

MEDICAL SCHEMES ACCOUNTING GUIDE

FOR THE YEAR END 31 DECEMBER 2022

*With suggested amendments and comments for
the year end 31 December 2022*

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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), primarily 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 International Financial Reporting Standards (IFRS) and any additional requirements of CMS and addresses only the accounting and reporting issues that are specific to schemes that carry on the business of a medical scheme. The guide is therefore not considered to be complete in all aspects, and members and associates are advised to read this guide in conjunction with applicable legislation, circulars from CMS, and IFRS, where appropriate, to ensure that all areas are adequately covered in any work that they are undertaking.

Every effort has been made to ensure that where reference is made to quotes, extracts and paragraphs from IFRS the references are correct. The information contained in the guide is for information purposes only and 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 given 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 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 from 1 July 2018.
2. The CMS is the regulatory body tasked with regulating medical schemes in South Africa.
3. The main sources of business are from employers that wish to arrange healthcare benefits for their employees and their employees' dependants and from individuals that 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), and these are referred to as "open medical schemes".
4. Business is introduced to medical schemes by direct marketing or by 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).

5. In practice, an employer may negotiate certain terms and conditions in the contract of membership with a medical scheme on behalf of its employees, such as eliminating the waiting period. Each individual member is still required to 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.
6. 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 on the basis of income or the number of dependants, or both the income and the number of dependants.

7. 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 of 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 in nature and managed together, with medical schemes setting a price that fully reflects the risk at the overall scheme level. Medical schemes may provide for members' health requirements through benefit options which 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.
8. 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 in- and out-of-hospital. Co-payments on PMBs will occur when the member has voluntarily not made use of the scheme's designated service provider.

9. Healthcare benefit limits (no limits are applicable 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 a period of the year in which the contract is first entered into after the commencement of the benefit period. No apportionment of limits is permitted should a contract be terminated prior to the end of a benefit period. Unexpended benefits may not be accumulated by a beneficiary from one year to the next other than as provided for in the personal medical savings accounts.
10. Certain risks may be reinsured by the medical scheme, in terms of which certain risks for healthcare benefits are underwritten by another party. This transfer of risk can take the form of a commercial

reinsurance contract or of 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.

- 10a. Provider: The provider carries the risk of the number of incidents that occur during the specified period and the cost of providing the service. Entering into 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 in order that the financial extent of such arrangements may be clearly demonstrated.
- 10b. 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.
11. 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.
12. Some medical schemes provide for personal medical savings account facilities to assist members in managing cash flow for the payment of healthcare services for which they are responsible. In accordance with the Act, a maximum of 25% of the total gross contribution 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 (includes benefits and co- payments).
13. 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 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' personal medical savings accounts in terms of the rules of the scheme.
14. 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 rules of the scheme with no portion retained by medical schemes.

15. 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.
16. 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, subjected 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.

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.

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 the managing of 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, or 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 to 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 members of the medical scheme.

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 an application for membership 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.

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.

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

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

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

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

Incurred but not reported (IBNR) – see the definition of outstanding risk claims provision

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 who elected to defer implementation of IFRS 9: Financial Instruments) and net gains or losses on financial assets at fair value through profit or loss.

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 is 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 claims incurred – mean risk claims incurred net of third party recoveries (such as the Road Accident Fund (RAF)).

Net income/(expense) on risk transfer arrangements – means the result of the premiums/fees paid after deducting estimated claims recoveries for relating to risk transfer arrangements.

¹ Insurance Act No. 18 of 2017

Non-healthcare expenditure – comprises broker service fees, administration fees, other operating expenses incurred in operating a medical scheme, and impairment losses incurred in respect of trade and other receivables.

Outstanding claims provision – mean a provision for the estimated cost of settling all claims incurred (healthcare benefits) that have occurred before the end of the accounting period but have not been reported to a medical scheme by that date and for which the medical scheme is liable to settle. The provision is net of estimated recoveries from members for co-payments, and from personal medical savings accounts. This provision is also known as “provision for claims incurred but not reported” (IBNR).

Own facility costs – represent costs incurred by a medical scheme in operating its own medical equipment, hospital, clinic, pharmacy, pathology laboratory and radiology facility or any other 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 account of the member, in terms of the rules of the medical scheme. These funds are also referred to as a personal medical savings account liability on the statement of financial position.

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.

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

Relevant healthcare expenditure – represents net claims incurred, accredited managed healthcare services and net income/ (expense) on risk transfer arrangements.

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 who oversee 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 and 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 claims incurred – are risk claims paid and reported adjusted by the outstanding risk claims provision at the beginning and end of the accounting period.

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

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

Risk transfer arrangement – is a reinsurance contract as defined in IFRS 4 Insurance Contracts. This is a contractual arrangement in terms of which a third party undertakes to compensate a medical scheme for all or a significant part of the loss that the medical scheme may suffer as a result of carrying on the business of a medical scheme. Risk transfer arrangements do not reduce a medical scheme's primary obligations to its members and their dependants, but the arrangements only decrease the loss the medical scheme may suffer as a result of the carrying on of the business of a medical scheme.

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 Council for Medical Schemes as a juristic person; provides for the appointment of the Registrar of Medical Schemes; 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 co-ordination 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 of Medical Schemes (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 requires 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 becoming 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 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 29A of the Act stipulates the conditions under which a medical scheme may apply general and specific waiting periods:

<i>(Uncovered period – time period between your last day of notice period of previous medical scheme to the date of application for membership with the new medical scheme)</i>			
Break MORE than 90	Break LESS than 90 days (0 to 89 days)		
<i>Previous membership period</i>			
Regardless of previous membership	24 Months and longer	Shorter than 24 months (previous waiting periods may still be in place)	Regardless of previous membership <ul style="list-style-type: none">• Change of employment• Employer changing / terminating medical scheme• Plan movements
<ul style="list-style-type: none">• General waiting period – 3 Months• Condition specific – 12 months• Waiting period applies to PMB's	<ul style="list-style-type: none">• General waiting period – 3 months• Waiting period does not apply to PMB's	<ul style="list-style-type: none">• Condition specific - 12 months• Waiting period does not apply to PMB's	<ul style="list-style-type: none">• No general or condition specific waiting periods may be imposed

14. Section 33(2) of the Act contains provisions relating to the approval of new benefit options and the conditions that must be addressed to the satisfaction of the Registrar before approval of such benefit options can occur.
15. 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, or any administrator or any arrangement associated with the medical scheme, any 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 required to be audited in terms of Circular 4 of 2008.
16. 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.
17. Section 44(8) provides the Registrar, with the concurrence of CMS, with the power to place restrictions on the administration costs of medical scheme in respect of any financial year, and may for this purpose prescribe the basis on which such costs shall be calculated.
18. 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.
19. 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.

