial risk.
Paragraph 102	The objective of the reconciliations in paragraphs 100–101 is to provide different types of information about the insurance service result.
Paragraph 103	A scheme shall separately disclose in the reconciliations required in paragraph 100 each of the following amounts related to insurance services, if applicable: (a) Insurance revenue. (b) Insurance service expenses, showing separately: i Incurred claims (excluding investment components) and other incurred insurance service expenses; ii Amortisation of insurance acquisition cash flows; iii Changes that relate to past service, i.e. changes in fulfilment cash flows relating to the liability for incurred claims; and iv Changes that relate to future service, i.e. losses on onerous groups of contracts and reversals of such losses. (c) Investment components excluded from insurance revenue and insurance service expenses.
Paragraph 105	To complete the reconciliations in paragraphs 100–101, a scheme shall also disclose separately each of the following amounts not related to insurance services provided in the period, if applicable: (a) Cash flows in the period, including: i Premiums received for insurance contracts issued (or paid for reinsurance contracts held); ii Insurance acquisition cash flows; and iii Incurred claims and other insurance service expenses paid for insurance contracts issued (or recovered under reinsurance contracts held), excluding insurance acquisition cash flows. (b) The effect of changes in the risk of non-performance by the issuer of reinsurance contracts held; (c) Insurance finance income or expenses; and (d) Any additional line items necessary to understand the change in the net carrying amount of the insurance contracts.
Paragraph 105A	A scheme shall disclose a reconciliation from the opening to the closing balance of assets for insurance acquisition cash flows recognised applying paragraph 28B. An entity shall aggregate information for the reconciliation at a level consistent with that for the reconciliation of insurance contracts, applying paragraph 98 (not applicable if insurance acquisition cash flows are expensed).
Paragraph 105B	A scheme shall separately disclose in the reconciliation required by paragraph 105A any impairment losses and reversals of impairment losses recognised applying paragraph 28E–28F (not applicable if insurance acquisition cash flows are expensed).
Paragraph 109A	A scheme shall disclose quantitatively, in appropriate time bands, when it expects to derecognise an asset for insurance acquisition cash flows applying paragraph 28C (not applicable if insurance acquisition cash flows are expensed).

Paragraph 121 - 132	Nature and extent of risks that arise from contracts within the scope of IFRS 17

120. With medical schemes using the PAA, it shall disclose:

(a) Whether it makes an adjustment for the time value of money and the effect of financial risk;

(b) The method it has chosen to recognise insurance acquisition cash flows: Insurance acquisition costs are expensed as incurred or recognised as part of the liability for remaining coverage and amortised; and

(c) Whether the scheme presents the reinsurance income and expense net or gross on the face of the statement of profit or loss and other comprehensive income.

Sensitivity analysis

121. Medical schemes should disclose information about sensitivities to changes in risk variables arising from contracts within the scope of IFRS 17. Refer to IFRS 17 paragraphs 128 and 129 for disclosure requirements.

The impact of IFRS 7 Financial Instruments: Disclosures

Disclosure for financial instruments

122. The impact of IFRS 7 on medical schemes has been summarised below. Refer to Appendix II for illustrative disclosures.

123. IFRS 7 requires entities to provide disclosures in their financial statements that enable users to evaluate the significance of financial instruments for the entity's financial position and performance and the nature and extent of risks arising from financial instruments to which the entity is exposed during the period and at the end of the reporting period and how the entity manages those risks.

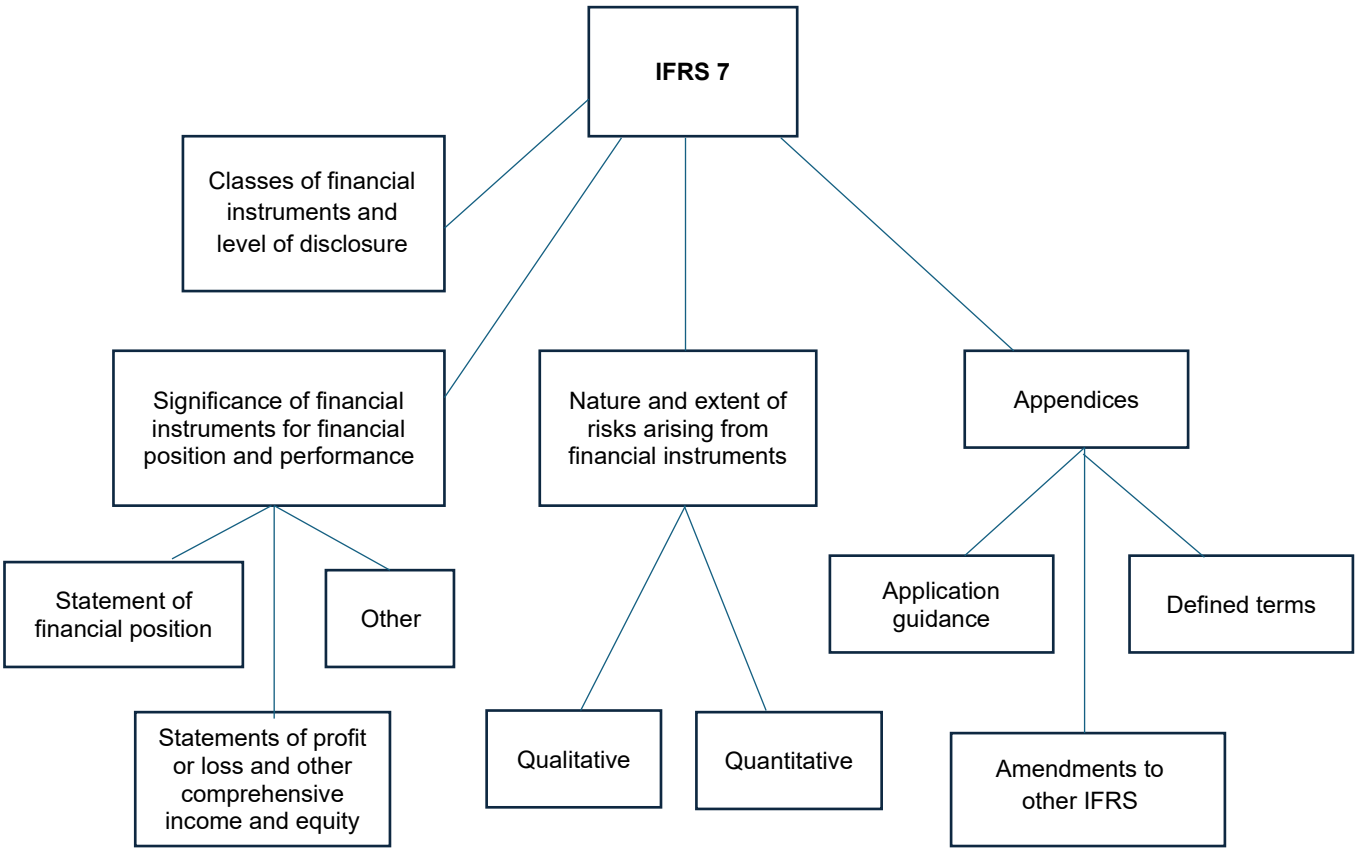
IFRS 7 applies to any medical scheme that holds financial instruments. The level of disclosure required depends on the extent of the medical scheme's use of financial instruments and its exposure to financial risk. The overriding objective of the standard is that preparers should provide disclosures that enhance a user's understanding of the medical scheme's exposures to financial risks and how the medical scheme manages those risks.

124. To this end, the standard requires a medical scheme to disclose:

- Information on the significance of financial instruments to the medical scheme's financial position and performance
- The nature and extent of risk exposures arising from financial instruments.

- Quantitative information about exposure to risks arising from financial instruments; and
- The approach taken in managing those risks (qualitative disclosures).

125. Diagrammatically IFRS 7 can be summarised as follows:



126. IFRS 7 is divided into two sections: the first section deals with the significance of the financial instruments for the entity's financial position and performance and relevant qualitative disclosure. The qualitative disclosure includes disclosure that pertains to fair value, collateral, and defaults and breaches. The second section deals with risk disclosure. The risk disclosure required in terms of IFRS 7 should reflect the way the scheme's risks are perceived, measured, and managed by management.

Categories vs classes

127. It should be noted that IFRS 7 requires certain disclosures to be made per category of financial instrument and others per class of financial instrument. A class of financial instruments is not the same as a category of financial instruments.

    Categories of financial instruments determine how financial instruments are measured and where changes in fair value are recognised.

Categories of financial instruments are defined in IFRS 9 as financial assets at fair value through profit or loss, financial assets measured at amortised cost, financial assets at fair value through other comprehensive income, financial liabilities at fair value through profit or loss and financial liabilities measured at amortised cost.

128. The standard itself does not provide a prescriptive list of classes of financial instruments. However, IFRS 7.6 states that a scheme should take into account the characteristics of financial instruments and that the classes selected should be appropriate to the nature of the information disclosed. Classes should be determined at a lower level than the IFRS 9 categories and reconciled back to the statement of financial position. The level of detail for a class should be determined on a scheme-specific basis.

129. In determining classes of financial instruments, the application guidance in Appendix B of IFRS 7, at a minimum, requires that a scheme distinguishes between the following:

- Financial instruments measured at fair value and those measured at amortised cost, e.g., trade receivables (measured at amortised cost) and investments in listed securities (measured at fair value) cannot be grouped together in one class; and
- Financial instruments within the scope of IFRS 7 and other assets and liabilities not within the scope of IFRS 7. For example, the following cannot be grouped together in one class:
    - Investments in subsidiaries (within the scope of IAS 27) and investments in bonds (within the scope of IFRS 7); and
    - Insurance liabilities (within the scope of IFRS 17) and trade payables (within the scope of IFRS 7).

130. Paragraph B3 of the application guidance further states: "*It is necessary to strike a balance between overburdening financial statements with excessive detail that may not assist users of financial statements and obscuring important information as a result of too much aggregation.*" A scheme should, therefore, apply its judgment in determining the appropriate level of detail to be disclosed to comply with the IFRS 7 requirements.

131. IFRS 7 *requires* disclosure of the following items by class:

- Financial assets not qualifying for de-recognition;
- The reconciliation of the loss allowance account;
- Effect of collateral and credit enhancements;
- For all financial instruments within the scope of IFRS Accounting Standards, but to which impairment requirements in IFRS 9 do not apply; and
- Fair value.

Information disclosed on the significance of financial instruments for the scheme's financial position and performance.

132. IFRS 7 prescribes certain minimum disclosures that have to be made that relate to the statement of financial position, statement of profit or loss and other comprehensive income and statement of changes in equity. In addition, disclosures of accounting policies, hedge accounting, and fair values are required. A summary of these requirements is provided below.

Statement of financial position

133. The information that shall be disclosed either on the face of the statement of financial position or in the notes thereto is outlined below:

- The carrying amounts of financial assets and financial liabilities under each of the *categories* in IFRS 9:
    - Financial assets measured at amortised cost.
    - Financial assets measured at fair value through profit or loss, showing separately (IFRS 7.8(a)):
        i. Those designated as such upon initial recognition or subsequently in accordance with par 6.7.1 of IFRS 9
        ii. Those measured as such in accordance with the election in paragraph 3.3.5 of IFRS 9.
        iii. Those measured as such in accordance with the election in paragraph 33A of IAS 32.
        iv. Those mandatorily measured at fair value through profit or loss in accordance with IFRS 9 if it is a debt instrument that has failed the "solely payments of interest and principal" criteria or are equity instruments held for trading.
    - Financial assets measured at fair value through other comprehensive income, showing separately:
        v. Financial assets that are measured at fair value through OCI in accordance with paragraph 4.1.2A of IFRS 9
        vi. Investments in equity instruments designated as such upon initial recognition in accordance with paragraph 5.7.5 of IFRS 9
    - Financial liabilities measured at amortised cost.
    - Financial liabilities at fair value through profit or loss, showing separately (IFRS 7.8 (e)):

vii. Those designated as such upon initial recognition or subsequently in accordance with paragraph 6.7.1 of IFRS 9 and

viii. Those that meet the definition of held for trading in IFRS 9

- IFRS 7.9 provides the disclosure requirements if a scheme has designated a financial asset (or group of financial assets) at fair value through profit or loss that would otherwise be measured at fair value through other comprehensive income or amortised cost.

- Where financial liabilities have been designated at fair value through profit or loss in accordance with IFRS 9.4.2.2 and are required to present the effects of changes in that liability's credit risk in other comprehensive income (see IFRS 9.5.7), the disclosure requirements as per IFRS 7.10 should be provided. A scheme is required to disclose the amount of change in a liability's fair value attributable to changes in the liability's credit risk.

- The standard provides a method in IFRS 9.B5.7.18 to compute the amount to be disclosed if the only significant change relevant to market conditions for the liability is a change in the observed (benchmark) interest rate.

- This method would not be appropriate if changes in fair value arise from other factors that are significant, e.g., the price of another financial instrument, a commodity price, a foreign exchange rate, or an index of rates. The entity is required to use an alternative method that more faithfully measures the effects of changes in the liability's credit risk.

- The methods used to comply with IFRS 7.9-10A must be disclosed as required by IFRS 7.11.

- IFRS 7.11A provides the disclosure requirements when an entity has made an irrevocable election to present in other comprehensive income subsequent changes in the fair value of equity instrumentsas permitted by IFRS 9.5.7.5.

- IFRS 7.11B provides the disclosure requirements when an entity derecognises investments in equity instruments measured at fair value through other comprehensive income during the reporting period.

- If a financial asset measured at amortised cost has been reclassified to fair value, or vice versa, the amount and reason for reclassification have to be disclosed. The disclosure required by IFRS 7.12B-12D should be provided.

- Additional disclosures are required for all recognised financial instruments that are set off in accordance with IAS 32.42 and financial instruments that are subject to an enforceable master netting arrangement, irrespective of whether they are offset in accordance with IAS 32.42. The disclosures required by IFRS 7.13B-13E should be provided.

- The carrying amount of financial assets pledged as collateral for liabilities or contingent liabilities, including amounts that have been reclassified in circumstances where the transferee has the right to sell or pledge the transferred asset, shall be disclosed together with the terms

and conditions relating to the pledge (IFRS 7.14).

- When a scheme holds collateral (of financial or non-financial assets) and is permitted to sell or re-pledge the collateral in the absence of default by the owner of the collateral, certain disclosure requirements are prescribed by IFRS 7.15.

- When a scheme has issued compound financial instruments with multiple embedded derivatives, whose values are interdependent, the existence of such instruments should be disclosed (IFRS 7.17).

- A scheme is required to disclose information on defaults and breaches of loans payable (financial liabilities other than short-term payables on normal credit terms). Any defaults or breaches may affect the liability's classification as current or non-current in accordance with IAS 1. A scheme should provide the disclosure in IFRS 7.18 for loans payable recognised at the reporting date for which there were defaults.

- For loan agreements other than loans payable, if a breach permitted the lender to demand accelerated repayment (unless the breach was remedied or the terms of the loan were renegotiated on or before the reporting period), the disclosure in IFRS 7.18 is required.

Statement of profit or loss and other comprehensive income

134. The following shall be disclosed on the face of the statement of profit or loss and other comprehensive income:

    - Revenue, presenting separately:

        - Interest income calculated using the effective interest method (i.e., interest earned for financial assets that are measured at amortised cost or financial instruments measured at fair value through OCI) (IAS 1.82(a)).

        - Insurance revenue (IAS 1.82(a)).

    - The amount of gains/losses from the derecognition of financial assets measured at amortised cost (IAS 1.82(aa)).

    - Insurance service expenses from contracts issued within the scope of IFRS 17 (see IFRS 17) (IAS 1.82(ab)).

    - Income or expenses from reinsurance contracts held. (IAS 1.82(ac))

    - Finance cost (IAS 1.82(b)).

    - The amount of impairment losses, reversals of impairment losses or impairment gains determined in accordance with section 5.5 of IFRS 9 for financial assets measured at amortised cost or at fair value through other comprehensive income, a lease receivable, a

contract asset or a financial guarantee contract (IAS 1.82(ba)).

- Insurance finance income or expenses from contracts issued within the scope of IFRS 17 (IAS 1.82(bb))

- Finance income or expenses from reinsurance contracts held. (IAS 1.82(bc))

The following shall be disclosed in the notes to the statement of profit or loss and other comprehensive income:

- Net gains or net losses on the various categories of financial instruments at fair value.

- For financial assets or financial liabilities that are measured at fair value through profit or loss, show separately those that are designated as such on initial recognition or subsequently in accordance with IFRS 9.6.7.1 and those that are mandatorily measured at fair value through profit or loss in accordance with IFRS 9 (e.g. financial liabilities that meet the definition of held for trading).

- The accounting policies of the scheme should also indicate how net gains or net losses on each category of financial instruments are determined. As an example, in IFRS 7.B5(e), a scheme would disclose whether or not net gains or net losses on financial instruments at fair value through profit or loss include or exclude interest and/or dividend income.

- Fee income and expense arising from financial instruments that are not at fair value through profit or loss (and which have not been included in the effective interest rate calculation) as well as from a trust or other fiduciary activities.

Other disclosures

135. The following are required to be disclosed regarding accounting policies, hedge accounting and fair values:

- All material accounting policies relevant to understanding the financial instruments should be disclosed. This includes the information about the measurement basis (or bases) used in the preparation of the financial statements. For detailed guidance on what constitutes material accounting policies, refer to paragraphs 117A – 117E of IAS 1.

- Detailed information is required to be disclosed if a scheme applies hedge accounting. For more detail in this regard, reference should be made to paragraphs 21A to 24G of IFRS 7.

- Except when the carrying amount is a reasonable approximation of the fair value, the fair value of all financial instruments should be disclosed. A scheme should disclose the fair value per class of financial assets and liabilities in a way that permits it to be compared with its carrying amount.

In some cases, an entity does not recognise a gain or loss on initial recognition of a financial asset or financial liability because the fair value is neither evidenced by a quoted price in an active market for an identical asset or liability nor based on a valuation technique that uses only data from observable markets. In such cases, the scheme should disclose the disclosure requirements of IFRS 7.28 by class of financial instrument.

Medical schemes should consider IFRS 7.29, which exempts fair value disclosure under certain conditions.

Nature and extent of risks arising from financial instruments.

136. IFRS 7 prescribes certain minimum disclosures that will enable users of financial statements to evaluate the nature and extent of risks arising from financial instruments to which a scheme is exposed at the reporting date. These risks typically include, but are not limited to, credit risk, liquidity risk and market risk. A summary of these requirements is provided below.

Qualitative disclosures

137. For each type of risk arising from financial instruments, a scheme shall disclose:

    (a) The exposure to risk and how they arise;

    (b) Its objectives, policies and processes for managing the risk and the methods used to measure the risk; and

    (c) Any changes in (a) or (b) from the previous period

    Refer to Implementation Guidance paragraphs IFRS 7 IG15- IG17.

Quantitative disclosures

138. For each type of risk arising from financial instruments, a scheme shall disclose:

    (a) Summary quantitative data about its exposure to that risk at the reporting date. This disclosure should be based on the information provided internally to the scheme's key management personnel, for example, the scheme's Board of Trustees.

    (b) The disclosure required by paragraphs 35A – 42 of IFRS 7, to the extent not provided in accordance with (a) above.

    (c) Concentrations of risk if not apparent from the disclosures in accordance with (a) and (b) above.

    Concentrations of risk arising from financial instruments that have similar characteristics and are affected similarly by changes in economic or other conditions should be disclosed if not already disclosed in the

quantitative data. The identification of concentrations of risk requires judgment, considering the scheme's circumstances. IFRS 7.B8 indicates what should be included in the disclosure for concentration of risk. The minimum risk disclosures required by IFRS 7 are summarised below. Additional disclosure is required where qualitative disclosure does not represent an entity's risk exposure.

Credit risk

139. IFRS 7.35 requires the scheme to explain the recognition and measurement of expected credit losses. To meet this objective, a medical scheme should disclose:

    (a) How it determined whether the credit risk of financial instruments has increased significantly since initial recognition, including if and how:

        i Financial instruments are considered to have low credit risk in accordance with IFRS 9.5.5.10, including the classes of financial instruments to which it applies; and

        ii The presumption in IFRS 9.5.5.11, that there have been significant increases in credit risk since initial recognition when financial assets are more than 30 days past due, has been rebutted;

    (b) Definitions of default, including reasons for selecting those definitions;

    (c) How instruments were grouped if expected credit losses were measured on a collective basis;

    (d) How a medical scheme determined that the financial assets were credit-impaired financial assets;

    (e) A medical scheme's write-off policy, including indicators that there is no reasonable expectation of recovery and information about the policy for financial assets that are written off but are still subject to enforcement activity; and

    (f) How the requirements in paragraph 5.5.12 of IFRS 9 for the modification of contractual cash flows of financial assets have been applied (there are further disclosure requirements in IFRS.7.35F(f)(i) and IFRS.7.35F(f)(ii) if there have been modifications).

140. A medical scheme should explain the inputs, assumptions and estimation techniques used to apply the impairment requirements described in section 5.5 of IFRS 9. For this purpose, the following should be disclosed:

    (a) Basis of inputs, assumptions and estimation techniques used to:

        i Measure the 12-month and lifetime expected credit losses;

        ii Determine whether the credit risk of financial instruments has increased significantly since initial recognition;

        iii Determine whether a financial asset is a credit-impaired financial asset.

(b) How forward-looking information has been incorporated into the determination of expected credit losses, including the use of macroeconomic information; and

(c) Changes in the estimation techniques or significant assumptions made during the reporting period and the reasons for those changes.

Quantitative and qualitative information about amounts arising from expected credit losses.

141. To explain the changes in the loss allowance and the reasons for those changes, a reconciliation from the opening balance to the closing balance of the loss balance shall be provided per class of financial instrument, in a table format, showing separately:

(a) Loss allowance measured at an amount equal to 12-month expected credit losses;

(b) Loss allowance measured at an amount equal to lifetime expected credit losses for:

i Financial instruments for which credit risk has increased significantly since initial recognition but that are not credit-impaired financial assets;

ii Financial assets that are credit-impaired at the reporting date (but that are not purchased or originated credit-impaired); and

iii Trade receivables, contract assets or lease receivables for which the loss allowance is measured in accordance with the simplified approach under IFRS 9.

(c) Purchased or originated credit-impaired assets should be reconciled.

142. Disclosure with regards to how significant changes in the gross carrying amount of financial instruments during the period contributed to changes in the loss allowance. The information should be provided separately for financial assets that represent the loss allowance and should include relevant qualitative and quantitative information. IFRS 7.35I provides examples of changes in the gross carrying amount of financial instruments that may contribute to the changes in the loss allowance.

143. A medical scheme should disclose information to enable users of financial statements to understand the nature and effect of modifications that have not resulted in the financial instrument being derecognised and the effect of such modifications on the measurement of the expected credit losses. Refer to paragraph 35J of IFRS 7.

144. To enable users of financial statements to understand the effect of collateral and other credit enhancements on the amounts arising from expected credit losses, the following details should be disclosed:

(a) The amount that best represents the maximum exposure to credit risk at the end of the reporting period without taking account of any collateral held or other credit enhancements.

(b) A narrative description of collateral held as security and other credit enhancements, including:

i Description of the nature and quality of the collateral held;

ii An explanation of any significant changes in the quality of that collateral or credit enhancements as a result of deterioration or changes in the collateral policies of the entity during the reporting period; and

iii Information about financial instruments for which an entity has not recognised a loss allowance because of this collateral.

(c) Quantitative information about the collateral held as security and their credit enhancements for financial assets that are credit-impaired at the reporting date.

145. Disclose the outstanding contractual amount on financial assets written off during the reporting period and still subject to enforcement activity.

Credit risk exposure

146. A medical scheme should disclose by credit risk rating grades, the gross carrying amount of financial assets and the exposure to credit risk on loan commitments and financial guarantee contracts. This information shall be applied separately for financial instruments. Refer to paragraph 35M of IFRS 7 for detailed disclosures required.

147. For trade receivables, contract assets and lease receivables for which the simplified model is used to determine the loss allowance in terms of IFRS 9, the information provided above may be done on the basis of a provision matrix. Refer to paragraph 35N of IFRS 9.