20. Section 59(2) of the Act and Regulation 6 set out the payment periods by the scheme to a member or a supplier of service in the case where an account has been rendered.
21. Section 61 of the Act speaks to undesirable business practices. 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 exists.
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. 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.
24. Section 66 contains details of offences and penalties.
25. 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.
26. Regulation 4(4) prohibits the ring-fencing of reserves.
27. Regulation 6A sets out the requirements for disclosure of trustees' remuneration.
28. Regulation 8 and Annexure A provide information on PMBs.
29. Regulation 9A states that a medical scheme may not provide in its rules for the accumulation of unexpended benefits by a beneficiary from one year to the next other than as provided for in a personal medical savings account.
30. Regulation 10 stipulates the requirements in respect of savings accounts.
 - (a) Regulation 10(1) limits the amount of the total gross contribution that is allocated to the member's 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 enrolls in another medical scheme without a personal medical savings account provision or selects a benefit option without a personal medical savings account; and

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.

31. 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.*"
32. Administration of a medical scheme by a third party should comply with Chapter 6 of the Regulations."
33. 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.
34. 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.
35. 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.

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

36. 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 Act² 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.
37. 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.

Income Tax Act 58 of 1962, as amended

38. 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

39. The Minister of Health publishes Regulations and the Registrar, from time to time, publishes directives and circulars that govern the operation of medical schemes.

The following circulars are of importance to note:

- 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

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

- 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
40. 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 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 International Financial Reporting Standards (IFRS), 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 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; 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;
 - Are prepared in the manner required by the Act;
 - As a minimum adhere to the presentation and disclosure requirements of International Accounting Standard (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 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 that is required to be included in the Highlights document that is distributed to members:

- 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 have been extracted from and are 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. Refer to Circular 41 of 2012 – *Prescribed format for the Statement of Comprehensive Income (and disclosures requirement in respect of PMSA (Annexure A))*, issued by CMS, for the prescribed format of the statement of comprehensive income.
11. Circular 56 of 2015 – *Accounting for accredited managed care services based on comments received from industry*, stated that 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.
12. 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.

13. 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).
14. Medical schemes should still consider IAS 1 in preparing a statement of comprehensive income.

Statement of financial position

15. Medical schemes should refer to IAS 1 in preparing a statement of financial position.

Statement of changes in funds and reserves

16. Medical schemes should refer to IAS 1 in preparing a statement of changes in funds and reserves.

Statement of cash flows

17. 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

18. 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

19. Paragraph 5 of IFRS 3 requires the use of the acquisition method to account for business combinations.
20. The acquisition method involves the following steps:
 - Identifying the acquirer (being the entity that obtains *control* of another entity (as defined in IFRS 10 refer to 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).
21. 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, that 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.

22. 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.
23. 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 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

24. 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.
25. 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 should rather be added to a separate reserve. It should be noted that this separate reserve is available to all members of the amalgamated entity.
26. 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

27. 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

28. With effect from 1 January 2xx1, 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.
 - The reserves of medical scheme B equal R50 million. This amount covers the R25 million reserve requirement, and the additional R25 million of the reserve will compensate medical scheme A for the higher risk profile of the additional members (originally medical scheme B members).
 - The current trustees of medical scheme A will have control over the amalgamated scheme.
29. In this example, medical scheme A is identified as the acquirer. It has control over the amalgamated scheme through its current trustees.
30. Members of medical scheme B have effectively exchanged their interest in that scheme for a member's interest in medical scheme A.
31. 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.
32. 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 4 Insurance Contracts

33. IFRS 4 is the result of the first phase of the International Accounting Standards Board's (IASB) project to develop an accounting standard for insurance contracts. The main purpose of IFRS 4 is to provide guidance on the classification of insurance contracts and their disclosure in the financial statements. Limited guidance is given by IFRS 4 for the recognition and measurement of insurance contracts. IFRS 17 replaces IFRS 4 and becomes effective for annual periods beginning on or after 1 January 2023. Early adoption is permitted for entities that have applied IFRS 9 and IFRS 15. Entities will be required to apply IFRS 17 retrospectively unless it is impracticable to do so, in which case an entity can either apply the fair value approach or the modified retrospective approach. Medical schemes are advised to start engaging in discussions on how to prepare for the implementation of IFRS 17.

The definition of an insurance contract

34. IFRS 4 is applicable to all *issuers* of insurance contracts.
35. It is important to note that the definition of an insurance contract in IFRS 4 is not a legalistic definition

and that the definition addresses the substance of the agreement with a client 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.

36. A medical benefit plan or contract entered into with a member is an insurance contract as defined by IFRS 4, to the extent that:
 - It transfers a risk other than a financial risk to the scheme (for example, the risk that the member may seek medical treatment);
 - There is no certainty as to *whether* the member will seek medical treatment; *when* the member will seek medical treatment; or *how much will be payable* by the medical scheme if the member seeks medical treatment; and
 - The member (i.e. policyholder) is adversely affected by the insured event (i.e. it costs the member money to seek medical treatment in the event of illness) and the medical scheme agrees to compensate the member for these costs.
37. A reinsurance contract is defined by IFRS 4 as an insurance contract issued by one insurer (the reinsurer) to compensate another insurer (the cedant) for losses on one or more contracts issued by the cedant.
38. Within a medical scheme context this definition needs to be considered in respect of commercial reinsurance contracts as well as capitation agreements where the medical scheme has transferred significant risk to a third party provider. Therefore, a contract held by a medical scheme will meet the definition of a risk transfer arrangement and be accounted for in terms of IFRS 4 if:
 - The contract meets the definition of an insurance contract; and
 - The reinsurer/provider compensates the medical scheme for losses on insurance contracts issued to members.
39. IFRS 4 specifically includes contracts that provide for payments in kind, instead of cash compensation for losses, within the definition of insurance contracts. To illustrate this, the appendix to IFRS 4 provides the example of an insurer that uses its own hospital and medical staff to provide medical services covered by the insurance contracts.
40. A medical scheme should apply IFRS 4 to all medical benefit plans or contracts that are insurance contracts, as defined by IFRS 4. In applying IFRS 4, 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.

Deposit components

41. Paragraphs 10 to 12 of IFRS 4 require, permit or prohibit the unbundling of deposit components within insurance contracts on the basis of certain criteria. On the basis of those criteria, a medical

scheme is *permitted, but not required*, to unbundle the deposit component separately if it can measure the deposit component separately and if its accounting policies require it to recognise all obligations and rights arising from the deposit component.

42. The scheme applies IFRS 4 to the insurance component of the medical benefit plan or contract, and IAS 39 *Financial Instruments: Recognition and Measurement* (if the scheme qualified and elected to defer IFRS 9: *Financial Instruments*) / IFRS 9 *Financial Instruments* to the deposit component of the medical benefit plan or contract. Therefore, to the extent that the medical benefit plan or contract consists of a risk portion and a personal medical savings account component, the risk portion should be accounted for in terms of IFRS 4 and the savings portion may be unbundled as a deposit component and recognised in accordance with IAS 39 (if the scheme qualified and elected to defer IFRS 9) / IFRS 9. Refer to Circular 41 of 2012 – *Prescribed format for the Statement of Comprehensive Income and disclosures required in respect of PMSA* (Annexure B), issued by CMS, for the prescribed disclosure relating to the deposit component in those instances that the scheme rules create a trust relationship.