148. For all financial instruments within the scope of IFRS 7 but to which the impairment requirements in IFRS 9 are not applied, a medical scheme shall disclose by class of financial instrument (financial instruments in the same class share economic characteristics with respect to the risk being disclosed):

(a) The amount that best represents its maximum exposure to credit risk at the reporting date without taking account of any collateral held or other credit enhancements. This disclosure is not required for financial instruments whose carrying amount best represents the maximum exposure to credit risk.
(b) A description of collateral held as security and other credit enhancements and their financial effect (e.g. quantification of the extent to which collateral and other credit enhancements mitigate credit risk) in respect of the amount that best represents the maximum exposure to credit risk. (IFRS 7.36)

149. Disclosure is required for financial or non-financial assets obtained during the period by taking possession of collateral held by the scheme as security and other credit enhancements. Refer to IFRS 7.38 for detailed disclosures required.

150. The disclosure around expected credit losses and related methodology is not included because insurance receivables do not have a forward looking/expected credit model applied to them. Therefore, these disclosures would not be applicable.

Liquidity risk

151. In terms of IFRS 7.39, a scheme shall disclose the following:

    (a) A maturity analysis for both non-derivative and derivative financial liabilities that shows the remaining undiscounted contractual maturities; and

    (b) A description of how it manages the liquidity risk.

Market risk

152. Market risk is defined by IFRS 7 as “the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market price risk comprises three types of risks: currency risk, interest rate risk and other price risk”. The disclosure requirements per IFRS 7.40 and 41 should be provided for market risk.

Disclosures regarding capital

153. The scheme should include disclosures regarding the scheme’s objectives, policies and processes for managing capital. Among other requirements, medical schemes are required to disclose whether they have adhered to the regulatory capital requirements applicable to schemes. If not, additional disclosures have to be provided regarding the action to be taken to ensure compliance with these external (i.e. regulatory) capital requirements. Quantitative data about what it manages as capital should also be provided. Refer to IAS 1.134 -135 for more information.

Transfers of financial assets

154. Paragraphs 42A - 42H of IFRS 7 include disclosure requirements that a scheme should provide for financial assets that have been transferred, which are either derecognised in their entirety or not derecognised in their entirety. This should be disclosed in a single note.

    A scheme is considered to transfer all or part of a financial asset if it either:

    (a) Transfers the contractual rights to receive the cash flows of that financial asset; or

    (b) Retains the contractual rights to receive the cash flows of that financial asset but assumes a contractual obligation to pay the cash flows to one or more recipients in an arrangement.

    When a scheme has transferred financial assets, yet all or part of the transferred financial asset does not qualify for de-recognition, the disclosure in terms of IFRS 7.42D should be provided.

    When a scheme derecognises transferred financial assets in their entirety, but has a continuing involvement in them, disclosures in terms of IFRS 7.42E - 42G should be provided.

The impact of IFRS 9 Financial Instruments

155. IFRS 9 includes the requirements on classification and measurement, impairment and hedge accounting. The classification and measurement approach for financial assets should reflect the business model in which they are managed and their cash flow characteristics.

Impairment of debt instruments measured at amortised cost or at fair value through other comprehensive income is based on a forward-looking expected credit loss model that will result in more timely recognition of losses.

156. IFRS 9 contains three major categories relating to the classification of debt instruments. Classification determines how financial assets are measured on an ongoing basis. Those three categories are:

- Measured at amortised cost;
- Measured at fair value through other comprehensive income (FVOCI); and
- Measured at fair value through profit or loss (FVTPL)

157. Held-to-maturity financial assets, loans and receivables and available-for-sale financial assets have not been carried forward to IFRS 9. The classification of financial assets is determined on the basis of the entity's business model for managing the financial assets and the contractual cash flow characteristics of the financial asset. A business model refers to how an entity manages its financial assets in order to generate cash flows by collecting contractual cash flows, selling financial assets or both.

IFRS 9 requires financial assets to be reclassified between measurement categories when, and only when, the entity's business model for managing them changes. Reclassification between measurement categories is a high hurdle (IFRS 9.B4.4.1). This ensures that users of financial statements are always provided with information reflecting how the cash flows on financial assets are expected to be realised. For example, schemes should note that their business model would not change in the event of a sale of financial assets measured at amortised cost if such sale is affected due to increased credit risk of the financial assets. Schemes should follow the guidance in IFRS 9.5.6 for any reclassification between measurement categories.

Financial liabilities are not reclassified.

Impairment

158. IFRS 9 has a single impairment model that applies to all financial debt instruments within the scope. The model uses a dual measurement approach, under which the loss allowance is measured as either:

i 12-month expected credit losses; or

ii Lifetime expected credit losses.

159. The measurement generally depends on whether there has been a significant increase in credit risk since initial recognition. However, a practical expedient exists for trade receivables, contract assets and lease receivables, allowing the recognition of lifetime expected credit losses. An entity is required to measure the loss allowance using the lifetime expected credit losses for trade receivables and contract assets that do not contain a significant financing component – referred to as the simplified approach. For trade receivables and contract assets which include a significant financing component, as well as for lease receivables, an accounting policy choice exists as to whether to apply the simplified approach or the full impairment model.

Hedge accounting

160. The objective of hedge accounting is to represent, in the financial statements, the effect of an entity's risk management activities that use financial instruments to manage exposures arising from particular risks that could affect profit or loss (or other comprehensive income, in the case of investments in equity instruments for which an entity has elected to present changes in fair value in other comprehensive income).

Presentation and disclosure

161. IFRS 9 introduced new presentation requirements, while IFRS 7 requires extensive additional disclosure requirements as a result of IFRS 9.

The impact of IFRS 12 Disclosure of Interests in Other Entities

162. The impact of additional disclosure requirements in terms of IFRS 12 *Disclosure of Interests in Other Entities* should be considered by medical schemes. These considerations have been included under *Appendix II* of this Guide.

163. IFRS 12 aims to provide users of financial statements with sufficient disclosures for them to assess the nature of, and risks and financial effects associated with, the scheme's interest in subsidiaries, joint arrangements, associates and unconsolidated structured entities. Medical schemes do, however, have investments in unconsolidated structured entities, mainly through investment funds (applicable only if the investee meets the definition of a structured entity). A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity.

164. Schemes should consider the level of detail needed to satisfy this objective, how much emphasis to place on each requirement, and to what extent the information should be aggregated.

165. To the extent that schemes have subsidiaries, joint arrangements or associates, schemes should disclose significant judgments and assumptions made in determining that (for example):

- It holds more than half of the voting rights of another entity where it does not have control;
- It holds less than half of the voting rights of another entity where it has control;
- It is an agent or principal with respect to another entity;

- It does not have significant influence even though it holds 20 per cent or more of the voting rights of another entity; and

- It has significant influence even though it holds less than 20 per cent of the voting rights of another entity.

Consolidated structured entities.

166. If the scheme holds interests in consolidated structured entities, it must disclose information that enables users of its financial statements to evaluate the nature of, and changes in, the risks associated with its interests in consolidated structured entities. This includes, for example, disclosures of:

    - The terms of any contractual arrangements that could require the provision of financial support to a consolidated structured entity;

    - The type and amount of financial or other support (e.g. purchasing assets of or instruments issued by the structured entity) provided to a consolidated structured entity during the reporting period (including assistance to the structured entity in obtaining financial support), and the reasons for providing such support; and

    - Any current intentions to provide financial or other support to a consolidated structured entity (including intentions to assist the structured entity in obtaining financial support).

Interests in unconsolidated structured entities

167. If the scheme has any interest in unconsolidated structured entities such as collective investment schemes (which include money market unit trusts), there are a number of disclosures that will apply. In summary, the scheme has to provide:

    - Qualitative and quantitative information about the scheme's interest in unconsolidated structured entities (nature, purpose, size and activities of the entity and how the entity is financed);

    - The carrying amounts of assets and liabilities recognised in the scheme's financial statements relating to its interests in unconsolidated structured entities and the line items in the statement of financial position in which those assets and liabilities are recognised;

    - The amount that best represents the scheme's maximum exposure to loss from its interests in unconsolidated structured entities, including how the maximum amount is determined; and

    - A comparison of the amounts from the last two points above.

    The quantitative disclosures above should be provided in tabular format unless another format is more appropriate.

The impact of IFRS 13 Fair Value Measurement

168. IFRS 13 is a single source of fair value measurement guidance that clarifies the definition of fair value, provides a clear framework for measuring fair value and enhances the disclosures about fair value measurements. It does not give rise to any new requirements as to when fair value measurements are required.

Definition of fair value

169. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date, i.e., it is an "exit price" (IFRS 13.9).

Fair value principles

170. Fair value takes into account the characteristics of the asset or liability that would be considered by market participants and is not based on the medical scheme's specific use or plans. Such characteristics may include the condition and location of an asset and restrictions on an asset's sale or use (IFRS 13.11).

171. A fair value measurement assumes that the asset or liability is exchanged in an *orderly transaction* between market participants to sell the asset or transfer the liability at the measurement date under current market conditions (IFRS 13.15). An orderly transaction is a transaction that assumes exposure to the market for a period before the measurement date to allow for marketing activities that are usual and customary for transactions involving such assets or liabilities; it is not a forced transaction, e.g. a forced liquidation or distress sale (IFRS 13. Appendix A).

172. Fair value measurement assumes that the transaction to sell the asset or transfer the liability takes place in the *principal market* for the asset or liability, i.e. the market with the greatest volume or level of activity. In the absence of a principal market, the transaction is assumed to take place in the most advantageous market. This is the market that maximises the amount that would be received to sell the asset or minimises the amount that would be paid to transfer the liability after transaction and transport costs (IFRS 13.16).

173. Fair value is based on assumptions that *market participants* would use in pricing the asset or the liability, assuming that the market participants act in their economic best interest (IFRS 13.22).

174. A fair value measurement of a non-financial asset considers a market participant's ability to generate economic benefits by using the asset or by selling it to another market participant who will use it in its highest and best use. "Highest and best use" refers to the use of a non-financial asset by market participants that would maximise the value of the asset or the group of assets and liabilities with which the asset would be used (IFRS 13. 27 and Appendix A).

Financial liability with a demand feature

175. The fair value of a financial liability with a demand feature (e.g. a demand deposit or the personal medical savings account of the medical schemes) is not less than the amount payable on demand, discounted from the first date that the amount could be required to be paid (IFRS 13.47).

Valuation techniques

176. A quoted price in an active market is the most reliable evidence of fair value. When this is unavailable, medical schemes should use a valuation technique to measure fair value, which maximises the use of relevant observable inputs and minimises the use of unobservable inputs (IFRS 13.61).

177. The objective of using a valuation technique is to estimate the price at which an orderly transaction to sell the asset or to transfer the liability would take place between market participants at the measurement date under current market conditions (IFRS 13.62).

178. Three widely used valuation techniques are (IFRS 13.62):

    (a) Market approach: This uses prices and other relevant information generated by market transactions that involve identical or comparable (i.e. similar) assets, liabilities or a group of assets and liabilities, such as a business (IFRS 13.B6).

    (b) Cost approach: This reflects the amount that would be required currently to replace the service capacity of an asset, often referred to as “current replacement cost” (IFRS13.B8).

    (c) Income approach: This converts future amounts (e.g. cash flows or income and expenses) to a single current (i.e. discounted) amount, reflecting current market expectations about those future amounts (IFRS 13.B10).

Inputs based on bid and ask prices.

179. If an asset or a liability measured at fair value has a bid price and an ask price (e.g. an input from a dealer market), the price within the bid-ask spread that is most representative of fair value in the circumstances shall be used to measure fair value regardless of where the input is categorised within the fair value hierarchy. The use of bid prices for asset positions and ask prices for liability positions is permitted but is not required (IFRS 13.70).

180. This IFRS does not preclude the use of mid-market pricing or other pricing conventions used by market participants as a practical expedient for fair value measurements within a bid-ask spread (IFRS 13.71).

Disclosure objective

181. The objective of the IFRS 13 disclosure is to help users of financial statements assess the valuation techniques and inputs used in the fair value measurements. Fair value disclosures are based on the level within which a measurement falls in the fair value hierarchy.

    Furthermore, the disclosures differentiate fair value measurements that are recurring from those that are non-recurring.

    IFRS 13 requires an entity to disclose information that helps users of its financial statements assess both of the following:

- For assets and liabilities that are measured at fair value on a recurring or non-recurring basis in the statement of financial position after initial recognition, the valuation techniques and inputs

used to develop those measurements; and

- For fair value measurements using significant unobservable inputs (Level 3), the effect of the measurements on profit or loss or other comprehensive income for the period (IFRS 13.91).

Recurring vs non-recurring

182. Recurring fair value measurements arise from assets and liabilities measured on a fair value basis at each reporting date (this does not necessarily mean that a valuation is performed every reporting period, e.g. land and building carried using the revaluation model under IAS 16 *Property, Plant and Equipment*). Non-recurring fair value measurements are fair value measurements triggered by particular circumstances, e.g. an asset held for sale.

Fair value hierarchy

183. IFRS 13 establishes a fair value hierarchy based on the inputs to valuation techniques used to measure fair value to increase consistency and comparability. The inputs are categorised into three levels, with the highest priority given to unadjusted quoted prices in active markets for identical assets or liabilities and the lowest priority given to unobservable inputs (IFRS 13 paragraph 72).

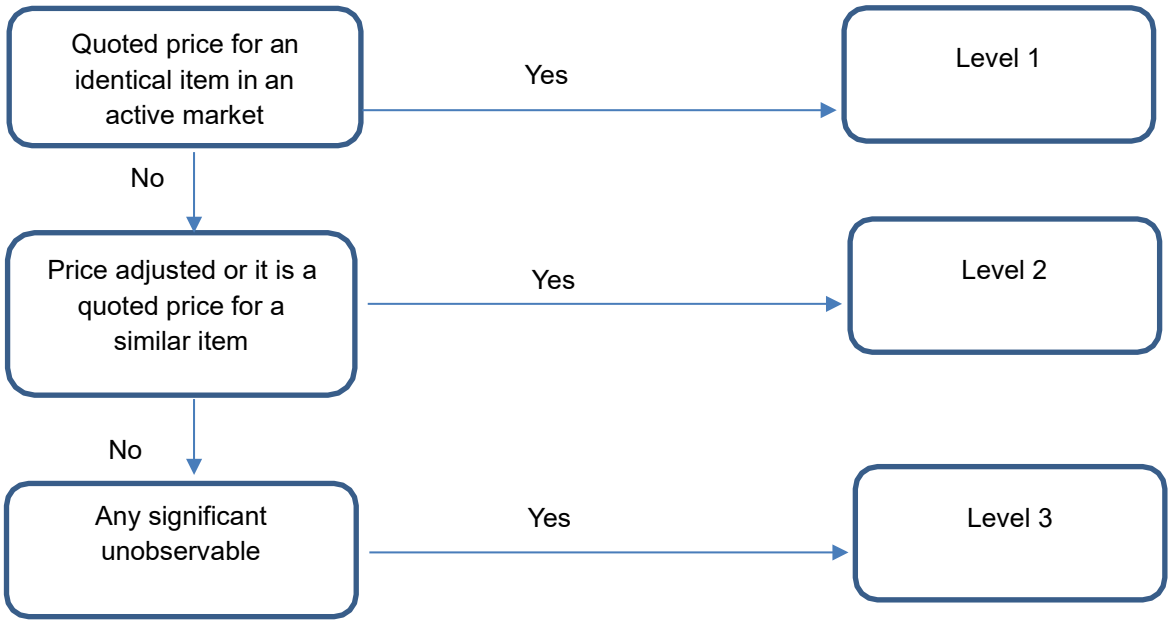
    The three fair value hierarchy levels are:

    - Level 1 inputs are unadjusted quoted prices in active markets for identical assets or liabilities. The medical scheme must have access to that market at the measurement date (IFRS 13.76).

    - Level 2 inputs are inputs other than quoted prices included within Level 1 that are directly or indirectly observable for the asset or liability (IFRS 13.81).

    - Level 3 inputs are unobservable inputs for the fair value measurement of an asset or a liability (IFRS 13.86).

184. The diagram below outlines the approach to determine the classification of fair value measurements in the fair value hierarchy:



Specific disclosures required.

185. To meet the disclosure objective, the following minimum disclosures are required for each class of assets and liabilities measured at fair value in the statement of financial position after initial recognition (IFRS 13.93):

- The fair value measurement for recurring and non-recurring fair value measurements at the end of the reporting period (IFRS 13.93(a)). For non-recurring fair value measurements, the reasons for the measurement (IFRS 13.93(a));
- The level of the fair value hierarchy within which the fair value measurements are categorised (Levels 1, 2 or 3) (IFRS 13.93(b));
- For assets and liabilities held at the reporting date that are measured at fair value on a recurring basis, the amounts of any transfers between Level 1 and Level 2 of the fair value hierarchy, the reasons for those transfers and the medical scheme's policy for determining when transfers between levels are deemed to have occurred, separately disclosing and discussing transfers into and out of each level (IFRS 13.93(c));
- For fair value measurements (recurring and non-recurring) categorised within Level 2 and Level 3 of the fair value hierarchy, a description of the valuation technique(s) and the inputs used in the fair value measurement, any change in the valuation techniques and the reason(s) for making such change (with some exceptions) (IFRS 13.93(d));
- For fair value measurements categorised within Level 3 of the fair value hierarchy, quantitative information about the significant unobservable inputs used in the fair value measurement (IFRS 13.93(d));

- For recurring fair value measurements categorised within Level 3 of the fair value hierarchy, a reconciliation from the opening balances to the closing balances, disclosing separately changes during the period attributable to the following (IFRS 13.93(e)-(f)):
    - Total gains or losses for the period recognised in profit or loss, and the line item(s) in profit or loss in which those gains or losses are recognised. The amount included in profit or loss that is attributable to the change in unrealised gains or losses relating to those assets and liabilities held at the end of the reporting period should be separately disclosed, and the line item(s) in profit or loss in which those unrealised gains or losses are recognised;
    - Total gains or losses for the period recognised in other comprehensive income, and the line item(s) in other comprehensive income in which those gains or losses are recognised;
    - Purchases, sales, issues and settlements (each of those types of changes disclosed separately);
    - The amounts of any transfers into or out of Level 3 of the fair value hierarchy, the reasons for those transfers and the medical scheme's policy for determining when transfers between levels are deemed to have occurred. Transfers into Level 3 shall be disclosed and discussed separately from transfers out of Level 3;
    - For recurring and non-recurring fair value measurements categorised within Level 3 of the fair value hierarchy, a description of the valuation processes used by the entity (IFRS 13.93(g));
    - For recurring fair value measurements categorised within Level 3 of the fair value hierarchy (IFRS 13.93(h)):
- A narrative description of the sensitivity of the fair value measurement to changes in unobservable inputs if a change in those inputs to a different amount might result in a significantly higher or lower fair value measurement. If there are interrelationships between those inputs and other unobservable inputs used in the fair value measurement, the medical scheme should also provide a description of those interrelationships and of how they might magnify or mitigate the effect of changes in the unobservable inputs on the fair value measurement;
- For financial assets and financial liabilities, if changing one or more of the unobservable inputs to reflect reasonably possible alternative assumptions would change fair value significantly, a medical scheme shall state that fact and disclose the effect of those changes. The medical scheme shall disclose how the effect of a change to reflect a reasonably possible alternative assumption was calculated;
- For recurring and non-recurring fair value measurements, if the highest and best use of a non-financial asset differs from its current use, a medical scheme shall disclose that fact and why the non-financial asset is being used in a manner that differs from its highest and best use (IFRS 13.93(i)).
- The scheme shall disclose and consistently follow its policy for determining when transfers

between levels of the fair value hierarchy are deemed to have occurred. The policy about the timing of recognising transfers shall be the same for transfers into levels as for transfers out of the levels. Examples of policies for determining the timing of transfers include the following:

- The date of the event or change in circumstances that caused the transfer.
- The beginning of the reporting period.
- The end of the reporting period.

- For each class of assets and liabilities not measured at fair value in the statement of financial position but for which the fair value is disclosed. The disclosures relating to IFRS 13.93 (b), (d), and (i), as described above, are required. However, an entity is not required to provide quantitative disclosures about significant unobservable inputs used in the fair value measurement categories within the level 3 fair value hierarchy required by IFRS 13.93 (d) as described above.

The impact of IFRS 16 Leases

186. A lessee shall either present in the statement of financial position or disclose in the notes:

(a) right-of-use assets separately from other assets. If a lessee does not present right-of-use assets separately in the statement of financial position, the lessee shall:

i include right-of-use assets within the same line item as that within which the corresponding underlying assets would be presented if they were owned; and

ii disclose which line items in the statement of financial position include those right-of-use assets.

(b) lease liabilities separately from other liabilities. If the lessee does not present lease liabilities separately in the statement of financial position, the lessee shall disclose which line items in the statement of financial position include those liabilities (IFRS 16.47).

187. The requirement of IFRS 16.47(a) does not apply to right-of-use assets that meet the definition of investment property, which shall be presented in the statement of financial position as investment property.

188. In thestatement of profit or loss and other comprehensive income, a lessee shall present interest expense on the lease liability separately from the depreciation charge for the right-of-use asset. Interest expense on the lease liability is a component of finance costs, which paragraph 82(b) of IAS 1 requires to be presented separately in the statement of profit or loss and other comprehensive income.

189. In the statement of cash flows, a lessee shall classify:

(a) Cash payments for the principal portion of the lease liability within financing activities;

(b) Cash payments for the interest portion of the lease liability applying the requirements in IAS 7 for interest paid; and

(c) Short-term lease payments, payments for leases of low-value assets, and variable lease payments not included in the measurement of the lease liability within operating activities.

190. A lessee shall disclose the following amounts for the reporting period in tabular format:

(a) Depreciation charge for right-of-use assets by class of underlying asset;

(b) Interest expense on lease liabilities;

(c) The expense relating to short-term leases accounted for by recognising the lease payments as an expense on either a straight-line basis over the lease term or another systematic basis. This expense need not include the expense relating to leases with a lease term of one month or less;

(d) The expense relating to leases of low-value assets accounted for by recognising the lease payments as an expense on either a straight-line basis over the lease term or another systematic basis. This expense shall not include the expense relating to short-term leases of low-value assets;

(e) The expense relating to variable lease payments not included in the measurement of lease liabilities;

(f) Income from subleasing right-of-use assets;

(g) Total cash outflow for leases;

(h) Additions to right-of-use assets;

(i) Gains or losses arising from sale and leaseback transactions; and

(j) The carrying amount of right-of-use assets at the end of the reporting period by class of underlying asset.

191. The amount of short-term leases and low-value leases need to be disclosed.

192. If right-of-use assets meet the definition of investment property, a lessee shall apply the disclosure requirements in IAS 40 *Investment Property*.

193. A lessee shall disclose a maturity analysis of lease liabilities applying paragraphs 39 and B11 of IFRS 7 separately from the maturity analyses of other financial liabilities.

194. A lessee shall disclose the amount of its lease commitments for short-term leases accounted for applying IFRS16. 6 (where the lessee shall recognise the lease payments as an expense on either a straight-line basis over the lease term or another systematic basis) if the portfolio of short-term leases to which it is committed at the end of the reporting period is dissimilar to the portfolio of short-

term leases to which the short-term lease expense disclosed applying paragraph 53(c) relates (IFRS 16.55).

195. A lessee shall disclose additional qualitative and quantitative information about its leasing activities necessary to meet the disclosure objective of giving a basis to users to assess the effect leases have on the financial statements. This additional information may include, but is not limited to, information that helps users of financial statements to assess:

    (a) The nature of the lessee's leasing activities;

    (b) Future cash outflows to which the lessee is potentially exposed that are not reflected in the measurement of lease liabilities. This includes exposure arising from:

        i. Variable lease payments (as described in IFRS 16.B49);

        ii. Extension options and termination options (as described in IFRS 16.B50);

        iii. Residual value guarantees (as described in IFRS 16.B51); and

        iv. Leases not yet commenced to which the lessee is committed.

    (c) Restrictions or covenants imposed by leases; and

    (d) Sale and leaseback transactions (as described in IFRS 16.B52).

196. A lessee that accounts for leases of low-value assets applying IFRS 16.6 shall disclose that fact.

The impact of IAS 38 Intangible Assets

197. In some cases, expenditure is incurred to provide future economic benefits to an entity, but no intangible asset or other asset is acquired or created that can be recognised. In these cases, the entity recognises such expenditure as an expense when it has the right to access those goods or when it receives the services. For example, the advertising and promotional expenditure (IAS 38.69).