Liability adequacy test

43. A medical scheme is required to perform an annual liability adequacy test (LAT) in terms of paragraphs 15 to 19 of IFRS 4. The purpose of the LAT is to determine whether the carrying amount of the insurance liabilities is adequate on the basis of a review of future cash flows. Should the LAT reveal that the insurance liabilities are insufficient; the insurance liabilities should be increased through the statement of comprehensive income (i.e. through profit or loss).
44. At year-end medical schemes should:
 - Determine the carrying amount of all the relevant insurance liabilities (this would include, but would not be limited to, the outstanding claims provision, claims reported but not yet paid and risk contributions). It should be noted that risk transfer arrangements are not considered because they are recognised separately; and
 - Determine whether the amount described above is less than the carrying amount that would be required if the relevant insurance liabilities were within the scope of IAS 37 *Provisions, Contingent Liabilities and Contingent Assets*. If the amount is less, the entire deficiency should be recognised in the statement of comprehensive income (in profit or loss) as part of the movement in the outstanding claims provision.
45. Contracts that are subject to broadly similar risks that are managed together as a single portfolio may be aggregated in applying the LAT.
46. The LAT should not take into account medical benefit plans or contracts not yet effective at year end. Provisions should only be raised on current or existing contracts not for future claims under contracts not in existence at the reporting date. The year-end usually coincides with the last date of members' contracts. Any contracts signed before year end that relate to the new financial year should be ignored for the purposes of the LAT.

47. Medical schemes should, consider whether their IBNR calculation meets the requirements of the LAT, as per paragraph 16 of IFRS 4.

Impairment of insurance receivables

48. Insurance receivables fall under the scope of IFRS 4 and the accounting policy adopted under this standard to determine the provision for impairment may still apply. Insurance contracts under IFRS 4 are scoped out of IFRS 9 and this policy can continue to be applied. In most instances the impairment policy under IFRS 4 was the incurred loss model.

Sensitivity analysis

49. Medical schemes should take cognisance of the disclosure requirements of IFRS 4, particularly those of IFRS 4 paragraphs 39(c) (i) (with reference to paragraph 39A). Refer to Appendix II for disclosure requirements.

Disclosures for insurance contracts

50. Certain changes were made to IFRS 4 as a result of IFRS 7. Similar to IFRS 7, the amendments to IFRS 4 had to be applied for the first time in the financial periods beginning on or after 1 January 2007.
51. The consequential amendments to IFRS 4 mainly relate to the following:
- A scheme is required to disclose information that helps users to evaluate the nature and extent of financial risks arising from insurance contracts.
 - IFRS 4 requires information about credit risk, liquidity risk and market risks to be provided as if the insurance contracts were within the scope of IFRS 7.
 - The maturity analysis required by IFRS 7 for liabilities may be replaced with disclosure of the estimated timing of the net cash outflows from the recognised insurance liabilities. Paragraphs IG65B and IG65C of the Implementation Guidance to IFRS 4 provide additional guidance on how this disclosure requirement may be met.
 - If a scheme uses an alternative method of managing sensitivity to market conditions, such as the embedded value analysis, then that sensitivity analysis may be used to meet the requirements of IFRS 7, paragraph 40(a) in this regard. However, the disclosure requirements of paragraph 41 in IFRS 7 must be provided.

52. The main disclosures in the Implementation Guidance to IFRS 4 as a result of IFRS 7 can be summarised as follows:

IG45	When determining the broad classes for which separate disclosure is required, a scheme might consider how best to indicate the level of uncertainty associated with the risks underwritten.
IG48	<p>Disclosures are required about the objectives, <i>policies and processes</i> followed in managing the risks from insurance contracts. Among others, disclosure has to be provided about –</p> <ul style="list-style-type: none"> • The structure and organisation of a scheme's risk-management functions as well as information regarding the independence and accountability of these risk-management functions; • The process for accepting, measuring, monitoring and controlling insurance risks; and • The process for managing, monitoring and controlling additional debt or capital commitments on the occurrence of specified events.
IG62 to IG65	<p>The disclosures regarding the credit risk, liquidity risk and market risk may either be provided in the financial statements or incorporated by cross- reference to another statement that is available to users of the financial statements on the same terms and at the same time as the financial statements.</p> <p>Among others, these disclosures may include the following:</p> <ul style="list-style-type: none"> • The risk that a scheme may incur a financial loss because a reinsurer fails to pay in accordance with the terms of a reinsurance contract, i.e. credit risk exposure from balances owed by reinsurers. • IFRS 7 requires the remaining contractual maturities of financial liabilities to be disclosed. For insurance contracts the remaining contractual maturities refer to the estimated date when the contractually required cash flows will occur. Should a scheme already disclose an analysis, by estimated timing, of the amounts recognised in the statement of financial position, the IFRS 7 maturity analysis is not required for insurance liabilities. A scheme may also consider disclosing how the maturity analysis could be influenced by changes in suspension of medical insurance contracts. • A sensitivity analysis for each type of market risk should be disclosed at the reporting date. This requirement may be met by disclosing an embedded value sensitivity analysis for insurance contracts; and • If no reasonable possible change in the relevant market risk variables will impact profit or loss and equity, a statement to that effect should be included in the financial statements.

The impact of IFRS 7 Financial Instruments: Disclosures

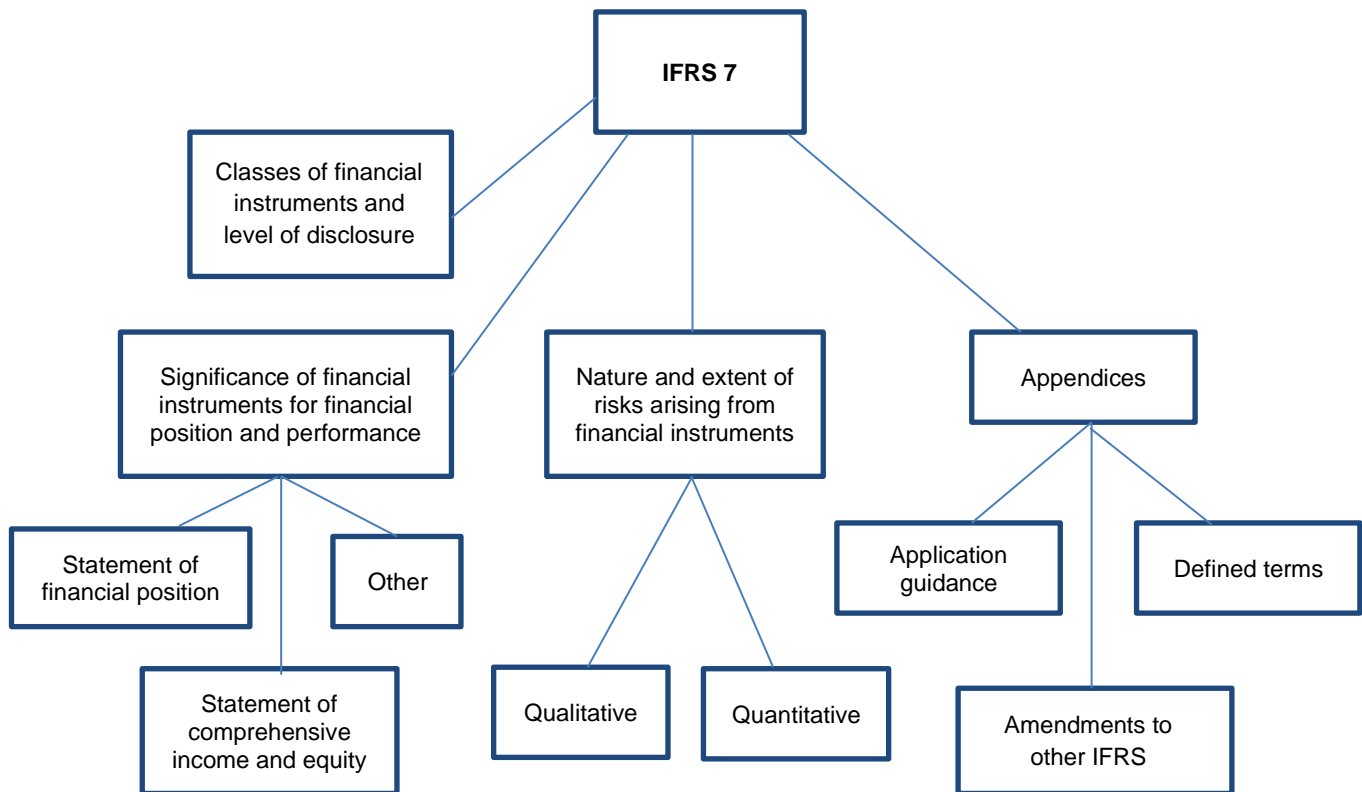
Disclosure for financial instruments

53. The impact of IFRS 7 on medical schemes has been summarised below. Refer to Appendix II for illustrative disclosures. Some of the detailed disclosures required by IFRS 7, as described in the following paragraphs might be different if the scheme qualified and elected to defer IFRS 9.
54. IFRS 7 require 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.

55. 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).

56. Diagrammatically IFRS 7 can be summarised as follows:



57. IFRS 7 is divided into two sections: the first section deals with the significance of the financial instruments for the financial position and performance of the entity and relevant qualitative disclosure. The qualitative disclosure includes disclosure that pertains to fair value, collateral, and defaults and breaches. The second section, which 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

58. 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 those:

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.

Defined in IAS 39 as financial assets at fair value through profit or loss, held to maturity investments, loans and receivables, available-for-sale financial assets, financial liabilities at fair value through profit or loss and financial liabilities measured at amortised cost.

59. 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 information disclosed. Classes should be determined at a lower level than the IFRS 9/IAS 39 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.
60. 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 inside and outside the scope of IFRS 7. For example, the following cannot be grouped together in one class:
 - Investments in subsidiaries (outside the scope of IFRS 7) and investments in bonds (within the scope of IFRS 7); and
 - Incurred but not reported claims (outside the scope of IFRS 7) and trade payables (within the scope of IFRS 7).
61. Paragraph B3 of the application guidance further states that: *“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.
62. 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, 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

63. IFRS 7 prescribes certain minimum disclosures that have to be made that relate to the statement of financial position, statement of 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

64. The information that shall be disclosed either on the face of the statement of financial position or in the notes thereto is outline 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 principle” 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 is 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 liabilities fair value that is 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., 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 designated investments in equity instruments measured at fair value through other comprehensive income as 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 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 comprehensive income

65. The following shall be disclosed on the face of the statement of comprehensive income:

- 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)).
- Finance cost (IAS 1.82(b)).

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

- 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)).

The following shall be disclosed in the notes to the statement of 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 to 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 calculation of the effective interest rate) as well as from trust or other fiduciary activities

Other disclosures

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

- All accounting policies relevant to an understanding of the financial instruments should be disclosed, including the measurement basis (or bases) used in the preparation of the financial statements.
- Detailed information is required to be disclosed if a scheme applies hedge accounting. Reference should be made to paragraphs 21A to 24G of IFRS 7 for more detail in this regard.
- Except when the carrying amount is a reasonable approximation of the fair value, the fair value of all financial instruments should be disclosed so that the fair value can be compared to the carrying amount. Fair value should be disclosed per class 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 by class of financial instrument the disclosure requirements of IFRS 7.28.

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

Nature and extent of risks arising from financial instruments

67. 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

68. For each type of risk arising from financial instruments, a scheme shall disclose the requirements of IFRS 7.33, IG 15-17.

Quantitative disclosures

69. For each type of risk arising from financial instruments, a scheme shall disclose the requirements of IFRS 7.34. Summary quantitative data about its exposure to that risk at reporting date should be based on the information provided internally to the scheme's key management personnel, for example, the scheme's Board of Trustees.

Concentrations of risk arising from financial instruments that have similar characteristics and are affected similarly by changes in economic or other conditions should also be disclosed if not disclosed as part of the quantitative data. The identification of concentrations of risk requires judgment, taking into account the scheme's circumstances. IFRS 7B.8 indicates what items 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

70. Where an entity has deferred applying IFRS 9, IFRS 7.36-37 under IAS 39, require the following disclosures for credit risk:
- The amount that best represents its maximum exposure to credit risk at the end of the reporting period 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.
 - A description of collateral held as security and other credit enhancements, and their financial effect in respect of the amount that best represents the maximum exposure to credit risk.
 - Information about the credit quality of financial assets that are neither past due nor impaired.
 - For financial assets that are either past due or impaired, an entity shall disclose by class of financial asset:
 - an analysis of the age of financial assets that are past due as at the end of the reporting period but not impaired; and
 - an analysis of financial assets that are individually determined to be impaired as at the end of the reporting period, including the factors the entity considered in determining that they are impaired

Where an entity is applying IFRS 9, the following disclosure requirements of IFRS 7.35 for credit risk are required:

- Credit risk management practises (IFRS 7.35A-N) - what they are and how they relate to the recognition and measurement of expected credit losses. The following detail should be disclosed:

- i. How an entity determined whether the credit risk of financial instruments has increased significantly since initial recognition including, if and how:
 - o 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
 - o The presumption in of 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;
 - ii. Definitions of default, including reasons for selecting those definitions;
 - iii. How instruments were grouped if expected credit losses were measured on a collective basis;
 - iv. How an entity determined that the financial assets were credit impaired financial assets;
 - v. Entity'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;
 - vi. How the requirement of 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 has been modifications); and
 - vii. Explain the inputs, assumptions and estimation techniques used to apply the impairment requirements described in IFRS 9, the following should be disclosed:
 - o Basis of inputs, assumptions and estimation techniques used to:
 - Measure the 12-month and lifetime expected credit losses;
 - Determine whether the credit risk of financial instruments has increased significantly since initial recognition;
 - Determine whether a financial asset is a credit-impaired financial asset.
 - o How forward looking information has been incorporated into the determination of expected credit losses, including the use of macroeconomic information; and
 - o 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
 - i. 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, showing separately (in table format):