198. The costs of advertising and promotion, which include scheme brochures, benefit booklets and application forms, shall be expensed when incurred, i.e., when an entity has a right to access the goods or services received. An entity has a right to access goods when it owns them. Similarly, it has a right to access goods when they have been constructed by a supplier in accordance with the terms of a supply contract and the entity could demand delivery of them in return for payment. Services are received when a supplier performs them in accordance with a contract to deliver them to the entity and not when the entity uses them to deliver another service; for example, to deliver an advertisement to customers (IAS 38.69A).

199. If the entity has made a prepayment for the above items, that prepayment is recognised as an asset until the entity has a right to access the related goods or services (IAS 38.70).

Insurance revenue

200. A scheme shall present in profit or loss insurance revenue arising from the group of insurance contracts issued. The amount of insurance revenue recognised in the reporting period shall depict the consideration which a scheme expects to receive over the coverage period of the contracts, ,i.e. the amount the schemes expect to recover.

201. Insurance revenue presented in profit or loss shall exclude any investment components, i.e. PMSA contributions.

202. Section 26(7) of the Act requires that all contributions be paid directly to a medical scheme not later than three days after payment thereof becomes due.

Insurance service expenses

203. A scheme shall present in profit or loss insurance service expenses arising from a group of insurance contracts issued, comprising:

    i. Incurred claims (excluding investment components, i.e. PMSA claims);

    ii. Other incurred directly attributable insurance service expenses;

    iii. Amortisation of insurance acquisition cash flows (if the insurance acquisition cash flows are not expensed);

    iv. Changes that relate to past service, i.e. changes in fulfilment cash flows relating to the liability for incurred claims; and

    v. Changes that relate to future service, i.e. losses on the onerous group of contracts and reversals of such losses.

Accredited managed healthcare services (no risk transfer)

204. All accredited managed healthcare services (as specified in Circular 13 of 2014) delivered by accredited managed care organisations should be included as part of healthcare expenditure (i.e. insurance service expense) as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of medical schemes.

Net income/(expense) from risk transfer arrangements (RTA)

205. Risk transfer arrangements are contractual arrangements entered into by a medical scheme with a third party which undertakes to indemnify a medical scheme against all or part of the loss that the medical scheme may incur as a result of carrying on the business of a medical scheme.

206. Risk transfer arrangements do not reduce a medical scheme's primary obligations to its members, but the arrangements only decrease the expense a medical scheme may incur as a result of carrying on the business of a medical scheme.

207. These arrangements generally meet the definition of a reinsurance contract under IFRS 17.

208. Income and expenses that relate to risk transfer arrangements are disclosed separately in the statement of profit or loss and other comprehensive income.

209. The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the statement of profit or loss and other comprehensive income on a gross basis, i.e. the claims incurred are presented as part of insurance services expenses and the claims recovered are presented as part of the net income or expense from reinsurance contracts held. Amounts recoverable under risk transfer arrangements are recognised in the same year as the related claims.

210. Under most risk transfer arrangements, a fixed monthly fee per member is paid to a third party, who subsequently facilitates the delivery of healthcare services to the covered members. Generally, utilisation risk is transferred to the third party, reducing the expense to a medical scheme and providing certainty as to the cost to the medical scheme.

211. IFRS 17 requires the medical scheme to assess each contract separately to determine whether there is a transfer of significant insurance risk to the to the managed care organisation.organisation If a contract is entered into to compensate the medical scheme for claims arising from one or more of the underlying insurance contract issued by the medical scheme, it would be a risk transfer arrangement in the scope of IFRS 17. Reinsurance contracts often provide coverage for many underlying contracts, so the Reinsurer may not be exposed to the possibility of a significant loss even if each individual underlying contract exposes the medical scheme to significant insurance risk. However, applying IFRS 17, even if a reinsurance contract does not expose the reinsurer to the possibility of a significant loss, it is still deemed to transfer significant insurance risk if it transfers substantially all the insurance risk relating to the reinsured portion of the underlying insurance contracts to the reinsurer.

212. Medical schemes are therefore required to estimate the cost to the medical scheme of claims covered by risk transfer arrangements. This estimate is based on assumptions as to what it would cost the scheme to cover these claims should these services not be under a risk transfer arrangement. Utilisation information from the third-party provider may be used; however, the cost assumptions are based on those that are specific to the medical scheme and not those of the third-party provider. Once the claims under the risk transfer arrangement have been estimated, a recovery under the risk transfer arrangement is then recognised to the value of the estimated claim.

Example: Simple capitation agreement, without a profit/loss sharing mechanism

This example illustrates how a capitation agreement would be incorporated into the line items that relate to risk transfer arrangements.

Background

ABC Medical Scheme ("A") entered into a fixed-fee capitation agreement with an accredited managed care organisation ("B"). B provides medical care through a series of clinics. In terms of the agreement, B agrees to provide specified medical care at any one of its clinics to the members of A at no cost to the member. The total capitation fee paid to B for the specified members per the capitation

contract for the year to B was R50 000. Assuming the fixed fee capitation agreement meets the definition of a reinsurance contract in IFRS 17 and the requirement of the PAA is met.

Journal 1 – Recognition of total capitation fee paid

A would account for the capitation fee as follows:

Dr. Reinsurance expense (P/L) 50 000
Cr. Bank (SOFP) 50 000

Journal 2 – Recognition of total claims incurred

Claims incurred in respect of members of A utilising B's services during the year amount to R70 000. This was determined by A using utilisation statistics provided by B multiplied by the cost A would have incurred had there not been a capitation agreement in place. (This would be equal to the normal fee for service rate.)

A would account for the claims incurred in terms of the capitation agreement with B as follows:

Dr Insurance service expenses (P/L) [Value of the claims incurred from members] 70 000
Cr Liability for incurred claims (relating to insurance contracts issued to member) 70 000

Dr Asset for remaining coverage (Reinsurance contracts held) 70 000
Cr. Income from Reinsurance contracts (P/L) [Capitation claims recovered from B] 70 000
(This transaction is a non-cash transaction and should be disclosed as such in the notes to the statement of cash flows)

As there will be no cash flows, the liability and asset are effectively net settled.

Dr Liability for incurred claims (insurance contracts issued) 70 000
Cr Asset for remaining coverage (reinsurance contracts held) 70 000

Journals 3 and 4 – Recognition of capitation recovery

A member of A was admitted to one of B's clinics on 27 December 20xx for medical care covered by the capitation agreement. The member of A was discharged from the clinic on 5 January 20xx+1. The total cost A would have incurred (had it not entered into the capitation arrangement) to provide the ten days' medical care is R20 000. A only received the information regarding the treatment of its member by B on 10 January 20xx+1.

A has a 31 December year-end. All other medical care provided by B to members of A has been reported to A before 31 December 20xx.

A's best estimate at year-end of the costs it would have incurred to provide medical care to its members not yet reported to it by 31 December 20xx is R8 000. A does not expect any dispute with B regarding estimated medical cover provided by B to a member of A.

Journal 3: On 31 December 20xx A was unaware of the incurred expense. However, based on past experience, A recognised a liability for incurred claims based on its best estimate of costs it would

have incurred to provide the medical care to its members not yet reported to A by 31 December 20xx. This represents the costs A could be held accountable for in terms of its obligation to its members. The journal is as follows:

Dr. Insurance service expense (P/L) 8 000
Cr. Liability for incurred claims (insurance contracts issued) (SOFP) 8 000

Journal 4: On 31 December 20xx A was unaware of the income to be received, i.e. the cost ceded through the capitation agreement to B. However, based on past experience, A recognised a risk transfer recovery based on its best estimate of costs recovered from B for providing medical care to its members not yet reported to A by 31 December 20xx. This represents the costs B is settling in kind on A's behalf (i.e. capitation agreement with B). The journal is as follows:

Dr. Asset for remaining coverage (reinsurance contracts held) (SOFP) 8 000
Cr. Reinsurance income (P/L) 8 000

Journal 5 and 6 – Recognition of capitation recovery

The correct estimated cost the scheme would have incurred to provide medical care to its members not yet reported as at 31 December 20xx was R20 000. On 10 January 20xx+1, A received the information from B and confirmed that its estimate as of year-end was incorrect.

Journals 5 and 6: On 10 January 20xx+1, A receives the information from B and confirmation that its estimate as at year end was not in line with the information received from B. Thus, the change in estimate needs to be accounted for prospectively by adjusting the carrying amount of the related asset and liability in the period of the change (in the following financial year) (for the purpose of this example we have assumed it is not an error, but a change in estimate. Each scheme must carefully review facts and circumstances to determine if this is error or change in estimate).

The journals will be:

Dr. Insurance Service expense (P/L) 12 000
Cr. Liability for incurred claims (insurance contracts issued) (SOFP) 12 000

Dr. Asset for remaining coverage (reinsurance contracts held) (SOFP) 12 000
Cr. Reinsurance income (P/L) 12 000

Journal 7 – Recognition of capitation recovery

On 10 January 20xx+1 A also receives confirmation that the claim of R10 000 from a member was settled in kind by B under the capitation agreement. The journal is as follows:

Dr. Liability for incurred claims (insurance contracts issued) (SOFP) 10 000
Cr. Asset for remaining coverage (reinsurance contracts held) (SOFP) 10 000

In practice, journals 5 to 7 will be processed simultaneously.
The effect of the transaction on the note disclosure for the liability for incurred claims will be as follows:

Liability for incurred claims (insurance contracts issued)	20XX+1 (after year end)	20XX
Opening Balance	8000	XXX
Changes to estimates recognised in:		
Income or expense from RTA	12000	XXX
Claims Settled	(10000)	XXX
Claims recognised	XXX	8000
Closing Balance	XXX	8000

The transaction's effect on the note disclosure for the recovery under risk transfer arrangements (asset for remaining coverage) will be similar as presented for the liability for incurred claims above.

In the scheme's statement of profit or loss (forming part of the management accounts assuming that they are prepared before 10 January 20XX+1), the above entries would be represented as follows:

Insurance service expense	
Incurred claims (70 000 + 8 000)	78 000
Income/ expense from RTA	
Reinsurance expense	50 000
Reinsurance income (70 000 + 8 000)	(78 000)
Relevant healthcare expenditure	

Liability for incurred claims

213. The liability for incurred claims includes the estimated cost of healthcare benefits that have been incurred before the end of the accounting period but that have not been reported to the medical scheme by that date. This liability is determined as accurately as possible based on a number of factors, which may include previous experience in claims 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 liability is net of estimated recoveries from members for co-payments. The liability for incurred claims includes the PMSA utilised by members (transferred from the liability for remaining coverage). See also accounting policy choice in par 91 above regarding the treatment of a portion of PMSA payable in cash to members (for example if member exists the scheme).

Commercial reinsurance

214. A medical scheme may also enter into commercial reinsurance contracts, in terms of which it transfers some or all of its risk to a legally registered reinsurer. In this instance, the reinsurer will compensate the medical scheme in cash for losses incurred. In terms of section 20(3) of the Act, where a medical scheme intends to enter into any commercial reinsurance contract, or amend such a contract, the Board of Trustees shall furnish the Registrar with a copy of the contract or the amendment and an evaluation of the need for the proposed commercial reinsurance contract by a person who has the necessary expertise and who has no direct or indirect financial interest in the contract.

Insurance service expenditure (including insurance acquisition cash flows)

215. Cash flows within the boundary of an insurance contract are those that relate directly to the fulfilment of the contract. IFRS 17.B65 list the cash flows in the boundary of insurance contracts and IFRS 17.B66 list the cash flows that should not be included when estimating the fulfilment cash flows.

216. IFRS 17.B65(l) states that the cashflows within the boundary of a contract include: An allocation of fixed and variable overheads (such as the costs of accounting, human resources, information technology and support, building depreciation, rent, and maintenance and utilities) directly attributable to fulfilling insurance contracts. Such overheads are allocated to groups of contracts using methods that are systematic and rational and are consistently applied to all costs that have similar characteristics.

217. IFRS 17.B66(d) states that the following cash flows shall not be included in the fulfilment cash flows: Cash flows relating to costs that cannot be directly attributed to the portfolio of insurance contracts that contain the contract, such as some product development and training costs. Such costs are recognised in profit or loss when incurred.

Broker fees paid to brokers and fees paid for ongoing services

218. A medical scheme may compensate a person, in accordance with its rules and the provisions of the Act and the Regulations, for services provided to the medical scheme's members. Broker fees usually accrue and may only be paid on a monthly basis as and when member contributions are received. Amounts paid and payable for broker services comprise fees paid to brokers for new contracts initiated by the brokers and the fees subsequently paid to brokers as "ongoing fees" based on the current contract. These costs represent insurance acquisition cash flows which are defined as the costs that a medical scheme incurs to sell, underwrite, and initiate a new insurance contract and are generally expensed as incurred (unless the scheme has an accounting policy to recognise it in the liability for remaining coverage). Consideration should be given to related party relationships in transactions that relate to brokers' fees (for purpose of providing related party disclosures).

Other distribution costs

219. Distribution costs that are not considered to be directly attributable expenses and are incurred under co-administration or other agreements are included under administration expenses or broker service fees (as other operating expenses) in the statement of profit or loss and other comprehensive income (in profit/loss) and are separately disclosed in the notes.

Administration expenses

220. In addition to the minimum disclosure on the face of the statement of profit or loss and other comprehensive income in terms of IFRS Accounting Standards, material income and expenses that are relevant to an understanding of the medical scheme's financial performance should be disclosed separately in the notes as required by IAS 1. IAS 1.104 requires the disclosure of additional information on the nature of expenses for expenses classified by function. Under IFRS 17 this may include splitting the expenses into a minimum of three categories: Insurance acquisition cash flows, directly attributable expenses and other operating expenses. Medical schemes may wish to split the expenditure between the *medical scheme* and *own facilities*.

221. Each scheme should apply the requirements of IFRS 17.B65 based on its facts and circumstances, to determine if expenses are directly attributable.

222. Accredited administration service fees are considered to be directly attributable expenditure (i.e. part of insurance service expenses). Circular 77 of 2019 requires medical schemes to report on the accredited and any other administration fees paid per individual component per entity. This disclosure requirement was effective for year-ends beginning 1 January 2021.

223. Schemes need to disclose in the notes to the financial statements the fees and disbursements paid or payable to each third-party accredited medical scheme administrator for:

- Accredited administration of the medical scheme:
    - Member record management;
    - Contribution management;
    - Claims management;
    - Financial management;
    - Information management and data control;
    - Broker remuneration management; and
    - Customer services.
- Other contracted administration services:
    - Actuarial services;

- Benefit management services;
- Internal audit services;
- Distribution services;
- Broker services (accredited brokers and in-house sales and marketing services);
- Marketing services;
- Third party claim recovery services;
- Forensic investigations and recoveries; and
- Governance and compliance services rendered.

224. Schemes should furthermore consider disclosure for the following contracted services provided by other third parties, which is incurred in the administration of a medical scheme:

- Actuarial services;
- Association fees;
- Fees and disbursements to the auditors;
- Fidelity guarantee and professional indemnity insurance premiums;
- Marketing expenses;
- Penalties;
- Principal Officer's fees; and
- Trustee remuneration (see paragraph 188).

225. Medical schemes are required to disclose any payment or consideration made to trustees either on the face of the statement of profit or loss and comprehensive income or in the notes, in terms of Regulation 6A:

- Disbursements, including travelling and other expenses for attendance of meetings or conferences, accommodation and meals, and telephone expenses for business purposes, including reimbursement to trustees;
- Fees for attending meetings of the Board of Trustees or sub-committees of the Board;
- Fees due for holding a particular office on the Board or sub-committees of the Board;
- Fees for consultancy work performed for the medical schemes by a trustee; and

- Other remuneration paid to a trustee.

226. Circular 48 of 2014 requires that the individual components of administration costs are identified separately to enable transparent disclosure thereof. Examples of such administration cost type services / expenditure are:

    - Actuarial services;
    - Fidelity and indemnity insurance provided/ secured on behalf of medical schemes;
    - Marketing and advertising; and
    - Printing and stationary.

    Circular 77 of 2019 requires more detailed disclosures and is effective for year-ends beginning on 1 January 2021.

Administrative expenditure: benefit management services

227. It should be noted that there is a distinct difference between disease management programmes, which make use of the different techniques as mentioned in the definitions provided in Circular 13 of 2014 (i.e. managed healthcare, medically/clinically necessary, protocol) versus wellness programmes and nurse-advice lines.

228. Wellness programmes might be in the form of outreach programmes where members are sent for general evaluations (blood pressure, non-fasting glucose test, non-fasting total cholesterol test, weight, eyes, etc.), or it may be in the form of a benefit once yearly for instance a prostate antigen test that will be funded by the scheme (and not from the members' PMSA). This type of service does not make use of the techniques as specified in the definition of managed healthcare and is therefore not included in accredited managed healthcare services.

229. The same applies for nurse advice lines which are accessed ad hoc, and where the nurse has access to a database of information and only relays the information, which might include a referral to a doctor. None of the managed care techniques are used for these services – it is also not possible to really measure or monitor them for efficiency or effectiveness.

230. Other items to be included in this category are inter alia medical advisors, claims review and auditing, provider network management, etc. (where these services are not integral to the managed care services listed in Circular 13 of 2014).

231. These services are included in directly attributable expenditure (i.e. forming part of insurance service expenses), as part of administration expenditure: benefit management services (i.e. non-attributable expenses).

Own facility revenue

232. Medical schemes may include the provision of services in their own facilities. For example, some medical schemes have hospitals or clinics that are used by service providers to render services to

members and third parties.

Medical schemes may also make the facilities available to third parties on a short-term basis (hours, days, weeks) or over a longer period. The scheme should assess in terms of IFRS 16.B9 - B31 to identify whether there is a lease. If not, the medical scheme should recognise revenue for the services rendered in terms of IFRS 15: Revenue from Contracts with Customers. Cost incurred in operating own facilities, less costs allocated to claims for services rendered to members in own facilities, should be reflected as part of other expenses (i.e. non-attributable expenses).

233. Expenses included in operating own facilities, excluding costs allocated to claims for services rendered to members, are normally disclosed separately; for example, changes in inventories and administration expenditure (including salaries).

234. Benefits (services) rendered by the own facility to the medical scheme's members are included in the relevant expense category.

Grants

235. Where the medical scheme receives a grant, e.g. an employer or third-party medical scheme administrator, the grant is shown separately in the statement of profit or loss and other comprehensive income as part of other income.

Accounting for movements in the market value of investments in collective investment schemes

236. As per the Collective Investment Schemes Control Act, 2002:

"Collective investment scheme" means a scheme, in whatever form, including an open-ended investment company, in pursuance of which members of the public are invited or permitted to invest money or other assets in a portfolio, and in terms of which –

(a) two or more investors contribute money or other assets to and hold a participatory interest in a portfolio of the scheme through shares, units, or any other form of participatory interest; and

(b) the investors share the risk and the benefit of investment in proportion to their participatory interest in a portfolio of a scheme or on any other basis, determined in the deed.

"assets" means the investments comprising or constituting a portfolio of a collective investment scheme and includes any income accruals derived or resulting from the investments in the portfolio which are held for or are due to the investors in that portfolio.

"Income accruals" means any dividends or interest or any other income for distribution received by the trustee, custodian or manager on behalf of investors in a portfolio in the course of any income distribution period or carried forward from any previous income distribution period or due to such investors in respect of dividends or interest or any other income declarations made but not yet distributed.

237. Medical schemes should carefully inspect the terms of collective investment scheme agreements

entered into in order to determine whether the interest and dividends earned on the underlying assets may be recognised as income or should be accounted for as part of the fair value movement. Generally, the income on collective investment schemes is distributed to unit holders or automatically re-invested in additional units (which do not represent cash flows in the statement of cash flows). This income is normally realised and should be accounted for separately from fair value movements.

238. It should be considered further whether the underlying assets are classified as at fair value through profit or loss in terms of IFRS 9. For assets classified "at fair value through profit or loss", the interest, dividends and fair value movements are recognised in profit or loss. Please document in accounting policy that the interest and dividends are presented separate from the other fair value movements (if that is the case) (see IFRS 7 par B5(e)).

Accounting for movements in the market value of investments in linked policies

239. The definition of "linked policy", as included in section 1 of the Insurance Act, does not explicitly refer to interest or dividends but refers to the "value" of assets or categories of assets. The "value" referred to in the definition, therefore, would be those assets "that are specified in the policy and are actually held by or on behalf of the insurer for the purposes of the policy".

240. Medical schemes should carefully inspect the terms of investment agreements entered into in order to determine whether the interest and dividends earned on the underlying assets may be recognised as income or should be accounted for as part of the fair value movement. It should be considered how the underlying assets are classified in terms of IFRS 9.4.1.

    Interest and dividends earned on the underlying investments (assets) accrue to the policyholder (medical scheme). However, realisation of this income may only be possible upon surrender or maturity of the policy. The increase in value of such policies, where income may only be realised upon surrender or maturity, is generally not realised by the policyholder and forms part of the fair value movement.

Personal medical savings accounts

241. Some medical schemes provide for PMSA facilities to assist the members in:

    - Managing cash flow for costs to be borne by members during the accounting period by self-funding their out-of-hospital expenditure; and

    - Meeting or self-funding member co-payments for provider services rendered.

242. The Constitutional court judgment in the matter between Genesis Medical Scheme and the Registrar of Medical Schemes and another (the judgment) heard on 6 June 2017, found that PMSA funds enter the scheme's bank account without being impressed by a trust or fiduciary relationship and once paid into a scheme's bank account, become assets of the scheme, regardless of whether a proportion is later allocated by the scheme to a PMSA. Consequently, there is no distinction between scheme and PMSA assets – and all assets must be invested in accordance with the Medical Schemes Act and Regulations. There is no statutory requirement for assets arising from any unspent PMSA allocation to be invested separately. The judgment found that as PMSAs are not trust assets that schemes may keep interest accruing from PMSAs in its bank account. Medical schemes may provide for the

allocation of interest to be credited to the members' PMSA in terms of the rules of the scheme.

243. Should the medical scheme's rules state that the PMSA monies belong to members, a trust relationship is created. The necessary controls should then be put in place by the scheme to evidence this. PMSA then constitutes trust money as defined in section 1 of the Financial Institutions (Protection of Funds) Act 28 of 2001 read with Regulation 10 to the Act. PMSA must then be invested separately from scheme funds, which are further clarified by section 4(5) of the Financial Institutions (Protection of Funds) Act 28 of 2001. Interest earned on these funds must also be credited to the members' personal medical savings accounts in terms of the rules of the scheme.

244. Savings contributions are recognised when at least one of the parties has performed, and that is generally deemed to be when the contribution has been received, or when withdrawals (i.e. claims) have been paid.

245. In the event that the savings account contributions of a member are utilised for claims before the member has paid all of its monthly contributions, the medical scheme should continue to recognise the settlement of the claims by debiting the liability for remaining coverage and crediting the liability for incurred claims and then debiting the liability for incurred claims with the cash outflow. In essence, the treatment is similar to the issue of a "policy loan" to the member, in that the loan will form part of the liability for remaining coverage.

246. Any advances on savings contributions are funded from the scheme's funds, and the risk of "impairment" is carried by the scheme and will adjust the liability for remaining coverage.

247. Where interest accrued on the PMSA in terms of the rules of the scheme, it is allocated to this "non-distinct investment component" (see par 53 to 55 for discussion as to why it is a non-distinct investment component).

248. Unexpended savings at the end of the accounting period are carried forward to meet future expenses for which the members are responsible.

249. An accounting policy should be documented as to when the unexpended savings PMSA is transferred to the liability for incurred claims. This transfer could be done when an amount becomes payable in cash to the member (for example when the member exists the scheme). Only at the point when the amount becomes payable to the member, the relevant portion of the PMSA is transferred to the liability for incurred claims.

    Alternatively, the scheme should document in its accounting policies that all amounts relating to PMSA are transferred from the liability for remaining coverage to the liability for incurred claims at the end of each financial year as the underlying medical contract with the member then comes to an end.

250. This guide does not consider the treatment of embedded derivatives. Should schemes identify an embedded derivative within a contract, they should apply IFRS 9 to it.

Offsetting and reclassification

251. IAS 1.32 - 35 does not allow for the offsetting of assets and liabilities unless required or permitted

by an IFRS accounting standard.