- Loss allowance measured at an amount equal to 12-month expected credit losses;
 - Loss allowance measured at an amount equal to lifetime expected credit losses for:
 - Financial instruments for which credit risk has increased significantly since initial recognition but that are not credit-impaired financial assets;
 - Financial assets that are credit-impaired at the reporting date (but that are not purchased or originated credit-impaired); and
 - Trade receivables, contract assets or lease receivables for which the loss allowance are measured in accordance with the simplified approach under IFRS 9.
 - Purchased or originated credit-impaired assets should be reconciled.
- ii. 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 represents the loss allowance. IFRS 7.35I provides examples of changes in the gross carrying amount of financial instruments that contributed to the changes in the loss allowance.
 - iii. Refer to paragraph 35J for disclosure with regards to modifications that have not resulted in the financial instrument being derecognised and the effect of such modification on the measurement of the expected credit losses.
 - iv. The effect of collateral and other credit enhancements on the amounts arising from expected credit losses, the following detail should be disclosed:
 - 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 credit enhancements.
 - Narrative description of collateral held as security and other credit enhancements, including:
 - Description of the nature and quality of the collateral held;
 - 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
 - Information about financial instruments for which an entity has not recognised a loss allowance because of this collateral.
 - Quantitative information about the collateral held as security and their credit

enhancements for financial assets that are credit-impaired at reporting date.

- v. Disclose the contractual amount outstanding on financial assets that were written off during the reporting period and are still subject to enforcement activity.
- Credit risk exposure
 - i. Entity shall disclosure 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 instrument. Refer to paragraph 35M for detailed disclosures required.
 - ii. 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.
- For all financial instruments within the scope of IFRS 7, but to which the impairment requirements in IFRS 9 are not applied, an entity shall disclose by class of financial instrument (financial instruments in the same class share economic characteristics with respect to the risk being disclosed):
 - 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.
 - A description of collateral held as security and other credit enhancements and their financial effect (e.g. a 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)
- 71. Disclosure required for assets obtained by taking possession of collateral held by the scheme and other credit enhancements called upon. Refer to IFRS 7.38 for detailed disclosures to be made.
- 72. Insurance receivables are accounted for under IFRS 4. 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

- 73. In terms of IFRS 7.39, a scheme shall disclose the following:
 - A maturity analysis for both non-derivative and derivative financial liabilities that shows the remaining undiscounted contractual maturities; and
 - A description of how it manages the liquidity risk.

Market risk

74. 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

75. The scheme should include disclosures regarding the scheme’s objectives, policies and processes for managing capital. Medical schemes would, among other requirements, be 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

76. IFRS 7.42A to 42H 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:

- Transfers the contractual rights to receive the cash flows of the financial asset; or
- Retains the contractual rights to receive the cash flows of the 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/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

77. IFRS 9 includes the requirements on classification and measurement, impairment and hedge accounting and replaces IAS 39: *Financial Instruments: Recognition and Measurement*. 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. The standard is applicable for annual reporting periods beginning on or after 1 January 2018.

Temporary exemption from IFRS 9

78. A scheme may apply the temporary exemption from IFRS 9 if, and only if:

- it has not previously applied any version of IFRS 9
- its activities are predominantly connected with insurance, at its 31 December 2015 reporting date, or at a subsequent annual reporting date that precedes 1 April 2016.
- After 1 April 2016 an entity shall assess if it still adheres to the exemption.

A scheme's activities are predominantly connected with insurance if, and only if:

- the carrying amount of its liabilities arising from members' contracts, which includes any deposit components (i.e. the medical savings account liability), is significant compared to the total carrying amount of all its liabilities; and
- the percentage of the total carrying amount of its liabilities connected with insurance relative to the total carrying amount of all its liabilities is:
 - greater than 90 percent; or
 - less than or equal to 90 per cent but greater than 80 per cent, and the scheme does not engage in a significant activity unconnected with insurance.

For a scheme that meets the criteria above, IFRS 4 provides a temporary exemption that permits, but does not require, the scheme to apply IAS 39 rather than IFRS 9 for annual periods beginning before 1 January 2023.

When a Medical scheme has elected to apply the temporary exemption from IFRS 9, the Medical Scheme would be required to include additional disclosures per IFRS 4.39B, 39C, 38E-H. Refer to Appendix III for additional guidance.

A scheme that previously elected to apply the temporary exemption from IFRS 9 may at the beginning of any subsequent annual period irrevocably elect to apply IFRS 9.

79. IFRS 9 carries forward the scope as it was included under IAS 39, with some minor amendments. IFRS 9 also carries forward the recognition and de-recognition requirements of financial instruments as included under IAS 39, as well as the classification and measurement principles of IAS 39 for financial liabilities. However, movements in the fair value of a financial liability that relates to an entity's own credit risk, is presented in OCI. IFRS 9 carries forward the scope requirements under IAS 39 for derivatives where the host is not a financial asset. However, if a hybrid contract contains a host that is a financial asset, the instrument is not separated, instead the entire hybrid as a whole is assessed for classification.
80. 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)
81. 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.
82. 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 effected 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

83. 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:
1. 12 month expected credit losses; or
 2. Lifetime expected credit losses
84. The measurement generally depends on whether there has been 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

85. 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

86. IFRS 9 introduces new presentation requirements and IFRS 7 requires extensive new disclosure requirements as a result of the issue of IFRS 9.

The impact of IFRS 12 Disclosure of interests in other entities

87. 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.
88. 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.
89. Schemes should consider the level of detail that is needed to satisfy this objective, how much emphasis to place on each of the requirements, and to what extent it should aggregate the information.
90. 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

91. 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 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

92. If the Medical Scheme has any interests in unconsolidated structured entities such as collective investment schemes (which includes money market unit trusts), there are a number of disclosures that will apply. In summary, it has to provide:

- qualitative and quantitative information about the Medical 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 Medical 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 Medical 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

93. 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

94. 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

95. 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).
96. 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).
97. 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).
98. 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).
99. 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 the asset 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

100. 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

101. The most reliable evidence of fair value is a quoted price in an active market. When this is not available, 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).
102. 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).

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

- Market approach – 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).
- Cost approach – 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).
- Income approach – 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

104. 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).

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

Disclosure objective

106. IFRS 13 disclosure objective 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

107. 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 that are triggered by particular circumstances, e.g. an asset held for sale.