Related party disclosures

252. Related party disclosures are required in terms of IAS 24 *Related Party Disclosures* and are discussed in detail below - Refer to Appendix II for illustrative disclosures.

253. Regulation 6A to the Act requires schemes to disclose specific details per trustee relating to trustee remuneration.

Who are potential related parties to a medical scheme?

254. Each medical scheme needs to assess individually who its related parties are, considering its individual circumstances.

255. The following table considers the various parties with whom schemes would generally interact, and consider whether they may fall under the definition of a "related party" in terms of IAS 24 *Related Party Disclosures*:

"A related party is a person or entity that is related to the entity that is preparing its financial statements (referred to as the 'reporting entity' in IAS 24).

(a) A person or a close member of that person's family is related to a reporting entity if that person:

i *has control or joint control over the reporting entity;*

ii *has significant influence over the reporting entity; or*

iii *is a member of the key management personnel of the reporting entity or of a parent of the reporting entity.*

(b) An entity is related to a reporting entity if any of the following conditions applies:

i The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others).

ii One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member).

iii Both entities are joint ventures of the same third party.

iv One entity is a joint venture of a third entity, and the other entity is an associate of the third entity.

v The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity.

vi The entity is controlled or jointly controlled by a person identified in (a).

vii A person identified in (a)(i) has significant influence over the entity or is a member of the key management personnel of the entity (or of a parent of the entity).

viii The entity, or any member of a group of a group of which it is a part, provides key management personnel services to the reporting entity or to the parent of the reporting entity."

256. The members of the scheme own the scheme. As such, the terms "control" and "joint control", as defined by IFRS 10 *Consolidated Financial Statements* and IFRS 11 *Joint Arrangements* respectively, are not applicable in a medical scheme's scenario from the point of view that no single person can have control or joint control over the scheme.

Parts (a) (i) and (b) (vii) of the definition will, therefore, not be applicable to the scheme.

Party	IAS 24.9	Other considerations
1. Employer/Employer groups	Consider part (b) (v) of the definition	IAS 24.9 part (b) of the definition of a Related Party states that "An entity is related to a reporting entity if any of the following conditions applies: (v) The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity." Consider the definition in the following circumstances: — Closed scheme – Sponsoring employer is probably related — Open scheme – employers not likely to be related.
2. Trustees	Consider part (a) (iii) of the Definition	IAS 24.9 part (a) of the definition of a Related Party states that "A person or a close member of that person's family is related to a reporting entity if that person: (iii) is a member of the key management personnel of the reporting entity or of a parent of the reporting entity." *"Key management personnel* are defined as those persons having authority and responsibility for planning, directing and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that entity." (IAS 24.9)
3. Principal officer	Consider part (a) (iii) of the Definition	
4. Members of executive committee/ financial managers/ Chief Executive Officer, etc.	Consider part (a) (iii) of the definition	
5. Other key management personnel of the scheme	Consider part (a) (iii) of the definition	
6. Other persons with significant influence over an entity.	Consider part (a) (ii) of the definition	IAS 24.9 part (a) of the definition of a Related Party states that "A person or a close member of that person's family is related to a reporting entity if that person: (ii) has significant influence over the reporting entity" *Consider if relevant to the scheme*

7. Close family members of individuals identified in points 2-6 of this table.	Consider part (a) (ii) and (iii) of the definition	*Close members of the family of a person* are defined as those family members who may be expected to influence, or be influenced by, that person in their dealings with the entity and include: (a) that person's children and spouse or domestic partner; (b) children of that person's spouse or domestic partner; and (c) Dependants of that person or that person's spouse or domestic partner. (IAS 24.9) Specifically consider non-dependant family members that are in a related profession (e.g. son of trustee who is a doctor)
8. Administrators	Consider part (a) (iii) and (viii) of the definition	A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services. In considering the management entity, the entity's parent, its subsidiaries and its fellow subsidiaries should be considered if they provide key management services to the scheme. Administrators are not automatically related parties of the scheme by mere fact of the function that they perform in relation to the scheme and the service agreement in place. Administrators may not control a scheme (section 57(3) of the Act). IAS 24.11 "In the context of this Standard, the following are not related parties: (d) A customer, supplier, franchisor, distributor or general agent with whom an entity transacts a significant volume of business, is not considered a related party simply by virtue of the resulting economic dependence." Administrators could, however, form part of the key management of the scheme – consider the following: • Does the administrator have a strong influence over directing the scheme? Does this translate into participation in the policy decision-making process? • Does the administrator provide key management personnel and access to key resources that enable the Board of Trustees to make decisions? • Are the trustees effective in directing the scheme, or is there heavy reliance on

		administrators for guidance and advice? • Consider the pricing structure of administrator? Does the administrator charge a fixed fee?
9. Accredited managed care organisations	Consider part (a)(iii) and (b)(i) to (viii) of the definition	A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services. In considering the management entity, the entity's parent, its subsidiaries and its fellow subsidiaries should be considered. Reference should also be made to IAS 24.11 (see paragraph 8 above). IAS 24.9 part (b) of the definition of a Related Party states that "An entity is related to a reporting entity if any of the following conditions applies: (i) The entity and the reporting entity are members of the same group (which means that each parent, subsidiary and fellow subsidiary is related to the others). (ii) One entity is an associate or joint venture of the other entity (or an associate or joint venture of a member of a group of which the other entity is a member). Both entities are joint ventures of the same third party. (iii) One entity is a joint venture of a third entity, and the other entity is an associate of the third entity. (iv) The entity is a post-employment benefit plan for the benefit of employees of either the reporting entity or an entity related to the reporting entity. If the reporting entity is itself such a plan, the sponsoring employers are also related to the reporting entity. (v) The entity is controlled or jointly controlled by a person identified in (a). Consider: • Does the scheme have its own accredited managed care organisation? • Is the accredited managed care organisation an associate, joint venture or subsidiary of the scheme or its administrator?
10. Brokers and investment managers	Consider part (a)(ii) and (iii) and (b)(i) to (iv) of the definition	A management entity that provides key management personnel services to a scheme may be deemed a related party in respect of those key management personnel services.

		In considering the management entity, the entity's parent, its subsidiaries and its fellow subsidiaries should be considered to the extent that it provides key management services to the scheme. Consider: • Is the broker or investment manager an associate, joint venture or subsidiary of the scheme or its administrator? • Refer to IAS 24.11(d). Is the broker the exclusive or sole broker of the scheme?
11. Post-employment benefit plan	Consider part (b)(v) of the definition	This will only be applicable if the scheme has employees of its own.
12. Trade unions	Consider IAS 24.11	Trade unions are not necessarily related parties because of their normal dealings with the scheme (IAS 24.11(c)).
13. State-controlled schemes	Consider IAS 24.9 definition of government- related entities	A government-related entity is defined as an entity that is controlled, jointly controlled or significantly influenced by a government. (IAS 24.9)
14. Subsidiaries, associates and joint arrangements of the scheme, including other group	Consider part (b)(i) to (vi) of the definition	None
15. An entity that is: • **Controlled; or** • **Jointly controlled by any individual in points 2-7 of this table.**	Consider part (b)(vi) of the definition	None
16. Other significant parties	Consider part a(ii) and (iii) and (b)(i) to (vi) of the definition	None

What should be disclosed?

257. As a general guideline, depending on the circumstances, and transactions entered into by the scheme, disclosures should be made of relationships, key management personnel remuneration and other transactions.

Relationships

258. Relationships between schemes and subsidiaries shall be disclosed irrespective of whether there have been transactions between those related parties. (This is in addition to the disclosure requirements in IAS 27 which requires a listing and description of significant investments in subsidiaries, associates and joint ventures in the separate financial statements; and IFRS 12, which requires information about interests in subsidiaries, joint arrangements, associates, and structured entities that are not controlled by the reporting entity).

Key management personnel remuneration

259. In terms of IAS 24.17, an entity shall disclose key management personnel compensation in total and for each of the following categories:

- Short-term employee benefits;
- Post-employment benefits;
- Other long-term benefits;
- Termination benefits; and
- Share based payments.

260. Trustee remuneration is disclosed in a separate note in the financial statements. The related party note may simply refer to this note.

261. Schemes are reminded that the disclosure requirements as required per section 57[3] of the Act, read together with Regulation 6A[4], will also need to be met, which requires the remuneration and other

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[3] The members of the Board of trustees shall disclose annually in writing to the Registrar any payment or considerations made to them in that particular year by the medical scheme [Medical Scheme Act 131 of 1998 section 57(8)]

[4] Disclosure of trustee remuneration —The annual financial statements of a medical scheme shall contain the following information in relation to trustee remuneration, either in the income statement or by means of a note thereto, the amount paid, per trustee, in the following categories:
(a) disbursements, including but not limited to:
(i) travelling and other expenses for attendance of meetings or conferences;
(ii) accommodation and meals; and
(iii) telephone expenses for business purposes;
(b) fees for attendance of meetings of the board or committees of the board;
(c) fees due for holding particular office on the board or committees of the board;
(d) fees for consultancy work performed for the medical scheme by a trustee; and
(e) other remuneration paid to a trustee.
[Medical Scheme Act, 131 of 1998 Regulation 6A]

considerations to be disclosed per trustee.

Other transactions

262. If there have been transactions between related parties, the scheme shall disclose the nature of the related party relationship and information about the transactions and outstanding balances necessary for an understanding of the potential effect of the relationship on the financial statements. At a minimum, disclosures shall include:

- The amount of the transactions;
- The amount of outstanding balances (distinguish between payable to and receivable from);
- The terms and conditions of the balances, including:
- Whether they are secured;
- The nature of the consideration to be provided in settlement;
- Details of any guarantees given or received;
- Provisions for doubtful debts related to the amount of outstanding balances; and
- The expense recognised during the period in respect of bad or doubtful debts due from related parties.

263. The above disclosures shall be made separately for each of the following categories:

- Entities with significant influence over the entity;
- Subsidiaries;
- Associates;
- Joint ventures in which the scheme is a venture;
- Key management personnel of the scheme; and
- Other related parties.

264. Items of a similar nature may be disclosed in aggregate except when separate disclosure is necessary for an understanding of the effects of related party transactions on the financial statements of an entity.

265. Where the employer is a related party, transactions entered into by the employer when acting solely in its capacity as an intermediary are not considered to be related party transactions. The employer can be seen as an agent of its employees which is excluded as a related party in terms of IAS 24.11(d).

In such instances, the contracting parties are the scheme and the member, and the following will not need to be disclosed for related party purposes:

- Contributions received from employer group;
- Claims paid to members of the employer group;
- Contributions received in advance;
- Contribution debtors;
- Contribution subsidy paid by the employer (schemes would not have access to this information and this is also a payment made on behalf of the member); and
- Claims reported not yet paid to members of the employer group.

Government-related entities

266. A state-controlled scheme is exempt from the disclosure requirements of IAS 24.18 *in relation to related party transactions and outstanding balances, including commitments, with:*

- A government that has control, joint control or significant influence over the reporting entity; and
- Another entity that is a related party because the same government has control, joint control or significant influence over both the reporting entity and the other entity.

267. If a state-controlled scheme applies the exemption in IAS 24.25, it shall disclose the following about the transactions and related outstanding balances referred to in IAS 24.25:

- The name of the government;
- The nature of its relationship with the reporting entity (i.e. control, joint control or significant influence);
- The nature and amount of each individually significant transaction; and
- For other transactions that are collectively significant, a qualitative (by nature) or quantitative (by amount) indication of their extent.

How much should be disclosed?

268. Related party relationships and related party transactions should be disclosed when they are qualitatively (by nature) and quantitatively (by amount) material.

269. However, in the context of related party disclosures, size is not of primary importance, as IAS 24.9 defines a related party transaction as a transfer of resources, services or obligations between related parties, regardless of whether a price is charged.

270. The consolidated scheme financial statements must disclose all related party transactions even if

potentially all of the income and expenses of the scheme may derive from related party transactions (disclosures required by IAS 24 are essential to understanding the financial position and financial performance of such a scheme).

The following are examples of transactions that are disclosed if they are with a related party:

(a) Purchases or sales of goods;

(b) Purchases or sales of property and other assets;

(c) Rendering or receiving of services;

(d) Leases;

(e) Transfers of research and development;

(f) Transfers under licence agreements;

(g) Transfers under finance arrangements (including loans and equity contributions in cash or in kind);

(h) Provision of guarantees or collateral;

(i) Commitments to do something if a particular event occurs or does not occur in the future, including executory contracts (recognised and unrecognised); and

(j) Settlement of liabilities on behalf of the scheme or by the scheme on behalf of that related party.

271. IAS 24 does not allow for any relaxation for confidential or client-sensitive information.

Guarantees received by the medical scheme from a third party.

272. Where, in accordance with sections 24(5), 33(3) and 44(9)(b) of the Act, a third party has provided a guarantee to the medical scheme to ensure the financial soundness of the medical scheme, details of the guarantee and its cost are disclosed in the notes to the financial statements and the trustees' report.

273. In terms of section 35(6) of the Act, the medical scheme is not allowed to encumber its assets in support of any guarantee without the prior approval of the Registrar.

Solvency ratio

274. 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.

275. For the purpose of calculating the solvency ratio, the Act requires that:

- All cumulative unrealised net gains are to be excluded from the computation of accumulated

funds (i.e. even if the credit was taken to income);

- Any consolidated results from subsidiaries are included in the cumulative unrealised results in order to ensure that the solvency calculation is based on scheme-only results;
- Cumulative unrealised net losses are ignored in the calculation of accumulated funds as per Circular 13 of 2001;
- Funds set aside for specific non-claims purposes are to be excluded;
- Encumbered assets in respect of non-scheme liabilities are to be excluded; and
- Gross annual contributions include the annual contributions to members' personal medical savings accounts.

Road Accident Fund (RAF)

276. A medical scheme may grant assistance to its members in defraying expenditure incurred in connection with the rendering of any relevant health service. Such expenditure may be in connection with a claim that is also made to the RAF, administered in terms of the Road Accident Fund Amendment Act, 2005. If members are reimbursed by the RAF, they are generally obliged contractually to cede that payment to the medical scheme to the extent that they have already been compensated. This contractual obligation may be in the form of a separate agreement or by an acknowledgement of a clause to this effect in the rules of the medical scheme.

277. The medical scheme has no direct relationship with the RAF. IFRS 17.B65(k) states that cash flows within the boundary of an insurance contract would include potential cash inflows from recoveries on future claims are covered by existing insurance contracts and, to the extent that they do not qualify for recognition as separate assets, potential cash inflows from recoveries on past claims.

    If the RAF claim and related recovery have been included in the contract boundary on a probability weighted basis, the cash flow relating to the claim should be included. The RAF claim and related recovery will form part of the liability for incurred claims and part of the claims and estimates in profit or loss.

Income/ (expense) per benefit option

278. 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. The net income/ (expense) for the year and the number of members enrolled for each benefit option under a medical scheme should be disclosed separately in terms of IFRS 17. The accounting records are to be maintained in such a way that the net income/ (expense) for the year for each benefit option can be determined. This information is disclosed as a note to the financial statements in terms of Circular 4 of 2008 and is required to be audited as part of the financial statements.

279. The accounting policies should state the manner in which the different line items in the statement of profit or loss and other comprehensive income are allocated between the different benefit options, e.g. based on membership or contributions. Any changes in the allocation method from year to year

would result in a change in accounting policy.

280. Circular 12 of 2024 stated that in assessing the benefit options' compliance with Section 33(2) of the Act, the CMS will not consider the Amounts attributable to members. The assessment will be based on the previously known net healthcare result (now presented as insurance service result) and income/(expense) attributable to members.

Consolidation

281. A medical scheme should prepare consolidated financial statements in terms of IFRS 10 if it has subsidiaries.

282. The medical scheme's results and financial position should be presented separately in separate financial statements and the consolidated results and financial position should be presented in consolidated financial statements.

283. The benefit option results, and solvency calculation are based on scheme-only results.

The impact of IFRS 10 Consolidated Financial Statements

284. The impact of IFRS 10 and IFRS 3 should be assessed by the medical scheme and discussed with the scheme's auditors when it has entered into a business combination.

285. The following table provides a summary of the possible impact of IFRS 10 on medical schemes, which needs to be assessed:

IFRS Accounting Standard	**Details**	**Impact**
IFRS 10 *Consolidated Financial Statements*	• IFRS 10 defines the principle of control as the basis for determining which entities are to be consolidated. • IFRS 10 paragraph 7 states that an investor controls an investee if the investor has **all** of the three elements of control: 1. **Power** over the investee; 2. Exposure or rights to **variable returns** from involvement with the investee; and 3. The **ability to use power** over the investee to affect the amount of the investor's returns. • IFRS 10 states that for an investor to have power over the investee it must have existing rights that give it the	• Medical schemes should consider whether it has control over its investees. Control over these entities would require medical schemes to consolidate those entities in their financial statements. • Medical schemes' rights in investees are generally protective (i.e. rights designed to protect the interests of the investor), and IFRS 10 states that an investor that holds only protective rights, do not have power over an investee. • The medical scheme's investees will need to be regularly assessed to determine if the control definition in this IFRS is met (i.e. if there is a change in circumstances).

	current ability to direct the relevant activities of the investee. • In assessing power, only *substantive* rights and not protective rights are considered.	

Non-compliance matters

286. CMS issued Circular 11 of 2006 – *Issues to be addressed in the audited financial statements of medical schemes* and 23 of 2010 – *General notification: General concerns noted during the analysis of the 2009 annual financial statements and statutory returns* in terms of which the following non-compliance disclosures are required:

- All non-compliance matters noted should be disclosed in the notes to the audited financial statements, irrespective of whether they are considered to be material or not;
- All non-compliance matters which are material for the appreciation of the members should be reported on individually in the report of the Board of Trustees. CMS considers all non-compliance to be of such a nature. The nature of the non-compliance must be disclosed as the CMS does not consider it sufficient to make reference to the relevant notes in the annual financial statements.

287. Medical schemes are required to disclose the following information in respect of all non-compliance matters (regardless of whether the scheme has addressed the non- compliance or not):

- Nature and impact of the non-compliance;
- Cause of the non-compliance; and
- Corrective course of action adopted to ensure compliance, including the timing of the corrective action.

288. Corrective courses of action implemented would include exemptions obtained, suspension and termination of benefits in respect of outstanding contributions, and any other actions taken.

Report of the Board of Trustees

1. In accordance with section 37(1) of the Act, the Board of Trustees is to cause financial statements to be prepared and is to submit copies of these statements together with the report of the Board of Trustees to the Registrar within four months after the end of the accounting period. The trustees' report does not form part of the financial statements and, therefore, is not audited. However, the report is packaged and issued along with the financial statements in terms of section 37(1) of the Act and, therefore, the auditor is required to consider the requirements of International Standard on Auditing (ISA) 720 *The Auditor's Responsibilities Relating to Other Information in Documents Containing Audited Financial Statements*. The Board of Trustees is therefore encouraged to make the report available well in advance of the approval and issue of the financial statements. ISA 720 requires the auditor to check the consistency of the information contained in the report with that in the annual financial statements. If inconsistent information is identified and not corrected, then the auditor considers the quantitative and qualitative materiality of the difference and reports on it, if necessary, in the audit report.

2. The King IV Report on Corporate Governance for South Africa 2016 (King IV) was released on 1 November 2016. Although compliance with King IV is not mandatory, schemes are encouraged to comply with it. The report can be accessed on the Institute of Directors website and readers are referred therein for detailed information.

3. In South Africa, many organisations have been preparing integrated reports for the past few years stemming from the release of the King Report on Governance for South Africa 2009 and the Discussion Paper on Integrated Reporting, issued by South Africa's Integrated Reporting Committee in January 2011. Globally, the International Integrated Reporting Council (IIRC) released its International Integrated Reporting Framework (International <IR > Framework) in December 2013, setting out guidance on the content of integrated reports. The IIRC released the revised version of the International <IR> Framework on 19 January 2021 aimed at enabling more decision-useful reporting. This version supersedes the original Framework of 2013 and is effective for reporting periods commencing 1 January 2022.Medical schemes are encouraged to use the current report of the Board of Trustees to incorporate the integrated reporting approach as per the applicable frameworks.

4. 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 the medical scheme of the state of affairs and the business of the medical scheme and its results and is to contain relevant information that indicates whether or not the resources of the medical scheme have been applied economically, efficiently and effectively.

5. In terms of Circular 11 of 2006 all non-compliance matters should be reported in the report of the Board of Trustees, irrespective of whether the auditor considers them to be material or not. CMS does not consider it sufficient to make reference to the relevant notes in the financial statements. Schemes are required to disclose the following information in respect of non-compliance matters:

   - Nature and cause of the non-compliance.
   - Possible impact of the non-compliance; and

- The corrective action. Corrective courses of action implemented would include exemptions obtained, notifications and action plans sent to the Registrar, suspension and termination of benefits in respect of outstanding contributions, notifications sent to employer groups in respect of outstanding contributions on behalf of the employees of these employer groups, and any other actions taken.

6. The report of the Board of Trustees is to be presented in such a way that it:

- Deals in narrative form with all descriptive matters under appropriate headings and sets out amounts or statistics, as far as practicable, in tabular form and where it provides any amounts, states the corresponding amounts, if any, in respect of the immediately preceding accounting period;

- Reviews, in general, the business and operations of the medical scheme during the accounting period and the results thereof and addresses every fact or circumstance material to the appreciation of the state of affairs and financial position of the medical scheme by its members;

- Addresses any material fact or circumstance that has occurred between the accounting date and the date of the approval of the financial statements; and

- Includes the following information, unless such information is already disclosed in the financial statements/summarised financial statements:

    - Any special conditions that attach to the registration of the medical scheme or any of its benefit options, including guarantees received by the scheme from a third party;

    - Details of the nature of the medical scheme (for example, the terms of registration and the number of benefit options) and any major change therein during the accounting period;

    - The basis and calculation of the solvency ratio as per Regulation 29;

    - The amount and description of and reason for the creation of any reserves set aside for a specific purpose;

    - The reasons for and the detail of any major change in the nature of the property, plant and equipment and investments of the medical scheme during the accounting period, or any change in policy relating to the use of property, plant and equipment or to the investment portfolio, and any material disposals or purchases of property, plant and equipment;

    - The fact that the business of the medical scheme or any part of the business has been managed by a third party under any agreement during the accounting period, and the name of the third party. A third party would include a professional administrator and/or provider of healthcare management services to the medical scheme;

    - The names of the trustees and the Principal Officer, the Principal Officer’s business address and any changes therein during the accounting period;

- Note on expert advice obtained (if applicable);
- A summary of the objectives, policies and procedures for managing insurance risk and the methods used to manage those risks;
- The nature, terms and conditions of any risk transfer arrangements, including the results of these agreements;
- The basis for the outstanding risk claims provision, and whether or not the method of calculation is consistent with the previous years; and
- Minimum statistics for the current and comparative accounting period, as follows:
    - Average number of members during the accounting period and number of members at the end of the accounting period per option; *
    - Number of beneficiaries per option (at the end of the period and the average for the year); *
    - Dependant ratio in the medical scheme as a whole and for each benefit option, at the end of the accounting period;
    - Insurance revenue per average beneficiary per month for the medical scheme as a whole and for each benefit option; *
    - Relevant healthcare expenditure per average beneficiary per month for the medical scheme as a whole and for each benefit option; *
    - Directly attributable insurance service expenditure (DAE) per average beneficiary per month for the medical scheme as a whole and for each benefit option; *
    - Relevant healthcare expenditure as a percentage of insurance revenue per benefit option (claims ratio);
    - Directly attributable insurance service expenditure (DAE)as a percentage of insurance revenue benefit option;
    - Average age in the medical scheme as a whole and per benefit option;
    - Pensioner ratio in the medical scheme as a whole and for each benefit option, at the end of the accounting period;
    - Average amounts attributable to members (liability to members) per member at year-end; and
    - Return on investments as a percentage of investments.

**Averages are calculated using the sum of the 12 months' actual month-end membership divided by 12.*

7. The Board of Trustees' report should include a schedule of trustees' attendance of Board of Trustees' meetings and sub-committee meetings.

8. The Board of Trustees' report should mention that personal medical savings accounts are managed in terms of the scheme rules. The report must clearly indicate whether a trust relationship had been created in terms of the scheme's rules, or whether the PMSA monies belong to the scheme. The report should also state that savings contributions are refundable when a member enrols in another benefit option or another medical scheme without a personal medical savings account or does not enrol in another medical scheme, and that the accumulated unutilised personal medical savings account balance will be transferred to the member in terms of the medical scheme's rules. Details of any interest earned on the members' investment in terms of the rules of the scheme could also be provided.

9. The Board of Trustees' report is to address the operations of the audit committee and other relevant committees, such as the investment committee, the remuneration committee and the ex-gratia committee (as applicable to the medical scheme).

10. In terms of good corporate governance practices, financial statements are to include a responsibility statement/report by the Board of Trustees that addresses the following matters:

    - The trustees' responsibility for preparing financial statements that fairly present the state of affairs of the medical scheme as at the end of the accounting period and the results of its operations and cash flow information for the period that ended;
    - The trustees of the scheme are responsible for the controls over, and the security of the website and, where applicable, for establishing and controlling the process for electronically distributing annual reports and other financial information to members and to the CMS;
    - That the auditor is responsible for reporting on the fair presentation of the financial statements;
    - The maintenance of proper books and records of all operations of the medical scheme and of proper internal control systems;
    - The consistent use of appropriate accounting policies supported by reasonable and prudent judgements and estimates;
    - Where applicable, compliance with IFRS Accounting Standards or, if there has been any departure in the interests of fair presentation, the reasons for and effect of this departure; and
    - That there is no reason to believe that the medical scheme will not be a going concern in the year ahead or an explanation of any reasons to believe otherwise and how this is to impact the members and the operation of the medical scheme in the immediate future.

11. In terms of good corporate governance practices, financial statements are to include a statement of corporate governance by the Board of Trustees that addresses the following matters (this could be addressed in a separate Trustee's responsibility report):

    - Commitment to the principles and practices of responsibility, accountability, fairness and

transparency in all its dealings with stakeholders;

- Compliance with a recognised governance framework;
- Conducting of its affairs according to ethical values;
- Adoption of risk assessment, evaluation and management processes;
- Regular monitoring of the performance of third-party administrators and providers according to service level agreements;
- Evaluation of their performance as a Board and of the Board sub-committees against the agreed terms of reference and performance targets;
- Establishment and management of internal controls by assessing the adequacy and effectiveness through the appointment of internal auditors; and
- Calling on of expert and professional advice when required.

APPENDIX I – COMMON PROBLEM AREAS IDENTIFIED BY THE COUNCIL FOR MEDICAL SCHEMES

1. During the analysis of the 2023 annual financial statements, the Council for Medical Schemes (CMS) identified certain common problem areas regarding the application of IFRS Accounting Standards. These problem areas are listed below to assist the schemes in the preparation of the 31 December 2024 financial statements and provide detailed context for industry considerations in reporting. There are items below which are still to be further deliberated with both the industry and the CMS.

2. Please note that reference should be made to IFRS Accounting Standards to ensure compliance. Where these specific issues are addressed, schemes should understand the standard applicable and should comply with the applicable standard.

3. Schemes remain ultimately responsible for their annual financial statements and compliance with IFRS Accounting Standards.

Statement of Financial Position: Order of liquidity

4. Circular 41 of 2023 requested schemes to provide comments on the presentation of the Statement of Financial Position.

5. Paragraph 60 of IAS 1 Presentation of Financial Statements states that: “An entity shall present current and non-current assets, and current and non-current liabilities, as separate classifications in its statement of financial position in accordance with paragraphs 66–76 except when a presentation based on liquidity provides information that is reliable and more relevant. When that exception applies, an entity shall present all assets and liabilities in order of liquidity.”

6. Paragraph 62 of IAS 1 states that: “When an entity supplies goods or services within a clearly identifiable operating cycle, separate classification of current and non-current assets and liabilities in the statement of financial position provides useful information by distinguishing the net assets that are continuously circulating as working capital from those used in the entity’s long-term operations”.

7. The standard recognises that for some entities, such as financial institutions, presentation of assets and liabilities using the order of liquidity provides information that is reliable and more relevant than a current and non-current presentation as the entity does not supply goods or services within a clearly identifiable operating cycle (see IAS 1 paragraph 63).

8. CMS is of the view that medical schemes operate within a clearly identifiable operating cycle which would necessitate a current, non-current presentation to be used in the Statement of Financial Position.

9. Paragraph 61 of IAS 1 also indicates that regardless of which method of presentation has been adopted, the entity will still be required to disclose current and non-current assets and liabilities separately.

10. It was noted that 12 schemes adopted the order of liquidity to present their statement of financial position (11 of these schemes were administered by the same third-party administrator). Two of the

schemes who adopted this method of presentation, did not present the items on the statement of financial position from least liquid to most liquid as required by IAS 1.

11. CMS will be engaging further with the industry on the most appropriate method of presentation of the Statement of Financial Position.

Statement of comprehensive income – Insurance service result

12. Circular 12 of 2024 confirmed that the previously known "Net healthcare result" - Section 33(2)(b) (of the Medical Schemes Act 131 of 1998) compliance - is now evaluated at the insurance service result* – level (*excluding the "Amounts attributable to members").

13. The net healthcare result sub-total in the Statement of Profit or Loss and Other Comprehensive Income was previously the result of contributions, relevant healthcare expenditure and non-healthcare expenditure.

14. The insurance service result sub-total in the Statement of Profit or Loss and Other Comprehensive Income was considered a close proxy of the previous net healthcare result, as it represents the result of contributions, relevant healthcare expenditure and directly attributable insurance service expenditure (which represents slightly more than 80% of the total previously known non-healthcare expenditure). Investment income was always only taken into consideration after the net healthcare result sub-total.

Statement of Cash Flows – Investment income

15. IAS 7 paragraph 33 states that there is no consensus on the classification of interest paid and interest and dividends received for entities other than financial institutions. Interest paid and interest and dividends received may be classified as operating cash flows because they enter into the determination of profit or loss. Alternatively, interest paid and dividends received may be classified as financing cash flows and investing cash flows respectively, because they are costs of obtaining financial resources or returns on investments.

    In Circular 52 of 2021, CMS requested that schemes report their investment income under investing activities. This is due to Section 33(2)(b) of the Medical Schemes Act 131 of 1998 requiring each benefit option to be self-supporting in terms of financial performance. Compliance to Section 33(2)(b) is evaluated at the insurance service result level (i.e. before investment income is taken into account). This sub-total is deemed to reflect the scheme's operational result.

16. Although Circular 18 of 2022 delayed the implementation of the above-mentioned Circular 63 of 2021, CMS is still of the opinion that investment income should be disclosed under investing activities.

17. It was noted that six schemes presented their investment income (i.e. interest received from investments other than cash and cash equivalents, and dividends received) under operating activities. CMS will be engaging further with key industry stakeholders to determine the correct classification of investment income in the Statement of Cash Flows.

Insurance contract liabilities/assets

18. There is a difference in the technical interpretation of whether the following specific items within the Liability for Remaining Coverage (LFRC) may be transferred to the Liability for Incurred Claims (LIC) or not:

    - Contribution receivables.

    - Personal Medical Savings Accounts (PMSA's) contributions.

19. The following was noted regarding schemes' reconciliation of the liability for incurred claims:

    - Two schemes did not include the risk adjustment for non-financial risk in their liability for incurred claims as required by IFRS17 paragraph 100(c)(ii).

    - It was noted that one scheme incorrectly disclosed a provision for impairment for insurance receivables that are not expected to be recovered. This is not correct as contributions are only recognised in the liability for remaining coverage when the contributions are received in cash (insurance revenue is recognised based on the expected premium receipts).

20. Other items:

    - Cash Flows disclosed in the IFRS 17 reconciliations could not be fully reconciled back to the scheme's Statement of Cash Flows or the notes thereto. Kindly refer to the 'Additional disclosure considerations' below.

    - Schemes did not provide a breakdown of what is included in the final insurance asset/liability i.e. outstanding contributions, claims reported not yet paid etc (this disclosure is recommended in addition to the IFRS 17 reconciliations). This would assist members' understanding of these amounts and can also be reconcilable to the various parts within the Annual Return. Kindly refer to the 'Additional disclosure considerations' below.

Investments at fair value through other comprehensive income (FVOCI) reserve

21. Many schemes that had investments measured at FVOCI did not provide a reconciliation on the movements within this reserve in their financial statements. The CSM observed that some schemes included the reserve in the amounts attributable to members-liability due to medical schemes being considered mutual entities.

Amounts attributable to members

22. Medical schemes are considered to be mutual entities for the purposes of applying IFRS 17 Insurance Contracts. As a result, the amounts attributable to members (previously accumulated funds) are disclosed as a liability owing to its members. CMS would typically expect this liability to be disclosed under non-current liabilities due to the long-term nature of this liability. The CMS observed that a portion of this liability was disclosed under current liabilities where the scheme expects a deficit for the following year (i.e. it would be realised within the next 12 months).

23. Four schemes disclosed a separate liability (amounts attributable to members) under current liabilities but did not provide information that explains what this liability relates to (i.e. deficit budgeted for the following year).

24. Seven schemes included the full liability to members under current liabilities (stratification per auditor was noted). This disclosure originated from initial technical considerations in the IFRS17 journey that considered the liability being payable on demand. As this liability is not to be realised within the next year (unless there is a going concern issue), it is CMS's view that it represents a non-current liability.

Insurance Revenue: Recoverability of contribution receipt

25. Four schemes disclosed impairment losses on contribution receivables in the Statement of Comprehensive Income. Per IFRS 17 paragraph B126, for schemes that apply the premium allocation approach, insurance revenue for the period is the amount of expected premium receipts (excluding any investment component) allocated to the period. The scheme should therefore reduce the insurance revenue with the contributions that are not expected to be received and appropriately disclose this in the insurance revenue note in the financial statements.

Accredited managed care fees

26. It was noted that three schemes did not provide the necessary disclosure of the schemes' accredited managed care fees per service as required by Circular 56 of 2015. These services are required to be included as part of claims, but separate disclosure of the accredited services provided is necessary.

Accredited administration fees paid to the administrator

27. It was noted that two schemes did not disclose the necessary breakdown of the schemes' accredited administration fees per service as required by Circular 77 of 2019.

Directly attributable and not directly attributable insurance expenses

28. Circular 29 of 2023 was issued requesting comments from the industry on the proposed split of its operational expenditure between directly attributable and non-directly attributable expenditure. The results of the feedback from the industry were however not conclusive. CMS will be engaging further with the industry based on the findings of the 2023 annual financial statements analysis.

29. In many instances, the split between direct and not directly attributable expenditure was not clear from the notes to the financial statements.

30. It was observed that the allocation per the definition above was not consistently applied by schemes.

31. In four instances, the split between direct and not directly attributable expenditure was not clear from the notes to the schemes' financial statements.

32. It was also noted that one scheme did not include all the accredited administration fees as directly attributable expenditure in the financial statements.

Benefit options results

33. Circular 12 of 2024 confirmed that schemes must exclude the amounts attributable to members from its benefit options results (i.e. the amounts attributable to members must not be included in the insurance service expenditure line item and therefore should not be allocated to the benefit options).

34. It was noted that 16 schemes did not exclude the amounts attributable to members line item from its benefit options results note. It is not deemed sufficient to disclose only the insurance service result and net result without this figure. The exclusion of this item in all the individual lines within the benefit options' financial performance disclosure note would allow members to compute relevant healthcare expenditure ratios per benefit option and to determine which benefits options are not self-supporting in terms of Section 33(2) of the Act.

35. CMS is cognisant of the fact that reconciling the disclosure would be necessary in order to allow for the benefit option result disclosure note to agree to the results as disclosed in the Statement of Profit or Loss and Other Comprehensive Income. The reconciling items should however be presented in such a way that the medical scheme member can at a bird's eye view observe the benefit option performance excluding the amounts attributable to members.

IFRS 12 Disclosure of Interests in Other Entities

36. Five schemes did not consider IFRS 12 disclosures in their annual financial statements. Schemes are urged to include the disclosure required, ensuring that an accounting policy and detailed disclosure note has been included.

Additional disclosure considerations

37. IAS 1 paragraph 17(c) requires entities to provide additional disclosures when compliance with the specific requirements in IFRS Accounting Standards is insufficient to enable users to understand the impact of particular transactions, other events and conditions on the entity's financial position and financial performance.

38. The following additional disclosures by medical schemes were noted during our analysis of schemes' AFS, and were considered to meet the requirements imposed by paragraph 17(c):

- Reinsurance contracts: 17 medical schemes disclosed detailed information on each reinsurance arrangement contracted, and the value provided by these contracts (by virtue of the disclosure of the capitation fees paid and the estimated recoveries per individual contract) in their financial statements.

- Insurance contract liabilities:

    - Liability for Remaining Coverage and Liability for Incurred Claims: A: A reconciliation between the amounts disclosed as the cash flows for the year and the amounts presented in the Statement of Cash Flows were provided by 12 schemes.

    - Liability for Remaining Coverage and Liability for Incurred Claims: Detail: Detail was

provided on the balances that represented the liability (for example, claims reported not yet paid, outstanding contributions, etc.) by 21 schemes.

- Amounts attributable to members: A reconciliation between the opening and closing balances were provided by 23 schemes.

- Liquidity risk analysis: 18 schemes provided information on the matching of its assets with its liabilities.

39. Medical schemes are encouraged to add these disclosures to their annual financial statements going forward.

Financial risk management report

Credit risk ratings: 16 schemes provided inadequate disclosure of credit risk ratings per institution as required by IFRS 7 paragraph 35M: “An entity shall disclose, by credit risk rating grades, the gross carrying amount of financial assets”. Schemes are urged to ensure that the appropriate disclosure in terms of IFRS 7 is included in their annual financial statements.

Reporting of non-compliance matters

40. In Circular 11 of 2006, Circular 30 of 2007 and Circular 14 of 2008, the CMS has directed schemes that all non-compliance matters should be disclosed in the both the BoT Report and the scheme’s financial statements.

41. The following non-compliance matters were not reported:

- Six schemes did not disclose non-compliance with Regulation 30 read in conjunction with Annexure B.

- Three schemes did not disclose Section 33(2) non-compliance for benefit options that are not self-supporting.

42. Schemes are required to disclose the following information relating to all non-compliance issues (regardless of whether the scheme has addressed the non-compliance or not):

- Nature and impact;

- Causes of the failure; and

- Corrective course of action (including the timeframe, where applicable).

43. Corrective courses of action implemented would include exemptions obtained, suspension and termination of benefits in respect of outstanding contributions, and any other actions taken.

APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

These examples are intended mainly to illustrate some of the presentation and disclosure requirements of IFRS Accounting Standards and the Act. Reference should be made to the SAICA website (www.saica.org.za) for links to complete sets of illustrative financial statements.

The illustrative examples in this appendix specifically do not address the requirement to provide information about

- Interest and market risk sensitivity analysis
- Credit risk and
- Liquidity risk

as required by IFRS 17. 127 - 132

These illustrative disclosure examples contain general information only and are not intended to address all possible alternatives or to provide specific accounting, business, financial, investment, legal or other professional advice or services. Annual financial statements include the financial statements and report of the board of trustees.

The examples and policies provided in this Guide are for guidance purposes only and all medical schemes should apply themselves and ensure their policies and disclosures reflect what is applicable to their scheme.

1. ILLUSTRATIVE STATEMENT OF FINANCIAL POSITION

IAS 1 requires the statement of financial position to present current and non-current assets, and current and non-current liabilities as separate classifications, except when a presentation based on liquidity provides information that is reliable and more relevant. In such cases, an entity shall present all assets and liabilities in order of liquidity. The standard acknowledges that for some entities, such as financial institutions, the presentation of assets and liabilities using the order of liquidity provides information that is reliable and more relevant than a current/non-current presentation because the entity does not supply goods or services within a clearly identifiable operating cycle.

Whether or not the items are presented based on the order of liquidity is an area of management judgment, and the illustrative financial statements have been provided based on the current/non-current presentation.

Name of Medical Scheme			
(Registration Number: 1234)			
STATEMENT OF FINANCIAL POSITION AT 31 DECEMBER 20XX			
	Notes	**20XX (CY)**	**20YY (PY)**
ASSETS			
Non-current assets			
Property and equipment			
Right of use asset			
Investment property			
Investments	Note 1		
Financial assets at fair value through other comprehensive income			
Scheme			
Trust			
Financial assets at fair value through profit or loss			
Scheme			
Trust			
Financial assets at amortised cost	Note 1		
Current assets			
Investments	Note 1		
Financial assets at fair value through other comprehensive income			
Scheme			
Trust			
Financial assets at fair value through profit or loss			
Scheme			
Trust			
Financial assets at amortised cost / Trade and other receivables	Note 1		
Cash and cash equivalents	Note 2		
Insurance contract assets	Note 3		
Reinsurance contract assets	Note 4		
Total Assets			
FUNDS AND LIABILITIES			
Reserves (not required – particularly if reserves are zero)			
Accumulated funds			
Property revaluation reserve			
Investments at fair value through other comprehensive income fair value reserve			
Non-current liabilities			
Liability to future members (each scheme to review classification as current/non-current based on the requirements of IAS 1.69 and the scheme's facts and circumstances)			

Retirement benefit obligations			
Lease liability			
Current liabilities			
Liability to future members (each scheme to review classification as current/non-current based on the requirements of IAS 1.69 and the scheme's facts and circumstances)			
Insurance contract liability	Note 3		
Reinsurance contract liability			
Financial liabilities at amortised cost / Trade and other payables	Note 5		
Total funds and liabilities			

2. ILLUSTRATIVE STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

Name of Medical Scheme			
(Registration Number: 1234)			
STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 20XX			
	Notes	**20xx (CY)**	**20YY(PY)**
Insurance revenue	Note 6		
Insurance service expense (*suggested breakdown below could be provided in the notes or in the face)	Note 6		
Net claims incurred			
Claims incurred			
Third party claims recoveries			
Accredited managed healthcare services (no risk transfer)			
Directly attributable expenditure	Note 6		
Accredited administration services			
Other administration expenditure			
Insurance acquisition cash flows/ broker fees			
Net expenses from risk transfer arrangement/ reinsurance contracts (gross presentation was followed, however accounting policy choice)**	Note 8		
Amounts recovered from risk transfer arrangements/ reinsurance contract			
An allocation of premiums paid			
Insurance service result			
Other income			
Investment income	Note 7		
Revenue from use of own facilities by external parties	Note 9		
Grants			
Sundry income			
Gain on derecognition of financial assets measured at amortised cost			
Other expenditure			
Other administration expenditure			
Asset management fees			
Sundry expenses			
Cost incurred in provision of own facilities to external parties	Note 9		
Loss on derecognition of financial assets measured at amortised cost			
Net impairment losses on other financial assets	Note 13.3.2		
Net finance income/ expense from insurance contracts (if discounting is applied and interest is payable to members with PMSA)			
Finance cost			
Profit or loss for the year before amounts attributable to future members			
Amounts attributable to future members	Note 6		
Profit or loss for the year			
Other comprehensive income			
Items that will not be reclassified to profit or loss			
Property revaluation			
Equity investments at fair value through OCI – net change in fair value			
Items that will be reclassified to profit or loss			
Debt instruments at fair value through OCI – net change in fair value			
Debt instruments at fair value through OCI – reclassified to profit or loss			

OTHER COMPREHENSIVE INCOME FOR THE YEAR			
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			

*** Each scheme to review the appropriate location of items on the face of the statement of profit or loss and other comprehensive income.

3. ILLUSTRATIVE STATEMENT OF CHANGES IN RESERVES

Name of Medical Scheme (Registration Number: 1234)
STATEMENT OF CHANGES IN RESERVES FOR THE YEAR ENDED

31 DECEMBER 20XX

	Link to Notes	**Accumulated funds**	**Fair value through other comprehensive income investment reserve**	**Property revaluation reserve**	**Total reserves***
Balance as at 1 January 20YY					0
Profit or loss					
Other comprehensive income					
Equity investment at fair value through other comprehensive income					
Debt instruments held at fair value through other comprehensive income					
Total profit or loss and other comprehensive income					0
Balance as at 31 December 20YY					
Balance as at 1 January 20XX					
Profit or loss					
Other comprehensive income					
Equity investment held at fair value through other comprehensive income					
Debt instruments held at fair value through other comprehensive income					
Total profit or loss and other comprehensive Income					0
Balance as at 31 December 20XX					

* Total reserves should be Rnil (if scheme is not in a deficit position).

EXAMPLE

A R50 000 (20YY R60 000) gain was made on equity investments at Fair Value through Other Comprehensive Income. The equity investment was acquired at the **beginning of 20YY.**

Extract from statement of profit or loss and other comprehensive income:

Name of Medical Scheme			
(Registration Number: 1234)			
STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 20XX			
	Notes	**20XX (CY)**	**20YY (PY)**
Profit or loss for the year before amounts attributable to future members		120 000	100 000
Amounts attributable to future members		(170 000)	(160 000)
Loss for the year		(50 000)	(60 000)
Other comprehensive income			
Items that will not be reclassified to profit or loss			
Equity investments at fair value through OCI – net change in fair value		50 000	50 000
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		0	60 000

Extract from statement of changes in equity:

	Link to Notes	**Accumulated funds**	**Fair value through other comprehensive income investment reserve**	**Total reserves***
Balance as at 1 January 20YY		0	0	0
Loss		(60 000)		(60 000)
Other comprehensive income				
Equity investments at fair value through other comprehensive income			60 000	60 000
Total profit or loss and other comprehensive income				0
Balance as at 31 December 20YY		(60 000)	60 000	0
Balance as at 1 January 20XX				
Loss		(50 000)		(50 000)
Other comprehensive income				
Equity investments at fair value through other comprehensive income			50 000	50 000
Total profit or loss and other comprehensive Income				0
Balance as at 31 December 20XX		(110 000)	110 000	0

4. ILLUSTRATIVE STATEMENT OF CASH FLOWS

Name of Medical Scheme (Registration Number: 1234)

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 DECEMBER 20XX

	20XX R'000	20YY R'000
Cash flows from operating activities		
Cash receipts from members and providers		
Cash receipts from members and employees - contribution		
Cash receipts from members and provider – Other		
Cash paid to providers, employees and members		
Cash paid to providers, employees and members — insurance service expenditure		
Cash paid to members - savings plan refunds		
Cash generated from/ (used in) operations		
Interest paid		
Other (specify)		
Net cash from/ (used in) operating activities		
Cash flows from investing activities		
Purchase of property, plant and equipment		
Proceeds on disposal of property, plant and equipment		
Purchase of investment property		
Proceeds on disposal of investment property		
Purchase of investments		
Proceeds on disposal of investments		
Interest received		
Dividend received		
Rentals received		
Other (specify)		
Net cash from/ (used in) investing activities		
Cash flows from financing activities		
Repayments of borrowings		
Increase in borrowings		
Other (specify)		
Net cash from/ (used in) financing activities		
Net increase/(decrease) in cash and cash equivalents		
Cash and cash equivalents		
Other (specify)		
Cash and cash equivalents at the end of the year		

STANDARDS AND INTERPRETATIONS EFFECTIVE FOR THE FIRST TIME FOR DECEMBER 2024 YEAR-END

The following IFRS Accounting Standards and amendments are effective for the first time for 31 December 2024. For a full list of new standards and interpretations please refer to the IASB website.

The following standards are expected to be applicable to medical schemes:

Effective Date	Standard, Amendment or Interpretation	Summary of Requirements
Annual periods beginning on or after 1 January 2024	Amendments to IAS 1, 'Presentation of Financial Statements' - Non-current liabilities with covenants	*Classification of Liabilities as Current or Non-current:* Under existing IAS 1 requirements, companies classify a liability as current when they do not have an unconditional right to defer settlement of the liability for at least twelve months after the end of the reporting period. As part of its amendments, the Board has removed the requirement for a right to be unconditional and instead, now requires that a right to defer settlement must have substance and exist at the end of the reporting period. There is limited guidance on how to determine whether a right has substance and the assessment may require management to exercise interpretive judgement. The existing requirement to ignore management's intentions or expectations for settling a liability when determining its classification is unchanged. *Disclosure of Accounting Policies:* The amendments require schemes to disclose their material accounting policy information rather than their significant accounting policies, with additional guidance added to the Standard to explain how an entity can identify material accounting policy information with examples of when accounting policy information is likely to be material.
Annual periods beginning on or after 1 January 2024	IFRS 16 Lease Liability in a Sale and Leaseback	*Amendments to IFRS 16* Leases impact how a seller-lessee accounts for variable lease payments that arise in a sale-and-leaseback transaction. The amendments introduce a new accounting model for variable payments and will require seller-lessees to reassess and potentially restate sale-and-leaseback transactions entered into since 2019.