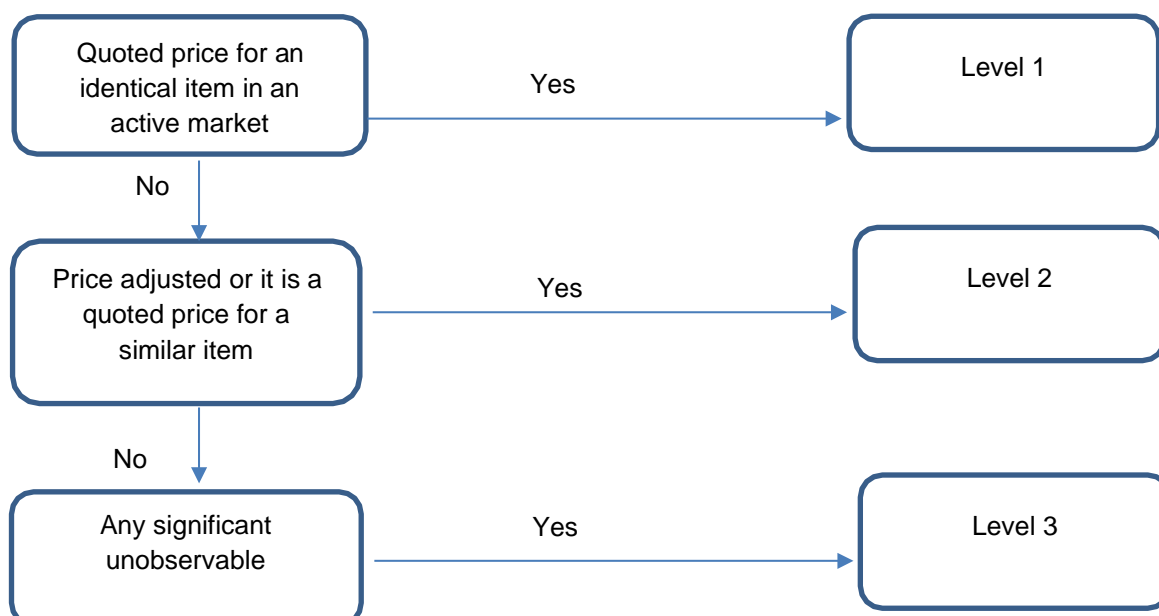
Fair value hierarchy

108. 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 be able to 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 either 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).

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



Specific disclosures required

110. 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 IFRS 13.93 (b), (d) and (i) as described above is required. However, an entity is not required to provide the quantitative disclosures about significant unobservable inputs used in the fair value measurement categories within level 3 fair value hierarchy required by IFRS 13.93 (d) as described above.

The impact of IFRS 16 Leases

111. 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).
112. 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.
113. In the statement 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 *Presentation of Financial Statements* requires to be presented separately in the statement of profit or loss and other comprehensive income.
114. 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 *Statement of Cash Flows* 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
115. 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 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

116. The amount of short-term leases and low value leases needs to be disclosed.

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

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

119. 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 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).

120. 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 that 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).

121. 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*

122. 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 advertising and promotional expenditure is recognised as an expense when it is incurred (IAS 38.69).

123. Cost of advertising and promotion, which include scheme brochures, benefit booklets and application forms, must be charged to expenses 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 they are performed by a supplier 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).

124. 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).

Contribution income

125. Gross contributions comprise risk contributions and Personal Medical Savings Account contributions and are determined and approved annually and included in the medical scheme rules. Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably assured. Risk contributions represent gross contributions after the deduction of Personal Medical Savings Account contributions. Risk contributions are recognised as revenue from the date of attachment of risk, over the indemnity period on a straight-line basis. For this reason, any unpaid contributions at the end of the accounting period are reflected as current assets, and any contributions received in advance are reflected as current liabilities. Risk transfer arrangement premiums/fees are not deducted from gross contributions, but are included with income and expenses from risk transfer arrangements. These amounts are disclosed separately.

126. In order for the overall size of a medical scheme's operations to be appreciated, the gross amount of contributions, which includes the contributions to personal medical savings accounts, is disclosed separately in the notes to the financial statements. The savings contributions do not meet the definition of income for the medical scheme, but are deposits received from members. Contributions disclosed are in respect of contributions that directly relate to the risks carried by the medical scheme before taking into account risk transfer arrangements.

127. In accordance with sections 26(1)(c) and 26(4) of the Act, a medical scheme is not allowed to collect fees payable by a member to a third party, e.g. a funeral fund, on behalf of that third party. Therefore, gross contributions should not include such fees. Gross contributions should only include contributions made in terms of the rules of the medical scheme, which must be in compliance with the Act.
128. 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 becoming due.

Relevant healthcare expenditure

129. Relevant healthcare expenditure consists of net claims incurred, accredited managed healthcare services (no risk transfer) and net income or expense from risk transfer arrangements.

Recognition of claims

130. In medical schemes, the insured event is the provision of a healthcare service to a member. Consequently, claims are recognised in the period that services are delivered to a member (i.e. on a day-by-day basis).

Net risk claims incurred

131. When accounting for claims, a medical scheme recognises the total estimated cost of settling all claims arising from healthcare costs that have been incurred in the period in terms of the scheme's registered rules, net of discounts, third party recoveries and recoveries from members for co-payments and personal medical savings accounts, whether or not reported by the end of the period. Provisions are made at the reporting date for the estimated cost of all claims not settled at that date, whether arising from events occurring during that period or earlier periods, and whether or not reported before the close of the accounting period.
132. Accordingly, the charge for claims for the accounting period will include not only amounts paid or payable relating to current period events but also payments made during the period relating to costs that have occurred previously and for which no provision was made.
133. With reference to paragraphs 131 and 132 above, claims incurred include the following items:
- Claims submitted and accrued for services rendered during the accounting period, net of discounts, third party recoveries and recoveries from members for co-payments and personal medical savings accounts;
 - Payments under provider contracts for services rendered to members;
 - Movement in the provision for outstanding claims;
 - Own facility cost for services to members using own facilities (refer to paragraphs 161 - 164);
 - Claims settled in terms of risk transfer arrangements (refer to paragraphs 136 – 144); and

- Charges for accredited managed healthcare services (excluding risk transfer arrangements).

134. Recoveries under risk transfer arrangements should not be netted off against claims incurred, but disclosed under the income / (expense) from risk transfer arrangements.

Accredited managed healthcare services (no risk transfer)

135. 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 as they directly impact on the delivery of cost-effective and appropriate healthcare benefits to beneficiaries of medical schemes.

Net profit/ (loss) on risk transfer arrangements

136. 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.

137. 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.

138. Income and expenses that relate to risk transfer arrangements are disclosed separately in the statement of comprehensive income. Risk transfer arrangement fees are recognised as an expense over the indemnity period on a straight-line basis.

139. The claims incurred under member insurance contracts and the equivalent claims recoveries are presented in the statement of comprehensive income on a gross basis. Amounts recoverable under risk transfer arrangements are recognised in the same year as the related claims. The claims incurred liability under risk transfer arrangements and the equivalent receivable are also presented in the statement of financial position on a gross basis.