STANDARDS AND INTERPRETATIONS ISSUED BUT NOT YET EFFECTIVE

The following IFRS Accounting Standards and amendments may affect financial statements for annual periods ending on 31 December 2024, however, are effective for periods after the current financial end. For a full list of new standards and interpretations please refer to the IASB website.

The following standards are expected to be applicable to medical schemes:

Effective Date	Standard, Amendment or Interpretation	Summary of Requirements	Early Application Permitted
Annual periods beginning on or after 1 January 2026	Amendment to IFRS 9, "Financial Instruments" and IFRS 7, "Financial Instruments: Disclosures" - Classification and Measurement of Financial Instruments	These amendments: ● clarify the requirements for the timing of recognition and derecognition of some financial assets and liabilities, with a new exception for some financial liabilities settled through an electronic cash transfer system; ● clarify and add further guidance for assessing whether a financial asset meets the solely payments of principal and interest (SPPI) criterion; ● add new disclosures for certain instruments with contractual terms that can change cash flows (such as some instruments with features linked to the achievement of environment, social and governance (ESG) targets); and ● make updates to the disclosures for equity instruments designated at Fair Value through Other Comprehensive Income (FVOCI).	Yes
1 January 2027	IFRS 18 Presentation and Disclosure in Financial Statements	*IFRS 18 Presentation and Disclosure in Financial Statements:* The new IFRS Accounting Standard IFRS 18 *Presentation and Disclosure in Financial Statements* replaces IAS 1 *Presentation of Financial Statements*. IAS 1 *Presentation of Financial Statements* did not have detailed requirements on: • classification of income and expenses in the statement of profit or loss. • presentation of subtotals above 'profit or loss' in the statement of profit or loss; or • aggregation and disaggregation of information presented in the primary financial statements or disclosed in the notes. This lack of detailed requirements led to diversity in practice as entities defined their own subtotals and performance measures. Investors found it difficult to analyse and compare companies' financial performance. IFRS 18 *Presentation and Disclosure in Financial Statements*, issued by the IASB on 9 April 2024, will improve the quality of financial reporting by: • requiring defined subtotals in the statement of profit or loss;	Yes

		• requiring disclosure about management-defined performance measures; and • adding new principles for aggregation and disaggregation of information. The IASB expects these improvements will enable investors to make more informed decisions leading to better allocations of capital that will contribute to long-term financial stability.	

EXTRACTS FROM THE PRINCIPAL ACCOUNTING POLICIES WHICH RELATE SPECIFICALLY TO MEDICAL SCHEMES

1. FINANCIAL INSTRUMENTS

ACCOUNTING POLICY

Recognition and initial measurement

On initial recognition, trade receivables and debt securities issued are recognised when they are originated, and all other financial assets are recognised when the scheme becomes a party to the contractual provisions of the instrument.

All financial assets are initially measured at fair value plus, for an item not at fair value through profit or loss, transaction costs that are directly attributable to its acquisition or issue.

Classification and subsequent measurement

The scheme classifies its financial assets in the following categories: at fair value through profit or loss, at fair value through other comprehensive income and at amortised cost. Management determines the classification of its financial assets at initial recognition.

Financial assets are not reclassified subsequent to their initial measurement unless the scheme changes its business model for managing financial assets, in which cases all affected financial assets are reclassified on the first day of the first reporting period following the change in the business model.

A financial asset is measured at amortised cost if it meets both of the following conditions and is not designated at fair value through profit or loss:

- It is held within a business model whose objective is to hold assets to collect contractual cash flows; and
- Its contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specified dates.

A debt instrument is measured at fair value through other comprehensive income if it meets both the following conditions and is not designated at fair value through profit or loss:

- It is held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and
- Its contractual terms give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specified dates.

On initial recognition of an equity instrument that is not held for trading, the scheme may irrevocably elect to present subsequent changes in the investment's fair value in other comprehensive income. This election

is made on an investment-by-investment basis.

All financial assets not classified as measured at amortised cost or fair value through other comprehensive income as described above, will be measured at fair value through profit or loss. On initial recognition, the scheme may irrevocably designate an asset that otherwise meets the criteria to be measured at amortised cost or at fair value through other comprehensive income as at fair value through profit or loss, if by doing so eliminates or significantly reduces an accounting mismatch that would otherwise arise.

Subsequent measurement and gains and losses

(a) Financial assets at fair value through profit or loss

These assets are subsequently measured at fair value. Net gains and losses, including any interest or dividend income, are presented separate to other fair value gains or losses in investment income in the statement of profit or loss and other comprehensive income.

(b) Financial instruments at amortised cost

These assets are subsequently measured at amortised cost. Interest income from these financial assets is included in finance income using the effective interest method. Any gain or loss arising on derecognition is recognised directly in profit or loss and presented in “gain/(loss) on derecognition of financial assets measured at amortised cost”. Impairment losses are presented as separate line items in the statement of profit or loss and reduce the amortised cost of the financial asset.

(c) Debt instruments at fair value through other comprehensive income

These assets are subsequently measured at fair value. Movements in the carrying amount are recognised in OCI, except for impairment gains or losses, interest income and foreign exchange gains and losses which are recognised in profit or loss.

On derecognition, the cumulative gain or loss previously recognised in OCI is reclassified from equity to profit or loss. Interest income from these financial assets is included in finance income using the effective interest method. Impairment losses are presented as separate line items in the statement of profit or loss and other comprehensive income.

(d) Equity instruments at fair value through other comprehensive income

These assets are subsequently measured at fair value. Dividends are recognised as investment income in profit or loss unless the dividend clearly represents a recovery of part of the cost of the investment. Other net gains and losses are recognised in other comprehensive income and are never reclassified to profit or loss.

Derecognition

The scheme derecognises a financial asset when the contractual rights to the cash flows from the asset expire, or it transfers the right to receive the contractual cash flows in a transaction in which substantially all of the risks and rewards of ownership of the financial asset are transferred, or it neither transfers nor retains substantially all of the risks and rewards of ownership, and it does not retain control over the transferred asset.

The scheme enters into a transaction whereby it transfers assets recognised in its statement of financial position but retains all or substantially all of the risks and rewards of the transferred assets. In these cases, the transferred asset is not derecognised.

Impairment

(a) Financial assets at amortised cost/ Trade receivables (does not include members that are in arrears)

The scheme assesses on a forward-looking basis the expected credit losses associated with its debt instruments carried at amortised cost and FVOCI.

For trade receivables, excluding insurance receivables, the scheme applies the simplified approach permitted by IFRS 9, which requires expected lifetime losses to be recognised from the initial recognition of the receivables.

Each entity should include specifics on how it has determined their simplified approach. The guidance in IFRS 9.5.5.15 should be used.

(b) Debt investments measured at amortised cost or fair value through OCI

For debt investments measured at amortised cost or at fair value through OCI, the scheme assesses the expected credit losses on a forward-looking basis. The impairment methodology applied depends on whether there has been a significant increase in credit risk.

Debt investments at fair value through OCI include listed and unlisted debt securities. The expected credit loss allowance for debt investments at amortised cost or fair value through OCI is recognised in profit or loss.

Each entity should include specifics on how it has determined its impairment methodology. The guidance in IFRS 9.5.5 should be used.

Equity instruments

The scheme subsequently measures all equity investments at fair value. Where the schemes' management has elected to present fair value gains and losses on equity investments in OCI, there is no subsequent reclassification of fair value gains and losses to profit or loss following the derecognition of the investment. Dividends from such investments continue to be recognised in profit or loss as investment income when the group's right to receive payments is established.

Changes in the fair value of financial assets at FVPL are recognised in other gains/ (losses) in the statement of profit or loss as applicable.

Offsetting financial instruments

Financial assets and liabilities are offset, and the net amount reported in the statement of financial position when there is a legally enforceable right to offset the recognised amounts, and there is an intention to settle on a net basis or realise the asset and settle the liability simultaneously. The legally enforceable right must not be contingent on future events. It must be enforceable in the normal course of business and in the event of default, insolvency or bankruptcy of the counterparty.

NOTE DISCLOSURES

	20XX R'000	20YY R'000
INVESTMENTS		
Scheme		
Listed equity securities		
Utilised equity securities		
Bonds and debentures		
Fixed deposits		
Personal medical savings account trust monies invested		
Money market		

The personal medical savings account trust monies were invested on behalf of members in money market instruments. The effective interest rate on the money market investments was x% (20yy: y %), and the investments have an average maturity of xxx days.

	20XX R'000	20YY R'000
FINANCIAL ASSETS AT AMORTISED COST/ TRADE AND OTHER RECEIVABLES		
Receivables		
Total arising from receivables		
Total financial assets at amortised cost		

2. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

In the statement of cash flows, cash and cash equivalents include cash in hand, deposits held at call with banks, other short-term, highly liquid investments with original maturities of three months or less.

NOTE DISCLOSURE

CASH AND CASH EQUIVALENTS[5]

	20XX R'000	20YY R'000
Scheme		
Bank accounts		
Personal medical savings account cash and cash equivalents		
Bank accounts		
Fixed deposits		
Call accounts		
Total cash and cash equivalents		

The personal medical savings account trust monies were invested on behalf of members in bank accounts and fixed deposits.

The effective interest rate on fixed deposits was x% (20yy: y %) and money markets was x% (20yy: y %) and the fixed deposits have an average maturity of xx days.

The effective interest rate on bank accounts was x% (20yy: y %) and call accounts was x% (20yy: y %). The carrying amount of the cash and cash equivalents approximates the fair values due to the short-term nature of the investments.

The total interest earned on the bank accounts and fixed deposits was Rxx (20yy: Ryy), which is included in investment income in profit or loss.

While cash and cash equivalents are also subject to the impairment requirements of IFRS 9, the identified impairment loss was immaterial.

3. INSURANCE CONTRACTS

Based on the requirements of IFRS 17, the scheme was identified as a mutual entity.

SCHEME AS MUTUAL ENTITY

It is expected that the net assets of the scheme will be used to pay current and future policyholders.
As the scheme is in a surplus position, it recognised a liability in its statement of financial position to provide coverage to future members.
This liability is, in essence, incurred because the scheme is obliged to:

- provide coverage to that member;
- pay incurred claims of that member; or
- provide coverage to future members (IFRS 17.B71 liability).

When measuring the liability to future members, the fulfilment cash flows of this liability are measured incorporating information about the fair value of the scheme's other assets and liabilities.

[5] All items disclosed as cash and cash equivalents should meet the definition of cash and cash equivalents in IAS 7 paragraph 6.

There is an accounting mismatch between the measurement of this liability and the measurement of property, which is measured at cost less accumulated depreciation and accumulated impairment. The mismatch has resulted in a liability that is greater than the recognised net assets in the financial statements. Consequently, although the scheme is solvent, for regulatory purposes it has negative equity.

As a result of the recognition of the liability to future members, an additional onerous contract liability was not recognised.

ACCOUNTING POLICY

Identification of insurance contracts

The contracts issued by medical schemes (the issuer) indemnify covered members (the policyholder) and their covered dependants against the risk of loss arising from the occurrence of a health event (insured event). The timing, frequency and severity of the health event covered is uncertain. These contracts fall under the scope of IFRS 17.
Whilst the timing, frequency, severity and type of health events are uncertain, the ultimate insurance risk covered by a medical scheme can be defined as a single risk – that of providing cover for a health event that the member may incur. The risk under the insurance contracts issued by medical schemes can be expressed as the probability that an insured event ("health event") occurs, multiplied by the expected amount of the resulting claim.

Separating components from an insurance contract

The PMSA meets the definition of an investment component in IFRS 17 as it requires the medical scheme to repay a member in all circumstances, regardless of if an insured event occurred. The investment component is not distinct and has to be accounted for in terms of IFRS 17.

The cash flows relating to the PMSA are not recorded in the statement of profit or loss and other comprehensive income but are considered in assessing onerous contracts.

Accounting policy choice (choose either option A or B)

Option A:

The investment component (PMSA) is recognised in the liability for remaining coverage at the inception of the insurance contract. The investment component is utilised during the year and the utilised amount is transferred from the liability for remaining coverage to the liability for incurred claims. At the end of the financial year, the balance of the investment component is transferred to the liability for incurred claims as it relates to a past contract. If interest is payable on the PMSA, the insurance finance income and expense is included in the liability for incurred claims.

Option B:

The investment component (PMSA) is recognised in the liability for remaining coverage at the inception of the insurance contract. The investment component is utilised during the year and the utilised amount is transferred from the liability for remaining coverage to the liability for incurred claims. At the end of the

financial year, the remaining balance of the PMSA is retained in the liability for remaining coverage as it is utilised for future contracts. If interest is payable on the PMSA, the insurance finance income and expense is included in the liability for remaining coverage.

Level of aggregation

The scheme as a whole was identified as a portfolio. All contracts issued by a scheme are subject to similar risks and managed together. As the Act specifically constrains the entity's practical ability to set a different price or level of benefits for members with different characteristics, the scheme as a whole was also identified as the group. The scheme assesses if the group as a whole is onerous or profitable. If the group is onerous, no further liability is recognised as a liability to future members is already recognised (as the scheme is regarded as a mutual entity for accounting purposes).

Recognition and derecognition

Insurance contracts issued shall be recognised from the earliest of the following:

(a) The beginning of the coverage period;

(b) The date when the first payment from a policyholder becomes due; and

(c) For onerous contracts when the contracts become onerous.

An insurance contract is derecognised when it is extinguished (i.e., when the obligation specified in the insurance contract expires, or is discharged, or cancelled.

Premium allocation approach (PAA)

The contract boundary for contracts issued does not exceed 12 months and consequently the scheme elected to apply the PAA.

The classification of medical schemes as mutual entities does not impact the extent of insurance cover/ insurance contract services to be provided by the medical scheme in terms of the member contracts and, therefore, the PAA is still applicable.

In applying the PAA, the medical scheme chose to recognise any insurance acquisition cash flows as expenses when it incurs those costs.

The scheme measures the liability for incurred claims as the fulfilment cash flows relating to incurred claims. The future cash flows are not adjusted for the time value of money and the effect of financial risk, as these cash flows are expected to be paid in one year or less from the date the claims are incurred.

Liability for remaining coverage

The coverage period and the financial year for a medical scheme are the same. There would be no liability for remaining coverage at the year-end reporting date, if the actual cash collected for contributions equals the contributions recognised as revenue and there is no unused PMSA (if applicable). (If there are unused PMSA, refer to "Separating components from an insurance contract" for accounting policy elected).

Liability for incurred claims: Risk adjustment

The estimate of future cash flows in terms of the liability for incurred claims is adjusted to reflect the compensation that the medical scheme requires for bearing the uncertainty about the amount and timing of the cash flows arising from non-financial risk.

The medical scheme shall apply judgement when determining an appropriate estimation technique for the risk adjustment for non-financial risk and consider whether the technique provides concise and informative disclosure so that users of financial statements can benchmark the performance against the performance of other medical schemes.

Insurance revenue

Insurance revenue for the period is the amount of expected premium receipts (excluding the PMSA) allocated to the period. The scheme allocates the expected premium receipts to each period of insurance contract services on the basis of the passage of time.

Insurance service expenses

The scheme presents insurance service expenses in profit or loss, comprising incurred claims (excluding repayments of investment components) and other incurred insurance service expenses.

Road Accident Fund recoveries

Cash flows within the boundary of an insurance contract would include potential cash inflows from recoveries on future claims are covered by existing insurance contracts and, to the extent that they do not qualify for recognition as separate assets, potential cash inflows from recoveries on past claims.

NOTE DISCLOSURE

The RAF claim and related recovery have been included in the contract boundary on a probability weighted basis and therefore form part of the liability for incurred claims and the claims and estimates in profit or loss.

Reconciliation of the liability for remaining coverage (LFRC) and the liabilities for incurred claims (LIC)Reconciliation of the liability for remaining coverage (LFRC) and the liabilities for incurred claims (LIC)	**LFRC exclude loss component**	**LIC PV of future cashflows**	**LIC Risk adjustment**	**Total R'000 R20XX**
Opening asset/liability				
Net opening balance				
Changes in the statement of profit or loss and OCI				
Insurance revenue				
Insurance service expenses				
Incurred claims and other insurance service expenses				
Losses and reversals of losses on onerous				

contracts (if applicable)				
Adjustments to liabilities for incurred claims				
PMSA (investment component)				
Insurance service result				
Net finance income or expense from insurance contracts				
Total changes in the statement of profit or loss and OCI				
Cash flows				
Contributions received				
Claims paid				
Directly attributable administration expenditure paid				
Insurance acquisition cash flows: Broker fees paid				
Total cash flows				
Non-cash settlement of claims through risk transfer arrangements				
Transfer to other items in the statement of financial position (amounts payable to other suppliers than members or for example depreciation if directly attributable expense)				
Net closing balance				
Closing asset/ liability				
Net closing balance				

Suggested additional disclosures not required by IFRS Accounting Standards, but recommend by CMS:

Closing balance consists of:

	20XX R'000
Insurance contract receivables	
Contributions outstanding	
Amount due from members and suppliers	
Advances on PMSAs	
Insurance contract payables	
Credit balances in insurance contract receivables	
Amounts due to the administrator	
Amounts due to brokers	
Amounts due to members	
Amounts due to service providers	
Liability for incurred claims	
Risk adjustment	
PMSA liability (Note 3.1)	
Net closing balance	

	LFRC	LIC PV of cash flows	LIC Risk adjustment	Total R'000 R20YY
Opening asset/liability				
Net opening balance				
Changes in the statement of profit or loss and OCI				
Insurance revenue				
Insurance service expenses				
Incurred claims and other insurance service expenses				
Losses and reversals of losses on onerous contracts (if applicable)				
Adjustments to liabilities for incurred claims				
PMSA (investment component)				
Insurance service result				
Net finance income or expense from insurance contracts				
Total changes in the statement of profit or loss and OCI				
Cash flows				
Premiums received				
Claims paid				
Directly attributable administration expenditure paid				
Insurance acquisition cash flows: Broker fees paid				
Total cash flows				
Non-cash settlement of claims through risk transfer arrangements				
Transfer to other items in the statement of financial position				
Net closing balance				
Closing asset/liability				

Suggested additional disclosures not required by IFRS Accounting Standards, but recommend by CMS:

Closing balance consists of:

	20YY R'000
Insurance contract receivables	
Contributions outstanding	
Amount due from members and suppliers	
Advances on PMSAs	
Insurance contract payables	
Credit balances in insurance contract receivables	
Amounts due to the administrator	
Amounts due to brokers	
Amounts due to members	
Amounts due to service providers	
Liability for incurred claims	

Risk adjustment	
PMSA liability (Note 3.1)	
Net closing balance	

3.1 PERSONAL MEDICAL SAVINGS ACCOUNT LIABILITY

ACCOUNTING POLICY

The personal medical savings account, *which is managed by the scheme on behalf of its members,* represents savings contributions, and accrued interest thereon in terms of the rules of the scheme, net of any savings claims paid on behalf of members in terms of the scheme's registered rules.

Unspent savings at year end are carried forward to meet future expenses for which the members are responsible. In terms of the Medical Schemes Act 131 of 1998, as amended, balances standing to the credit of members are refundable only in terms of Regulation 10 of the Act.

The personal medical savings accounts are invested *(on behalf of members)* in fixed deposits and deposits held at call with banks in terms of the rules of the scheme. These monies are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method.

The scheme elected to account for unspent PMSA to be accounted for in the liability for remaining coverage:

NOTE DISCLOSURE

	20XX R'000	**20YY R'000**
Balance of savings account balances at the beginning of the year [credit balances]		
Add:		
Savings account contribution received		
Transfers from other schemes in terms of Regulation 10(4)		
Interest and other income earned on monies invested in terms of the rules of the scheme		
Less amount transferred to the liability for incurred claims:		
Claims paid out of savings		
Refunds on death or resignation in terms of regulation 10(5)		
Transfers to other schemes in terms of Regulation 10(4)		
Unclaimed personal medical savings accounts written off to scheme funds *OR where a trust relationship exists* Unclaimed personal medical savings accounts paid over to the Guardian's Fund		
Balances due to members on personal medical savings account balances held at the end of the year [Credit balances only]		

The personal medical savings account liability contains a demand feature in terms of Regulation 10 of the Act that any credit balance on a member's personal medical savings account must be taken as a cash benefit when the member terminates his or her membership of the scheme or benefit option and then enrols in another benefit option or medical scheme without a personal medical savings account or does not enrol in another medical scheme.

Interest is paid in terms of the rules of the scheme on the personal medical savings accounts monthly, calculated using the effective interest method.

Suggested additional disclosures:

It is estimated that claims to be paid out of members' personal medical savings accounts in respect of claims incurred in 20xx but not recorded amount to RXX (20yy: RXX).

4. RISK TRANSFER ARRANGEMENTS

Contracts entered into by the scheme with third-party service providers under which the scheme is compensated for losses/claims (through the provision of services to members) on one or more underlying insurance contracts issued by the scheme are classified as risk transfer arrangements (reinsurance contracts). Only contracts that give rise to a significant transfer of insurance risk are accounted for as risk transfer arrangements. Risk transfer premiums/fees paid are recognised as an expense over the indemnity period.

Risk transfer claims and benefits reimbursed are presented in the statement of profit or loss and other comprehensive income and statement of financial position on a gross basis. Similar to insurance contracts, risk transfer arrangements are also measured using the premium allocation approach as these contracts have a boundary of one year or less.

Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the insurance contracts.

Amounts recoverable under risk transfer arrangements are assessed for non-performance at each reporting date. However, this is normally not significant.

Schemes should refer to commercial reinsurance agreements and should evaluate whether risk transfer arrangements and commercial reinsurance agreements will be combined for disclosure purposes. The disclosure below only deals with risk transfer arrangements.

NOTE DISCLOSURE

	Asset for remaining coverage (ARC)	Asset for incurred claims (AIC) PV of cashflows	AIC Risk adjustment	Total R'00 20XX
Opening assets				
Changes in the statement of profit or loss and OCI				
Allocation of RTA premiums paid				
Amounts recoverable from reinsurers				
Recoveries for incurred claims and other insurance service expenses				
Adjustments to assets for incurred claims				
Effect of changes in non-performance risk of reinsurers				
Net expense from RTA				
Net finance expenses from reinsurance contracts				
Total changes in the statement of profit or loss and OCI				

Cash flows				
Premiums paid				
Total cash flows				
Non-cash claims recovered through risk transfer arrangements				
Closing assets				

	Asset for remaining coverage (ARC)	**Asset for incurred claims (AIC) PV of cashflows**	**AIC Risk adjustment**	**Total R'00 20YY**
Opening assets				
Changes in the statement of profit or loss and OCI				
Allocation of RTA premiums paid				
Amounts recoverable from reinsurers				
Recoveries for incurred claims and other insurance service expenses				
Adjustments to assets for incurred claims				
Effect of changes in non-performance risk of reinsurers				
Net expense from RTA				
Net finance expenses from reinsurance contracts				
Total changes in the statement of profit or loss and OCI				
Cash flows				
Premiums paid				
Total cash flows				
Non-cash claims recovered through risk transfer arrangements				
Closing assets				

Suggested additional disclosures not required by IFRS Accounting Standards, but recommend by CMS

Reinsurance result

	20XX R'000	**20YY R'000**
Contract A		
Reinsurance expenses/ Premiums paid		
Reinsurance income/ Estimated recoveries		
Net expense/ (income)		
Contract B		
Reinsurance expenses/ Premiums paid		
Reinsurance income/ Estimated recoveries		
Net expense/ (income)		
Total reinsurance result		

[*Disclosure is required for all risk transfer arrangements and commercial reinsurance arrangements entered by the scheme with the total reconciling to the statement of comprehensive income.*]

5. TRADE AND OTHER PAYABLEE

ACCOUNTING POLICY

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Trade payables are classified as current liabilities if payment is due within one year or less (or in the normal operating cycle of the business if longer). If not, they are presented as non-current liabilities. Trade payables are recognised initially at fair value and subsequently measured at amortised cost using the effective interest method.