140. 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.

141. IFRS 4 requires the medical scheme to assess each contract separately for determining whether there is a transfer of significant insurance risk. The risk being transferred is evaluated for each contract in isolation and is not compared to the value of total claims. IFRS 4 also requires the claim and recovery to be shown on the gross basis.

142. 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 has been estimated, a recovery under the risk transfer arrangement is then recognised, to the value of the estimated claim.

143. There are instances where actual recoveries are due from the third party as contracted under the arrangement. These would also be recognised on the gross basis and be in addition to the estimated recoveries under risk transfer arrangements.
144. A medical scheme should consider its assets under risk transfer arrangements (mainly comprising recoveries) for impairment. An asset under a risk transfer arrangement is considered to be impaired when there is objective evidence, as a result of an event that occurred after initial recognition of the asset, that the medical scheme may not receive all amounts due to it under the terms of the contract, and that event has a reliably measurable impact on the amounts that the scheme will receive under the risk transfer arrangement.

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 for the specified members per the capitation contract for the year to B was R50 000.

Journal 1 – Recognition of total capitation fee paid

A would account for the capitation fee as follows:

Dr. Capitation fee (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. Claims (P/L) [Value of the claims incurred from members]	70 000
Cr. Claims recoveries (P/L) [Capitation claims recovered from B]	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 that 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 costs it would have incurred to provide the 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 not aware of the incurred expense. However, based on past experience A recognised an IBNR provision 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 member. The journal is as follows:

Dr. Claims incurred (P/L)	8 000
Cr. IBNR liability (SOFP)	8 000

Journal 4: On 31 December 20xx A was not aware 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 on the basis of 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. Recovery under risk transfer arrangements (SOFP)	8 000
Cr. Recovery under risk transfer arrangements (P/L)	8 000

Journal 5 and 6 – Recognition of capitation recovery

The correct estimate cost the scheme would have incurred to provide medical care to its members not yet reported as at 31 December 20xx was R10 000. On 10 January 20xx+1, A receives the information from B and confirmation that its estimate as at 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 incorrect. 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. The journals will be:

Dr. Claims Incurred (P/L)	2 000
Cr. IBNR Provision (SOFP)	2 000

Dr. Recovery under risk transfer arrangements (SOFP) 2 000
Cr. Recovery under risk transfer arrangements (P/L) 2 000

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. IBNR Provision (SOFP) 10 000
Cr. Recovery under risk transfer arrangements (SOFP) 10 000

In practice journals 5 to 7 will be processed simultaneously.

The effect of the transaction on the note disclosure for the outstanding risk claims provision will be as follows:

Outstanding Risk Claims provision	20XX+1 (after year end)	20XX
Opening Balance	8000	XXX
Changes to estimates recognised in		
Income/(expense)	2000	XXX
Claims Settled	(10000)	XXX
Claims Raised	XXX	8000
Closing Balance	XXX	8000

The effect of the transaction on the note disclosure for the recovery under risk transfer arrangements will be the same as presented for the IBNR provision above.

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

Claims Incurred	
Claims Paid by Scheme	XXX
Claims Settled	70 000
Outstanding Risk Claims Provision	8 000
Relevant transfer agreements (Capitation Agreement)	
Premiums/Fees paid	50 000
Claims Settled/Recoveries	(70 000)
Outstanding risk claims provision – Recoveries	(8000)
Relevant healthcare expenditure	

The total net effect of a risk transfer arrangement, which does not include a profit-sharing clause, on the income or expense is only the capitation premium/fee paid (in this example – the R50 000.)

Outstanding claims provision

145. The outstanding claims provision is a provision made for 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 provision is determined as accurately as possible on the basis of 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 provision is net of estimated recoveries from members for co-payments and personal medical savings accounts. The provision and its movement, including an under or over provision of the previous accounting periods, are disclosed separately. (Refer to paragraphs 43 - 47 of this guide for further details on the LAT.)

Trade and other payables (including claims reported not yet paid – accrual)

146. Recorded claims that have not been paid at the end of the accounting period are included in trade and other payables and disclosed separately as such. Outstanding cheques for claims are added back to the cash balance and included in trade and other payables (insurance payables).

Commercial reinsurance

147. 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.

Broker service fees

Broker fees (acquisition costs paid to brokers and fees paid for ongoing services)

148. 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 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" on the basis of the current contract. Acquisition costs are the costs that a medical scheme incurs to sell, underwrite and initiate a new insurance contract. Consideration should be given to related party relationships in transactions that relate to brokers' fees.

Other distribution costs

149. Distribution costs that are incurred under co-administration or other agreements are included under administration expenses or broker service fees in the statement of comprehensive income (in profit/loss) and are separately disclosed in the notes.

Administration expenses

150. In addition to the minimum disclosure on the face of the statement of comprehensive income in terms of IFRS, material income and expenses that are relevant to an understanding of the medical scheme's financial performance should be disclosed separately. Medical schemes may wish to split the expenditure between the *medical scheme* and *own facilities*.

151. 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 is effective for year-ends beginning 1 January 2021.

152. 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.

153. 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 155).
154. Medical schemes are required to disclose any payment or consideration made to trustees either on the face of the statement of 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.
155. Circular 48 of 2014 requires that the individual components of administration costs to 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

156. It should be noted that there is a distinct difference between disease management programmes, which makes 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.
157. 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' Personal Medical Savings Accounts). This type of services does not make use of the techniques as specified in the definition of managed healthcare and are therefore not included in accredited managed healthcare services.

158. 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 these services for efficiency or effectiveness.
159. 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).
160. These services are included in non-healthcare expenditure, as part of administration expenditure: benefit management services.

Own facility revenue

161. 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.

162. 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).
163. Benefits (services) rendered by the own facility to the medical scheme's members are included in the relevant expense category.

Grants

164. 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 comprehensive income as part of other income.

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

165. 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.

166. 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. This income is normally realised and should be accounted for separately from fair value movements. 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.
167. It should be considered further whether the underlying assets are classified as at fair value through profit or loss in terms of IAS 39/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.

IAS 39: For “available-for-sale” investments, fair value movements are recognised in other comprehensive income. Impairment losses are recognised in profit or loss. Interest is recognised in profit or loss, using the effective interest method. Dividends on available- for-sale equity instruments are recognised in profit or loss when the medical scheme’s right to receive payment is established (IAS 39.55(b)).

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

168. 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”.
169. 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 IAS 39.9/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

170. Some medical schemes provide for personal medical savings account 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.
171. 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' personal medical savings accounts in terms of the rules of the scheme.
172. Should the medical scheme's rules state that the PMSA monies belong to members, a trust relationship is created. Personal medical savings accounts accordingly 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. 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 rules of the scheme.
173. 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 and withdrawals (i.e. claims) when paid.
174. 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 recognise a trade receivable owing from the member.