	20XX R'000	20YY R'000
Trade and other payables		
Financial liabilities		
Trade payables		
Current portion of non-current borrowings		
Other payables		
Total arising from trade payables		
Balance at end of year		

Suggested additional disclosures not required by IFRS Accounting Standards, but recommend by CMS:

6. INSURANCE REVENUE AND SERVICE EXPENSES

	20XX R'000	20YY R'000
Insurance revenue		
Gross contributions		
Less: Personal Medical Savings Accounts contributions		
Changes in the expected recoverability of contributions		
Total insurance revenue		
Insurance service expenses		
Claims incurred		
Net claims incurred		
Changes that relate to past service - adjustments to the LIC		
Changes in expected recoverability of member and service provider claims receivables		
Accredited managed healthcare services (no transfer of risk)		
Other directly attributable insurance service expenses		
Fees paid in respect of accredited administration services		
Other directly attributable administration expenditure		
Broker service fees		
Total insurance service expenses		
Accredited managed healthcare services (no transfer of risk)		
Active risk management services		
Disease risk management support services		
Dental benefit management services		

Hospital benefit management services		
Managed care network management services and risk management		
Pharmacy benefit management services		
Total accredited managed healthcare		
Accredited administration services (disclosure per accredited entity)		
Member record management		
Contribution management		
Claims management		
Financial management		
Information management and data control		
Broker remuneration management		
Customer services		
Total accredited administration services		
Other administration services provided by accredited administrators (disclosure per accredited entity)		
Actuarial services		
Benefit management services		
Internal audit services		
Distribution service		
Broker service (accredited brokers and in-house sales and marketing services)		
Marketing services		
Third party claim recovery services		
Forensic investigations and recoveries		
Governance and compliance services rendered		
Total other administration services provided by accredited administrators		

Other administration expenditure	**20xx**		**20yy**	
	Directly attributable	**Not directly attributable**	**Directly attributable**	**Not directly attributable**
Actuarial fees				
Administration expenditure: benefit management services (not accredited managed care)				
Annual general meeting costs				
Audit expense				
Board: sub-committees				
Consultancy fees				
Council for Medical Schemes expenses				
Debt collection fees				
Depreciation				
Fidelity guarantee insurance premiums				
IT infrastructure				
Legal fees				
Marketing expenditure				
Principal Officer / curator expenditure				
Professional fees				
Staff remuneration and employment costs				

Trustees' remuneration and considerations				

[*The above table is not a comprehensive list of all other administration expenditure.*]

7. INVESTMENT INCOME

Interest and dividend income	**20XX R'000**	**20YY R'000**
Financial assets at fair value through profit or loss:		
-Dividend income		
-Interest income		
Financial instruments at amortised cost		
-Interest income		
Financial assets at fair value through OCI		
-Interest income		
-Dividend income		
Cash and cash equivalents		
-Interest income		
Net gains or losses		
Members' personal savings account investments		
Cash and cash equivalents: interest income		
Net fair value gains on financial assets at fair value through profit or loss, including derivatives:		
-Equity securities		
-Money market (not meeting definition of cash and cash equivalents)		
Net fair value gains on financial assets at fair value through other comprehensive income		
-Equity Securities		
-Money Market		
Other Income		
Interest on balances due by administrator		
Unallocated amounts written back as prescribed		
Outdated cheques written back		

(i) Insurance finance income and expense

Recognised as part of the liability for remaining coverage/LIC*
-PMSA

*Depends on accounting policy choice elected for PMSA

(ii) INCOME/ (EXPENSE) ON OWN FACILITY

ACCOUNTING POLICY

Own facility

The revenue generated on own facilities is measured in terms of IFRS 15. The profit on own facilities represents this income less the cost incurred in operating these facilities for third parties. Benefits relating to services rendered by the own facility for the scheme's members are reflected as part of claims incurred.

ACCOUNTING POLICY

	20XX R'000	20YY R'000
Income/(Expense) from operations		
Income from services rendered to third parties		
Less:		
Total costs incurred in operating own facility		
Total healthcare provider costs		
Change in inventories		
Administration expenses (including salaries)		
Other costs incurred in operating own facility		
Add:		

The scheme provides healthcare services to third parties in its own facilities, which generates its own revenue for the services rendered.

(iii) INCOME/ (EXPENSE) FROM OPERATIONS PER BENEFIT OPTION

ACCOUNTING POLICY

Allocation of income and expenditure to benefit options.

The following items are directly allocated to benefit options:

- Insurance Revenue;
- Net claims incurred;
- Accredited managed healthcare services (no transfer of risk);
- Directly attributable expenditure
- Reinsurance result
- Interest paid in terms of the rules of the scheme on personal medical savings account monies.

The remaining items are apportioned based on the number of members on each option *(or other suitable*

basis):

- Other administration expenditure;
- Investment income;
- Other income; and
- Other expenditure.

NOTE DISCLOSURE

INCOME/ (EXPENSE) FROM OPERATIONS PER BENEFIT OPTION

For management purposes the scheme is organised into three benefits options – ACB Comprehensive Option, ACB 70/100 Option and ACB Major Events Option. Principal features of the benefit options are as follows:

- ACB Comprehensive Option [*insert detail*]
- ACB 70/100 Option [insert detail]
- ACB Major Events Option [insert detail]

	ACB Comprehensive Option R'000	ACB 70/100 Option R'000	ACB Major Events Option R'000	Total Scheme R'000
20XX				
Insurance revenue				
Insurance service expenses				
Claims incurred				
Accredited managed healthcare services (no transfer of risk)				
Other directly attributable insurance service expenses				
Reinsurance result				
Insurance Service result				
Other income				
Other expenditure				
Income/(Expense) attributable to current members				
Amounts attributable to members				
Number of members				
Number of beneficiaries				
Average age				
Pensioner ratio				
20YY				
Insurance revenue				

Insurance service expenses				
Claims incurred				
Accredited managed healthcare services (no transfer of risk)				
Other directly attributable insurance service expenses				
Reinsurance result				
Insurance Service result				
Other income				
Other expenditure				
Income/(Expense) attributable to current members				
Amounts attributable to members				
Number of members				
Number of beneficiaries				
Average age				
Pensioner Ratio				

(iv) CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

This illustrative note only addresses areas of critical accounting judgment and key sources of estimation uncertainty to the extent that these relate to insurance contracts. As an alternative to describing the uncertainty surrounding calculation of the outstanding risk claims liability, schemes can include a cross-reference to the note in which the detail is already described.

In the process of applying the scheme's accounting policies, management has made the following judgments that have the most significant effect on the amounts recognised in the financial statements.

Certain critical accounting judgments were made in applying the scheme's accounting policies: [*provide details*]

Key assumptions concerning the future and other key sources of estimation uncertainty at the reporting date, which have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities in the next financial year, are discussed below.

Significant judgements and estimates for insurance liabilities (IFRS 17.117)

Disclosures include the following:

- Methods used to measure insurance contracts and the process for estimating the inputs.
- Quantitative information about the inputs used, unless impracticable.
- The approach used to determine the risk adjustment for non-financial risk.
- Approach used to determine investment components (PMSA)
- The confidence level used to determine the risk adjustment for non-financial risk.

(v) INSURANCE RISK MANAGEMENT (IFRS 17.124 – 125)

Disclose objectives, policies and processes for managing the risk and the methods used to measure the risk.

NOTE DISCLOSURE

Risk-management objectives, policies, processes and methods for mitigating insurance risk.

The scheme's primary insurance activity assumes the risk of loss from members and their dependants who are directly subject to the risk. This risk relates 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 insurance and investment activities.

The Board of Trustees has appointed an insurance risk-management committee. The insurance risk-management committee has developed and documented a policy for the acceptance and management of insurance risks to which the scheme is exposed. This policy has been approved by the Board of Trustees. Reference has also been made to the requirements of the Act in compiling the insurance risk-management policy. The insurance risk-management committee provides quarterly reports to the Board of Trustees regarding changes in the level of the scheme's exposure to insurance risk. The insurance risk-management committee is also responsible for recommending any changes to the benefit options in consultation with the scheme's actuary (where applicable) to ensure that the scheme's exposure to insurance risk remains within the specified levels. The insurance risk- management policy is incorporated in the annual business plan.

The health risk-management policy is reviewed annually and amended for changes in the Act (if any) and/or changes in the scheme's ability to accept insurance risk.

The insurance risk-management committee is also responsible for recommending whether or not the scheme should enter into any risk transfer arrangements or commercial reinsurance contracts. Similarly, the insurance risk-management committee reports to the Board of Trustees on the effectiveness and efficiency of risk transfer arrangements and commercial reinsurance contracts entered into by the scheme. The Board of Trustees ultimately decides on whether or not to enter into risk transfer arrangements or commercial reinsurance contracts.

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. Certain risks are mitigated by entering into risk transfer arrangements. In this regard the scheme has specifically decided to transfer all risks relating to general practitioner benefits to an external service provider.

The scheme uses several methods to assess and monitor insurance risk exposures both for individual types of risks insured and overall risks. The scheme analyses the distribution of claims per category of claim, average age of members per member group, average age per benefit option, actual number of members per benefit option and the geographic distribution of members.

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 are greater than expected. Insurance events are, by their nature, random, and the actual number and size of events during any one year may vary from those estimated with established statistical techniques.

Experience shows that the larger the portfolio of similar insurance contracts, the smaller the relative variability in the expected outcome will be. 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 of risk to achieve a sufficiently large population of risks to reduce the variability of the expected outcome.

Factors that aggravate insurance risk include a lack of risk diversification in terms of type and amount of risk, geographical location and demographics of members covered.

The scheme's strategy seeks diversity to ensure a balanced portfolio. It is based on a large portfolio of similar risks over a number of years and, as such, it is believed that the variability of the outcome is reduced.

The strategy is set out in the annual business plan, which specifies the benefits to be provided by each option, the preferred target market and demographic split of this market.

All the contracts are annual in nature and the scheme has the right to change the terms and conditions of the contract at renewal. Management information, which includes insurance revenue and relevant healthcare expenditure ratios by option, target market and demographic split, is reviewed monthly. An underwriting review programme reviews a sample of contracts on a quarterly basis to ensure adherence to the scheme's objectives.

Concentration of risk (IFRS 17.127)

Provide a description of the shared characteristics that identifies each concentration, for example insured event, geographical area.

Alternative 1

The following table summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (before and after risk transfer arrangements) by age group and in relation to the type of risk covered/benefits provided.

20XX

		General Practitioners R'000	Specialists R'000	Dentistry R'000	Optometry R'000	Medicines R'000	Hospital R'000	Total R'000
Age grouping (in years)								
< 26	Gross							
	Net							
26-35	Gross							
	Net							
36-50	Gross							
	Net							
51-65	Gross							
	Net							
> 65	Gross							
	Net							
Total	**Gross**							
	Net							

20YY

		General Practitioners R'000	Specialists R'000	Dentistry R'000	Optometry R'000	Medicines R'000	Hospital R'000	Total R'000
Age grouping (in years)								
< 26	Gross							
	Net							
26-35	Gross							
	Net							
36-50	Gross							
	Net							
51-65	Gross							
	Net							
> 65	Gross							
	Net							
Total	**Gross**							
	Net							

[*Schemes should note that this disclosure is illustrative only and will not be appropriate for all schemes.*

Sensitivities specific to the scheme should be determined in consultation with the scheme's actuary and disclosed accordingly.]

General practitioner benefits cover the cost of all visits by members to general practitioners and of the procedures performed by them.

Specialist benefits cover the cost of all visits by members to specialists and of the out-of-hospital procedures performed by specialists. Specialist benefits also include radiology and pathology benefits provided to members.

Dentistry benefits cover the cost of all visits by members to dental practitioners and the procedures performed by them, up to a prescribed annual limit per member.

Optometry benefits cover the cost of all visits by members to optometrists, the cost of prescribed glasses and contact lenses and the cost of procedures performed by optometrists, up to a prescribed annual limit per member.

Medicine benefits cover the cost of all medicines prescribed to members.

Hospital benefits cover all costs incurred by members while they are in hospital to receive pre- authorised treatment for certain medical conditions.

Alternative 2

The following table summarises the concentration of insurance risk, with reference to the carrying amount of the insurance claims incurred (before and after risk transfer arrangements) by age group and in relation to the type of risk covered/benefits provided. Where appropriate, prescribed minimum benefits (PMB) and non-PMB claims have been split.

Please note that the information provided below can also be presented in graphs.

20XX

		In- Hospital		**Chronic**		**Day-to- day**	**Total**
Age Grouping in years		**PMB R'000**	**Non- PMB R'000**	**PMB R'000**	**Non- PMB R'000**	**R'000**	**R'000**
< 26	Gross						
	Net						
26-35	Gross						
	Net						
36-50	Gross						
	Net						
51-65	Gross						
	Net						
>65	Gross						
	Net						

Total	**Gross**						
	Net						

20YY

		In- Hospital		**Chronic**		**Day-to- day**	**Total**
Age Grouping in years		**PMB R'000**	**Non-PMB R'000**	**PMB R'000**	**Non-PMB R'000**	**R'000**	**R'000**
< 26	Gross						
	Net						
26-35	Gross						
	Net						
36-50	Gross						
	Net						
51-65	Gross						
	Net						
>65	Gross						
	Net						
Total	**Gross**						
	Net						

[*Schemes should note that this disclosure is illustrative only and will not be appropriate for all schemes. Sensitivities specific to the scheme should be determined in consultation with the scheme's actuary and disclosed accordingly.*]

In-hospital benefits cover all costs incurred by members while they are in hospital to receive pre-authorised treatment for certain medical conditions.

Chronic benefits cover the cost of certain prescribed medicines for chronic conditions/diseases, such as high blood pressure, cholesterol and asthma.

Day-to-day benefits cover the cost (up to 100% of the National Health Reference Price List tariff) of all out-of-hospital medical attention, such as visits to general practitioners and dentists and prescribed non-chronic medicines.

Sensitivity analysis (IFRS 17.128)

Impact on profit or loss and equity reported caused by reasonable possible changes in key variables by the end of the reporting period:

	Change in variable	**Change in LIC**	**Change in LIC**
	%	**20xx R'000**	**20yy R'000**
Base Scenario			

Hospital admission rate			

This analysis is prepared for a change in a specified variable with other assumptions remaining constant. The change in liability also represents the absolute change in income / (expense) for the period. It should be noted that increases in the liability for incurred claims will result in decreases in members' funds and ultimately to the liability to future members and vice versa. These reasonable possible changes in key variables do not result in any changes directly in equity or reserves and ultimately in amounts attributable to future members.

Below is a summary of the impact on the risk adjustment on the liability for incurred claims (LIC) if higher confidence levels were used. Any change in the risk adjustment will impact the incurred claims in insurance service expenses with an equal and opposite impact on profit or loss and ultimately the amounts attributable to future members.
20xx

Risk adjustment on the LIC	75%*%*	80%	85%	90%	95%
% adjustment					
	R'000	R'000	R'000	R'000	R'000
Liability for incurred claims (LIC)					
Change in LIC					

20yy

Risk adjustment on the LIC	75%%	80%	85%	90%	95%
% adjustment					
	R'000	R'000	R'000	R'000	R'000
Liability for incurred claims (LIC)					
Change in LIC					

**in this example the base is 75%*

Claims development

[This disclosure is only required to the extent that the uncertainty regarding the amount and timing of claim payments is not typically resolved within one year. If this disclosure is not appropriate, a note should be included stating that claims development tables are not presented since the uncertainty regarding the amount and timing of claim payments is typically resolved within one year. Where disclosure is appropriate a claims development table should be presented.]

Risk transfer arrangements

The scheme reinsures a portion of the risks it underwrites so that it can control its exposures to losses and protect capital resources. The scheme has also entered into capitation agreements with two major hospital groups. The capitation agreements are, in substance, the same as a non-proportional commercial reinsurance contract.

The scheme cedes insurance risk to limit exposure to underwriting losses in terms of risk transfer arrangements where the third party agrees to reimburse the ceded amount in the event the claim is paid. According to the terms of the capitation agreements, 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 any reinsurer (or supplier) fails to meet the obligations it assumes.

When selecting a reinsurer (or supplier), the scheme considers its relative security. The security of the reinsurer (or supplier) is assessed from public rating information and from internal investigations [*such as considering capital adequacy, solvency, capacity and appropriate resources*].

[The above description should be tailored for the specific terms of the contracts entered into by the scheme.]

The following table summarises the concentration of insurance risk reinsured, with reference to the amount of the insurance claims incurred by option and in relation to the type of risk covered/benefits provided:

	General practitioners	**Specialists**	**Dentistry**	**Optometry**	**Medicines**	**Hospital**
Option 1	20%	2%	1%	20%	-	15%
Option 2	5%	20%	2%	-	-	-

(vi) FAIR VALUES AND FINANCIAL RISK MANAGEMENT

	Financial assets at fair value through profit or loss		Financial instruments at amortised cost (IFRS 9)	Financial assets at fair value through Other Comprehensive Income (IFRS 9)		Financial liabilities at fair value through profit or loss		Financial liabilities measured at amortised cost	Total carrying amount	Fair value hierarchy of financial instruments measured at fair value		
	Designated upon initial recognition	Mandatorily classified		Debt instruments	Equity instruments	Designated upon initial recognition	Mandatorily classified			Level 1	Level 2	Level 3
20xx	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**	**R'000**
Investments												
- Bonds and debentures												
- Equity investments												
- Unlisted investments												
Cash and cash equivalents												
Trade and other receivables*												
Trade and other payables*												

**Disclosure of fair values is not required when the carrying amount is a reasonable approximation of fair value; for example, short- term trade receivables and payables. Delete from the table if that is the case. We would recommend that schemes indicate the reasons for the approximation to fair value.*

Comparatives must also be disclosed.

[These are examples. The scheme should consider its specific instruments and evaluate and disclose the risks accordingly.]

13.1. Measurement of fair values

13.1.1. Valuation techniques and significant unobservable inputs

The following tables show the valuation techniques used in measuring Level 2 and Level 3 fair values, as well as the significant unobservable inputs used.

Financial instruments measured at fair value

Type	Valuation technique	Significant unobservable inputs	Inter-relationship between significant unobservable inputs and fair value measurement
Investments:			
-Bonds and Debentures*	Describe the valuation technique used by the scheme to determine the fair value (e.g. discounted cash flows, Market comparison, etc.)	Disclose the significant unobservable inputs used in determining the fair value (level 3 only)	Disclose how the fair value would change (e.g. increase or decrease) if one or more of the significant unobservable inputs used changes.
-Equity investments			
Unlisted Investments			

* We have assumed that the bonds were measured using a level 3 valuation technique. However, each scheme should assess the fair value hierarchy for the bonds and debentures that it holds.

Further, for fair value measurements categorised within Level 3 of the fair value hierarchy, the scheme must provide quantitative information about the significant unobservable inputs used in the fair value measurement

13.1.2. Transfers between Levels 1 and 2

For assets and liabilities held at the end of the reporting period that are measured at fair value on a recurring basis, disclose:

- The amounts of any transfers between level 1 and level 2
- The reasons for those transfers
- The scheme's policy for determining when transfers between levels are deemed to have occurred.

[Disclose transfers into each level separately from transfers out]

13.1.3. Level 3 fair values

Disclosure example of reconciliation of Level 3 fair values

	Financial assets at fair value through profit or loss		Total R'000
	Bonds **R'000**	**Equity investments** **R'000**	
Opening Balance			
Gains and losses for the period			
Gain or loss included in [insert name of line in statement of profit or loss and OCI]			
-Change in fair value (unrealised/realised)			
-Gain included in OCI			
Change in fair value (unrealised/realised)			
Purchases			
Issues			
Transfers out Level 3*			
Closing Balance			
Total Gains / (losses) for the period for assets held 31 December 20XX			

Note: comparative information also has to be presented, and a similar table might be presented for financial liabilities.

*Transfer out of Level 3

Disclose:

- the reasons for the transfers into or out of level 3
- the entity's policy for determining when transfers between levels are deemed to have occurred.

Sensitivity analysis

For the fair values of *[insert name of instrument here, e.g. equity securities]*, reasonably possible changes at the reporting date to one of the significant unobservable inputs, holding other inputs constant, would have the following effects:

OCI, net of tax

20xx

	Increase R'000	Decrease R'000
[insert significant observable input here] (xx% movement)		
[insert significant observable input here] (xx% movement)		

Equity securities – Designated as at fair value through profit or loss

Profit or loss

20xx

	Increase R'000	Decrease R'000
[insert significant observable input here] (xx% movement)		
[insert significant observable input here] (xx% movement)		

13.2. Financial risk management

The scheme has exposure to the following risks from financial instruments:

- Credit risk;
- Liquidity risk; and
- Market risk.

20xx	Credit Risk	Liquidity Risk	Equity Price	Market risk Interest rate	Currency
Investments					
- Bonds and debentures (listed)	x			x	
- Equity investments			x		
- Unlisted investment					
Reinsurance contracts held	x				
Cash and cash equivalents	x			x	x*
Personal medical savings account trust investment *	*x*				*x*
Trade and other receivables*	x				
Trade and other payables*		x			
Liability for incurred claims		x			
Borrowings		x		x	

*If foreign cash

[Include only the relevant risks applicable to the scheme]
[NOTE: The scheme should explain how the risks arise for each type of risk to which the scheme is exposed. This may include, for example, the specific financial instruments or insurance contract balances that give rise to each type of risk. These may be described under each heading, for example, trade receivables give rise to credit risk.]

13.2.1. Risk management framework

The scheme's *board of trustees [update as relevant to the scheme]* has overall responsibility for the establishment and oversight of the Scheme's risk management framework. *[Insert any other relevant information on how the Scheme monitors and sets the risk management framework.]*

The Scheme's risk management policies are established to identify and analyse the risks faced by the scheme, to set appropriate risk limits and controls and to monitor risks and adherence to limits. Risk management policies and systems are reviewed regularly to reflect changes in market conditions and the scheme's activities. *[Update as appropriate to the scheme] [Insert any other relevant information on how the scheme establishes a risk management framework within which it operates and how it maintains and monitors compliance with the risk management framework.]*

13.2.2. Credit risk

Credit risk is the risk of financial loss to the scheme if a member or counterparty to a financial instrument fails to meet its contractual obligations and arises principally from the scheme's receivables and investments in debt securities as well as reinsurance contracts held. *[Update as appropriate to explain how credit risk arises for the scheme.]*

The scheme manages credit risk by:

- Actively pursuing all contributions not received after 3 days of becoming due, as required by Section 26(7) of the Act;
- Monthly reconciliations between the Administrator and the Employer are discussed for possible suspensions of memberships; [update as appropriate for the scheme].

[*Provide details regarding the credit risk management, including identification, measuring and management. Include:*

- Summary quantitative data about the scheme's exposure to credit risk at the end of the reporting period. This disclosure is based on the information provided internally to key decision makers.
- The amount that best represents the scheme's maximum exposure to credit risk at the end of the reporting period (IFRS 17.131(a)).
- Information about the credit quality of RTA held as assets (IFRS 17.131(b)).

Example:

Financial instruments at amortised cost disclosed by class, including the quantitative analysis and maximum credit exposure at the end of year.

Trade receivables for which the provision matrix is used (IFRS 7 par 7.35N & IG 20D):

	Trade receivable days past due				
20XX	**Current**	**More than 30 days**	**More than 60 days**	**More than 90 days**	**Total**
Expected credit loss rate					

Estimated total gross carrying amount at default	x	x	x	x	x
Lifetime expected credit losses	x	x	x	x	x

Movements in the allowance for impairment in respect of trade receivables (IFRS 7 par 35H):

	20XX	**20YY**
Balance at the beginning of the year		
Amounts written off		
Amounts derecognised		
Net re-measurement of the loss allowance		
Balance at the end of year		

Other financial instruments for which the general approach is used (IFRS 7.35M)

20XX	**12-month ECL**	**Lifetime ECL – not credit impaired**	**Lifetime ECL- credit impaired**	**Total**
Per IFRS 9 category of financial instrument*				
> AAA-AA				
> A				
> BBB-BB days				
> B				
> CCC-CC				
> C				
> D				
Gross carrying amount before impairment				
Financial assets that are impaired				
Carrying amount of provision for impairment				

*The IFRS 9 categories to be included here are financial assets held at amortised cost and fair value through other comprehensive income in terms of IFRS 9.4.1.2A.

Suggested additional disclosures not required by IFRS Accounting Standards, but recommend by CMS:

Insurance contract receivables disclosed by quantitative analysis and maximum credit exposure at the end of the year:

	20XX	**20YY**
Insurance contracts assets that are neither past due		
Insurance contracts assets that are past due:		
Past due 30 days		
Past due 60 days		
Past due 90 days		
Insurance contracts assets that are not expected to be recovered:		
Past due 120 days and more		
Total insurance contract receivables		

Movement in the allowance for impairment for other financial instruments (IFRS 7.35H):

	12 month ECL	Lifetime ECL (collectively assessed)	Lifetime ECL (individually assessed)	Credit impaired financial assets (lifetime ECL)
Loss allowance at the beginning of the year	**x**	**x**	**x**	**X**
Changes due to financial instruments as at beginning of the year				
– Transfer to lifetime ECL	(x)	x	x	-
– Transfer to credit-impaired financial assets	(x)	-	(x)	X
– Transfer to 12-month expected credit losses	x	(x)	(x)	-
– Financial assets that have been derecognised during the period	(x)	(x)	(x)	(x)
New financial assets originated or purchased	X			
Write-offs	-	-	(x)	(x)
Changes in models/risk parameters	x	x	x	X
Foreign exchange and other movements	x	x	x	X
Loss allowance closing balance	**x**	**x**	**x**	**x**

These examples have been based on the illustrative examples in IFRS 7 par IG20B to IG20D and are specific to financial instruments.

IFRS 17.131 requires schemes to disclose:

(a) the amount that best represents its maximum exposure to credit risk at the end of the reporting period, separately for insurance contracts issued and reinsurance contracts held; and

(b) information about the credit quality of reinsurance contracts held that are assets.

Collateral held:
(Provide details)

13.2.3. Liquidity risk

Liquidity risk is the risk that the scheme will encounter difficulty in meeting the obligations associated with its financial liabilities that are settled by delivering cash or another financial asset. Ultimate responsibility for liquidity risk management rests with the Board of Trustees, which has built an appropriate liquidity risk management framework to manage the scheme's short-, medium- and long-term funding and liquidity management requirements.

[Provide details regarding systems in place to quantify, measure, and manage liquidity risks.]

Exposure to liquidity risk

The following are the remaining contractual maturities[6] of financial liabilities at the reporting date. The amounts are gross and undiscounted, and include estimated interest payments and exclude the impact of netting agreements:

[6] IFRS 7 does not mandate the number of time bands to be used in the contractual maturity analysis. The scheme should apply judgment to determine the appropriate number of time bands.

	Months R'000	Months R'000	Months R'000	Years R'000	Years R'000	Years R'000		Total R'000
Non-current assets (recommend that schemes include the financial assets as well)								
Financial assets at fair value through profit or loss								
Current assets (recommend that schemes include the financial assets as well)								
Financial assets at fair value through profit or loss								
Financial assets at amortised cost								
Cash and cash equivalents								
Current liabilities								
Insurance contract liability								
Trade and other payables								
Net positive liquidity (recommend disclosing this amount)								
Non-current liabilities								
Liability to future members (each scheme to review classification as current/non-current based on the requirements of IAS 1.69 and the scheme's facts and circumstances)								

A maturity analysis is required for insurance contracts issued and reinsurance contracts held that are liabilities in terms of IFRS 17.132. As a minimum, disclosure of the net cash flows of the portfolios for each of the first five years after the reporting date and in aggregate beyond the first five years, is required. In a medical scheme where claims are settled within one year, and there are no estimated cash flows beyond one year, this fact could be stated instead.

13.2.4. Market risk

Market risk is the risk that changes in market prices – such as foreign exchange rates, interest rates and equity prices – will affect the scheme's income or the value of its holdings of financial instruments.
[Provide details regarding systems in place to quantify, measure, and manage liquidity risks.]

Interest rate risk

[explain how the scheme manages its risk]

Sensitivity analyses variable-rate instruments

The sensitivity analyses below have been determined based on the exposure to interest rates for both derivatives and non-derivative instruments at the reporting date. For floating rate liabilities, the analysis is prepared assuming the amount of liability outstanding at the reporting date was outstanding for the whole year. A xx basis point increase or decrease is used when reporting interest rate risk internally to key management personnel and represents management's assessment of the reasonably possible change in interest rates.

If interest rates had been xx basis points higher/lower and all other variables were held constant, the scheme's profit or loss and ultimately the liability to future members for the year ended 31 December 20xx would decrease/increase by RXXX (20yy: decrease/increase by RXXX). This is mainly attributable to the scheme's exposure to interest rates on its variable rate borrowings and investments.

Fixed rate instruments

The scheme does not account for any fixed-rate financial assets or financial liabilities as at fair value through profit or loss. Therefore, a change in interest rates at the reporting date would not affect profit or loss.

A change of xx basis points in interest rates would have increased or decreased profit or loss & equity by Rxx (20yy: Rxx).

Equity price sensitivity analysis

[explain how the scheme manages its risk]

Sensitivity analyses

The sensitivity analyses below have been determined based on the exposure to equity price risks at the reporting date.

Disclose exposure and sensitivity analysis

The scheme used in the examples was only exposed to interest rate and equity price sensitivities. Additional market risks should be considered when compiling the financial statements.

IFRS 17 also requires a sensitivity analysis for each type of market risk – schemes should review if they are exposed to any market risks for insurance liabilities in the scope of IFRS 17.

Capital management

[explain how the scheme manages its risk (*IAS 1.134-136)]*

The scheme's objectives when managing capital are to maintain the capital requirements of the Medical Schemes Act 131 of 1998, as amended, and to safeguard the scheme's ability to continue as a going concern in order to provide benefits for its stakeholders.

The Medical Schemes Act 131 of 1998, as amended, requires a minimum ratio of accumulated funds expressed as a percentage of gross annual contribution income to be 25%. The scheme's accumulated funds ratio was XX% as at 31 December 20XX and YY% at 31 December 20YY.

Disclose information about the regulatory frameworks in which the schemes operate (IFRS 17.126).

The accumulated funds ratio is calculated as follows

	20XX	20YY
Total members' funds per Statement of Financial Position		
Less: Unrealised investment gains		
Accumulated funds per Regulation 29 of the Act		
Gross annual contribution income		
Accumulated funds ratio calculated as the ratio of accumulated funds/gross annual contributions x 100	**XX%**	**YY%**

8. IFRS 12: STRUCTURED ENTITIES

ACCOUNTING POLICY:

A structured entity is an entity that has been designed so that voting or similar rights are not the dominant factor in deciding who controls the entity, such as when any voting rights relate to administrative tasks only, and the relevant activities are directed by means of contractual arrangements. A structured entity often has some or all of the following features or attributes:

(a) restricted activities; (b) a narrow and well-defined objective, such as to provide investment opportunities for investors by passing on risks and rewards associated with the assets of the structured entity to investors; (c) insufficient equity to permit the structured entity to finance its activities without subordinated financial support; and (d) financing in the form of multiple contractually linked instruments to investors that create concentrations of credit or other risks (tranches).

The scheme has determined that some of its investments in pooled funds and collective investment schemes ("funds") are investments in unconsolidated structured entities. The scheme invests in these funds, whose objectives range from achieving medium- to long-term capital growth and whose investment strategy do not include the use of leverage. The funds are managed by unrelated asset managers and apply various investment strategies to accomplish their respective investment objectives.

The change in fair value of each fund is included in the statement of profit or loss and other comprehensive income in 'Net gains/ (losses) on financial instruments held at fair value through profit or loss'.

NOTE DISCLOSURE:

The scheme's investments in segregated portfolios and collective investment schemes are subject to the terms and conditions of the respective fund's offering documentation and are susceptible to market price risk arising from uncertainties about future values of those funds. The investment manager makes investment decisions after extensive due diligence of the underlying fund, its strategy and the overall quality of the underlying fund's manager. All of the funds in the investment portfolio are managed by portfolio managers who are compensated by the respective fund for their services. Such compensation generally consists of an asset- based fee and a performance-based incentive fee and is reflected in the valuation of the scheme's investment in each of the funds.

The right of the scheme to request redemption of its investments in the fund's ranges in frequency from weekly to semi-annually.

The exposure to investments in the funds at fair value, by strategy employed, is disclosed in the following

table.

These investments are included in financial assets at fair value through profit or loss in the statement of financial position.

Strategy	Number of investee funds	Net asset value of investee fund (range and weighted average)	Fair value of fund's assets of investment Rxxx*	%of net assets attributable to scheme**
Equity				
Fund of Funds				

**The fair value of financial assets (Rxxx) is included in financial assets at fair value through profit or loss in the statement of financial position*
***This represents the scheme's percentage interest in the total net assets of the funds*

The scheme's maximum exposure to loss from its interests in the funds is equal to the total fair value of its investments in the funds.

Once the scheme has disposed of its shares in a fund, it ceases to be exposed to any risk from that fund.

During the year ended 31 December 20XX, total net losses incurred on investments in the funds were Rxxx.

Disclosure for subsidiaries

Accounting policy note reflecting the definition of control

Subsidiaries are all entities (including structured entities) over which the scheme has control. The scheme controls an entity where the scheme is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power to direct the activities of the entity. Subsidiaries are fully consolidated from the date on which control is transferred to the scheme. They are deconsolidated from the date that control ceases.

Note disclosure for interest in subsidiaries

Set out below are the scheme's principal subsidiaries at 31 December 20xx. Unless otherwise stated, the proportion of ownership interests held equals the voting rights held by the scheme. The country of incorporation or registration is also their principal place of business.

Disclosure of investments in subsidiaries

Name of entity	Place of business/Country of incorporation	% of ownership interest held by the scheme		% of ownership interest held by the non- controlling interests (NCI)		Principal activities
		20XX	20YY	20XX	20YY	
Hospital	South Africa	100	100	0	0	Investments of funds for returns and capital growth
Accredited Managed Healthcare Organisations	South Africa	85	85	15	15	Accredited managed healthcare service provider

Significant restrictions

Assets of Rxxx held within subsidiary, accredited managed healthcare service organisation, cannot be transferred to any other company within the group.

The carrying amount of the assets included within the consolidated financial statements to which these restrictions apply is Rxxx (20yy – Rxxx).

Non-controlling interest

Set out below is summarised financial information for each subsidiary with non-controlling interests (NCI) that are material to the scheme. The amounts disclosed for each subsidiary are before inter-company eliminations.

Summarised Statement of Financial Position	Hospital		Accredited Managed Healthcare Organisations	
	31 December 20XX	31 December 20YY	31 December 20XX	31 December 20YY
Current assets				
Current liabilities				
Current net assets				
Non-current assets				
Non-current liabilities				
Non-current net assets				
Net assets				
Accumulated NCI				

Summarised statement of profit or loss and other comprehensive income	Hospital		Accredited Managed Healthcare Organisations	
	31 December 20xx R'000	31 December 20yy R'000	31 December 20xx R'000	31 December 20yy R'000
Revenue				
Income/(expense) for the period				
Other comprehensive income				
Total profit or loss and other comprehensive income				
Income/(expense) allocated to NCI				
Dividends paid to NCI				

	Hospital		Accredited Managed Healthcare Organisations	
Summarised cash flows*	31 December 20xx R'000	31 December 20yy R'000	31 December 20xx R'000	31 December 20yy R'000
Cash flows from operating activities				
Cash flows from investing activities				
Cash flows from financing activities				
Net increase/(decrease)in cash and cash equivalents				

*Although the summarised cash flows are not specifically required per the standard, IFRS 12 states that the summarised financial information included in the AFS should include summarised financial information about the assets, liabilities, profit or loss and cash flows of the subsidiary that enables users to understand the interest that non-controlling interests have in the group's activities and cash flows. That information might include but is not limited to, for example, current assets, non-current assets, current liabilities, non-current liabilities, revenue, profit or loss and total comprehensive income.

Disclosures for consolidated structured entities:

Critical judgments in applying the entity's accounting policies.

Consolidation of entities in which the group holds less than 50%

The trustees have concluded that the scheme controls Fund A, even though it holds less than half of its voting rights. This is because the scheme is the largest shareholder with a 45% interest, and the fund was created for the purposes of the scheme but was not restricted to the scheme and has other investors.

An agreement signed between the schemes and fund grants the scheme the right to appoint, remove and set the remuneration of management responsible for directing the fund's relevant activities. A 67% majority vote is required to change this agreement. This cannot be achieved without the scheme's consent as it currently holds 45% of the voting rights.

Disclosures for unconsolidated structured entities:

Summary of accounting policies

IFRS 12, 'Disclosure of Interests in Other Entities" requires schemes to disclose significant judgments and assumptions made in determining whether the scheme controls, jointly controls, significantly influences or has some other interests in other entities. Schemes are also required to provide more disclosures around certain 'structured entities'. Adoption of the standard has impacted the scheme's level of disclosures in certain of the above-noted areas but has not impacted the scheme's financial position or results of operations.

Structured entities

Example: Financial Risk Management Note

The exposure to investments in the funds at fair value, by strategy employed, is disclosed in the following table.

These investments are included in financial assets at fair value through profit or loss in the statement of financial position.

Strategy	**Number of investee funds**	**Net asset value of investee fund (range and Weighted)**	**Fair value of fund's assets of investment Rxxx***	**%of net assets attributable to scheme****
Equity				
Fund of Funds				

*The fair value of financial assets (Rxxx) is included in financial assets at fair value through profit or loss in the statement of financial position
**This represents the scheme's percentage interest in the total net assets of the funds

The scheme's maximum exposure to loss from its interests in the funds is equal to the total fair value of its investments in the funds.

Once the scheme has disposed of its shares in a fund, it ceases to be exposed to any risk from that fund.

During the year ended 31 December 20YY, total net losses incurred on investments in the funds were Rxxx.

9. RELATED PARTIES

The following is an illustrative example, and the disclosures should only be made where applicable to a particular medical scheme.

NOTE DISCLOSURE:

Background information: Related party relationships with subsidiaries

The consolidated financial statements include the financial statements of the subsidiaries listed in the following table:

	% equity interest	
Name	**20xx**	**20yy**
ABC (Pty) Ltd	100	-

There were no transactions between XYZ and ABC during the financial year (20yy: Nil).

Sponsoring employer

Employer EFG is the sponsoring employer of Medical Scheme XYZ.

Key management personnel and their close family members

Key management personnel are those persons having authority and responsibility for planning, directing and controlling the activities of the scheme. Key management personnel include the Board of Trustees, the Principal Officer and members of the executive committee. The disclosure deals with full-time personnel that are compensated on a salary basis (Principal Officer and executive committee) and part-time personnel that are compensated on a fee basis (Board of Trustees).

Close family members include close family members of the Board of Trustees, Principal Officer and members of the executive committee.

Parties that provide key management personnel services to the scheme

Administrator HIJ is deemed to form part of the key management personnel of Medical Scheme XYZ, as HIJ participates in XYZ's financial and operating policy decisions but does not control XYZ. HIJ provides administration services.

A division of HIJ, KLM, provides managed care services.

Accredited managed healthcare organisation NOP is a subsidiary of the administrator HIJ that is deemed to form part of the key management personnel of Medical Scheme XYZ. NOP provides accredited managed healthcare services for the scheme.

Investment management company QRS is a subsidiary of the administrator HIJ that is deemed to form part of the key management personnel of Medical Scheme XYZ. QRS manages the cash investments of the scheme.

Broker Company TUV is a subsidiary of the administrator HIJ that is deemed to form part of the key management personnel of Medical Scheme XYZ. TUV provides broker services to the scheme.

Transactions with related parties

The following table provides the total amount of transactions that have been entered into with related parties for the relevant financial year.

Key management personnel (Board of Trustees, Principal Officer and executive committee) and their close family members

	20XX R'000	20YY R'000
Compensation		
Short term employee benefits		
Post-employment pension and medical benefits		
Termination benefits		
Other long-term benefits		
Total compensation paid to key management personnel		

Contributions and claims

Statement of profit or loss and other comprehensive income

Insurance revenue received
PMSA contributions received
Claims paid from PMSA on behalf of the member
Ex gratia payments healthcare provider fees paid
Relevant healthcare expenditure incurred

Statement of financial position

Personal medical savings included in the liability for remaining coverage/ incurred claims.

Healthcare provider fees payable

The terms and conditions of the related party transactions were as follows:

Transaction	Nature of transactions and terms and conditions thereof
Contribution received	This constitutes the contributions paid by the related party as a member of the scheme, in their individual capacity. All contributions were at the same terms as applicable to third parties.
Claims incurred	This constitutes amounts claimed in respect of the scheme's registered benefits by the related parties, in their individual capacity as members of the scheme.
Healthcare provider fees paid/payable	Fees paid to a healthcare provider (medical practitioner). Fees are paid on the same basis as applicable to third parties.

Other transactions

- The scheme obtained legal services from key management personnel, which amounted to RXXX (20yy: RXXX). The legal fees were paid on an arm's length basis. The outstanding balance at year

end was RXXX (20yy: RXXX). The outstanding balance bears no interest and is payable within 30 days after becoming due.

- During the year, benefit management services were rendered by key management personnel totalling RXXX (20yy: RXXX) at normal market prices.

- The scheme made loans to key management personnel for which approval has been obtained in terms of the Act. The outstanding balance is RXXX (20yy: RXXX) and bears interest at prime less 2%. Instalments of RXXX are payable monthly.

	20XX R'000	20YY R'000
Sponsoring Employee		
EFG – Employer		
Statement of profit or loss and other comprehensive income		
Grant Received		
Rent Paid		
Statement of financial position		
Rent Due		
Parties that provide key management personnel services to the scheme		
HIJ-Administrator*		
Statement of profit or loss and other comprehensive income		
Administration fees		
Administration fees recovered		
Site office costs		
Rent received		
Statement of financial position		
Administration fees due		
NOP-Accredited managed care organisation *		
Statement of profit or loss and other comprehensive income		
Accredited managed healthcare service fees		
Statement of financial position		
Accredited managed healthcare service fees		
QRS- Investment manager		
Statement of profit or loss and other comprehensive income		
Investment fees		
Statement of financial position		
Investment fees due		
TUV – Broker*		
Statement of profit or loss and other comprehensive income		
Broker Fees		
Statement of financial position		
Broker fees due		

Terms and conditions of the rental agreement *

The rental transactions with related parties were made on terms equivalent to those that prevail in arm's length transactions. Office space is leased at a market-related price. The outstanding balance bears no interest and is payable within 30 days.

Terms and conditions of the administration agreement *

The administration agreement is in terms of the rules of the scheme and in accordance with instructions given by the trustees of the scheme. The agreement is automatically renewed each year unless notification of termination is received. The scheme has the right to terminate the agreement on 90 days' notice. The outstanding balance bears no interest and is due within 30 days.

Terms and conditions of the accredited managed healthcare service agreement *

The accredited managed healthcare services agreement is in accordance with instructions given by the trustees of the scheme. The agreement is automatically renewed each year unless notification of termination is received. The scheme has the right to terminate the agreement on 180 days' notice. The outstanding balance bears no interest and is due within 30 days.

Terms and conditions of the broker agreement *

The broker fees are paid in accordance with the requirements contained in the Act. The outstanding balance bears no interest and is due within 30 days.

Terms and conditions of the investment management contract *

The investment management contract is in accordance with instructions given by the trustees of the scheme. The agreement is automatically renewed each year unless notification of termination is received. The scheme has the right to terminate the agreement on 180 days' notice. The fees are calculated on an arm's length basis on market-related terms and any outstanding balances are payable within 30 days.

Terms and conditions of grants received.

Grants received are not subject to any conditions.

** Entities need to consider whether disclosure is applicable.*

10. TRUSTEES' REMUNERATION AND CONSIDERATIONS

	Fees for meeting attendance	Fees for holding of office	Fees for consultancy services	Other Remuneration	Total Remuneration	Training	Travelling and other expenses for meetings and conferences	Telephone expenses	Accommodation and meals	Other disbursements and reimbursements	Total
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
20xx Trustee 1 Trustee 2 Trustee 3 Trustee 4											
Total											
20yy Trustee 1 Trustee 2 Trustee 3 Trustee 4											
Total											

[*#Specific disclosure in respect of trustee remuneration and considerations is required by section 57(8) and Regulation 6(A) of the Act. The fees and expenses in this table are illustrative only and additional items should be included as appropriate*].

11. NON-COMPLIANCE MATTERS

Disclosure examples of non-compliance matters

NOTE DISCLOSURE:

Section 26(7)

Nature of non-compliance

Section 26 (7) of the Medical Schemes Act 131 of 1998, as amended (Act), states that all subscriptions or contributions shall be paid directly to a medical scheme not later than three days after payment thereof becomes due.

Cause of non-compliance

There are instances where the scheme received contributions three days after they became due. It should be noted that there are no contracts in place that are contrary to the legislation.

Corrective action taken

The scheme's credit policy is applied:

- Members are notified via SMS and email of the non-payment and requested to urgently address this matter.

- Where contributions owing to the scheme have not been paid within 30 days of the due date, the scheme suspends all benefit payments in respect of claims which arose during the period of default.

- Where the outstanding contributions are not paid within 21 days of the notification, membership is cancelled.

Section 33(2)

Nature of non-compliance

In terms of Section 32(2) of the Act each benefit option is required to be self-supporting in terms of membership and financial performance and be financially sound.

Cause of non-compliance

During the financial period under review, the following options did not comply with Section 33(2):

Benefit option	*Nr of members*	*Net healthcare deficit*	*Net result*
Option XX	70	(8 267)	2 100
Option XY	100 000	(456 789)	(210 711)

Corrective action taken

Benefit Option XX's membership is below the Council for Medical Schemes' guideline of 2 500 members and is not considered to be self-supporting in terms of its membership. This benefit option will be discontinued in the new financial year.

The scheme continues to monitor Benefit Option XY with a view to improve its financial outcome and will

evaluate different strategies to address the deficits in this benefit option. The net healthcare deficit reflects the higher disease burden in this benefit option. The scheme's strategy for the sustainability of this benefit option has to balance short- and long-term financial considerations, with considerations of fairness to both healthy and sick members and with continued affordability of cover for members with different levels of income and different healthcare needs. The scheme applied a small differential contribution increase on its benefit options for the new financial year. It is expected that the higher contribution increase on Benefit Option XY will address the minor pricing misalignment in the coming financial year; the remainder of the deficit will solely be attributable to the worse demographic profile and disease burden on this option.

Section 35(8)

Nature of non-compliance

Section 35(8)(a) and (c) of the Act states that a medical scheme shall not invest any of its assets in the business of an employer who participates in the medical scheme or any administrator or any arrangement associated with the medical scheme or any administrator.

Cause of non-compliance

The scheme has investments in certain employer groups and companies associated with medical scheme administration. The exposure to these entities had been obtained through the scheme's investment in Collective Investment Scheme AA. The scheme does not control the asset manager's investing activities.

Corrective action taken

The scheme obtained exemption in terms of Section 8(h) from Section 35(8) of the Act from the Council of Medical Schemes on 1 September 200x for a period of two years. The exemption had been granted with the proviso that the scheme does not make any direct investments in these entities.

Section 59(2)

Nature of non-compliance

Section 59(2) requires a medical scheme in the case where an account has been rendered, subject to the provisions of the Act and the rules of the medical scheme, to pay to a member or a supplier of service, any benefit owing to that member or supplier of service within 30 days after the day on which the claim in respect of such benefit was received by the medical scheme.

Cause of non-compliance

(a) During the period under review, the scheme had only one claims payment run on the last business day of each month. Claims received on the first of each month for those months with 31 days were, therefore, not paid within the required 30 days.

(b) The scheme suspended the payment of benefits owing in respect of three providers who were being investigated by the scheme for potential fraud.

Corrective action taken

(a) The scheme will be running additional claims run mid-month. It is envisaged that the additional claims run will also promote further goodwill between the scheme, its members and its providers.

(b) Valid claims are no longer suspended and are paid out to either the member or the provider.

Regulation 10(6)

Nature of non-compliance
Regulation 10(6) prohibits the funding of a prescribed minimum benefits (PMB) from a member's medical savings (PMSA) account.

Cause of non-compliance
(a) An automated error occurred where potential PMB claims were processed as non-PMB-related claims and paid incorrectly from members' PMSA accounts. This error was limited to a single benefit option.

(b) Five instances were identified where co-payments for PMBs were incorrectly paid from savings accounts.

Corrective action taken
These errors were subsequently rectified.