175. Any advances on savings contributions are funded from the scheme's funds, and the risk of impairment is carried by the scheme.
176. Where interest accrued on the personal medical savings account liability in terms of the rules of the scheme, it is allocated based on the effective interest method.
177. Unexpended savings at the end of the accounting period are carried forward to meet future expenses for which the members are responsible.
178. It is practice within the medical schemes industry to unbundle the PMSA (deposit component) in terms of IFRS 4 and measure it separately in terms of IAS 39 / IFRS 9 because the personal medical savings accounts are managed separately.
179. Annexure B to Circular 41 of 2012 contains the required disclosure necessary to provide members with sufficient information on how the PMSA monies are managed on their behalf in those instances where a trust relationship had been created in the scheme's rules.
180. The deposit component meets the definition of a financial liability. In terms of IAS 39/IFRS 9, the fair value of a financial liability with a demand feature (refer to the requirements in terms of Regulation 10) is not less than the amount payable on demand, discounted from the first date that the amount could be required to be paid. The deposit component is therefore initially measured at fair value and subsequently at amortised cost, using the effective interest method.
181. This guide does not consider the treatment of embedded derivatives. Should schemes identify an embedded derivative within a contract, they should apply IFRS 9 unless IAS 39 is still applicable.

Offsetting and reclassification

182. IAS 1.32 - 35 does not allow for the offsetting of assets and liabilities unless required or permitted by an IFRS standard. All credit balances that are included in receivables as well as unallocated deposits need to be reclassified to current liabilities and debit balances that are included in payables to current assets.

Related party disclosures

183. 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.
184. Regulation 6A to the Act requires schemes to disclose specific detail per trustee relating to trustee remuneration.

Who are potential related parties to a medical scheme?

185. Each medical scheme needs to assess individually who its related parties are, considering its individual circumstances.
186. The following table considers the various parties with whom schemes would generally interact, and

considers 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.”

187. 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 schemes 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	<p>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:</p> <p>(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."</p> <p>Consider the definition in the following circumstances:</p> <ul style="list-style-type: none"> — Closed scheme – Sponsoring employer is probably related — Open scheme – employers not likely to be related.
2. Trustees	Consider part (a) (iii) of the Definition	<p>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:</p> <p>(iii) is a member of the key management personnel of the reporting entity or of a parent of the reporting entity."</p> <p><i>"Key management personnel"</i> 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)</p>
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	<p>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:</p> <p>(ii) has significant influence over the reporting entity"</p> <p><i>Consider if relevant to the scheme</i></p>

<p>7. Close family members of individuals identified in points 2-6 of this table.</p>	<p>Consider part (a) (ii) and (iii) of the definition</p>	<p><i>Close members of the family of a person</i> 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:</p> <ul style="list-style-type: none"> (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) <p>Specifically consider non-dependant family members that are in a related profession (e.g. son of trustee who is a doctor)</p>
<p>8. Administrators</p>	<p>Consider part (a) (iii) and (viii) of the definition</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>Administrators may not control a scheme (section 57(3) of the Act).</p> <p>IAS 24.11 "In the context of this Standard, the following are not related parties:</p> <ul style="list-style-type: none"> (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." <p>Administrators could, however, form part of the key management of the scheme – consider the following:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>In considering the management entity, the entity's parent, its subsidiaries and its fellow subsidiaries should be considered.</p> <p>Reference should also be made to IAS 24.11 (see paragraph 8 above).</p> <p>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:</p> <ul style="list-style-type: none"> (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). <p>Consider:</p> <ul style="list-style-type: none"> • 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	<p>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.</p> <p>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.</p> <p>Consider:</p> <ul style="list-style-type: none"> • Is the broker or investment manager an associate, joint venture or subsidiary of the scheme or its

		<p>administrator?</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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?

188. 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

189. 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

190. 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.

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

192. Schemes are reminded that the disclosure requirements as required per section 57³ of the Act, read together with Regulation 6A⁴, will also need to be met, which requires the remuneration and other

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

193. 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.
194. 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 entity is a venture;
 - Key management personnel of the entity; and
 - Other related parties.
195. 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.
196. 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

197. A state-controlled scheme is exempt from the disclosure requirements of paragraph 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.

198. 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?

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

200. 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.

201. The consolidated scheme financial statements must disclose all related party transactions even if potentially all of the income and expenses for such an entity may derive from related party transactions (disclosures required by IAS 24 are essential to understanding the financial position and financial performance of such an entity).

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 entity or by the entity on behalf of that related party.

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

Guarantees received by the medical scheme from a third party

203. 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.
204. 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

205. 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.

206. 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 credited 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)

207. 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 acknowledgment of a clause to this effect in the rules of the medical scheme.

208. The medical scheme has no direct relationship with the RAF. Receivables are therefore raised for amounts ceded by members once the medical scheme is notified of the amount to be paid over and the RAF has indicated that the claim is ready for payment because it is only at this time that the asset can be reliably measured. Receivables from the RAF should still be tested for possible impairment despite the RAF's notification of payment of the claim. To the extent that the asset cannot be reliably measured, the disclosure requirements for contingent assets should be considered (refer to IAS 37.89). IAS 37 states that contingent assets are only recognised once it becomes virtually certain that an inflow of economic benefits will arise. The asset and the related income are recognised in the financial statements of the period in which the change occurs.

209. Where material, recoveries from third parties are disclosed separately in the statement of comprehensive income as part of the net claims incurred subtotal.

Income/ (expense) per benefit option

210. 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. 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.

211. The accounting policies should state the manner in which the different line items in the statement of 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.

Consolidation

212. A medical scheme should prepare consolidated financial statements in terms of IFRS 10 *Consolidated Financial Statements*, if it has subsidiaries.
213. The medical scheme's results and financial position should be presented separately in separate financial statements consolidated results and financial position should be presented in consolidated financial statements.
214. The benefit option results and solvency calculation are based on scheme-only results.

The impact of IFRS 10 Consolidated Financial Statements

215. The impact of IFRS 10 *Consolidated Financial Statements* together with the impact of IFRS 3 *Business Combinations*, should be assessed by the medical scheme and discussed with the scheme's auditors, when it has entered into a business combination.
216. The following table provides a summary of the possible impact of IFRS 10 on medical schemes, which needs to be assessed:

IFRS Standard	Details	Impact
IFRS 10 <i>Consolidated Financial Statements</i>	<ul style="list-style-type: none"> 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: <ol style="list-style-type: none"> Power over the investee; Exposure or rights to variable returns from involvement with the 	<ul style="list-style-type: none"> 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

	<p>investee; and</p> <p>3. The ability to use power over the investee to affect the amount of the investor's returns.</p> <ul style="list-style-type: none"> • IFRS 10 states that for an investor to have power over the investee it must have existing rights that give it the current ability to direct the relevant activities of the investee. • In assessing power, only <i>substantive</i> rights and not protective rights are considered. 	<p>an investor that holds only protective rights do not have power over an investee.</p> <ul style="list-style-type: none"> • 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).
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Non-compliance matters

217. 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 CMS does not consider it sufficient to make reference to the relevant notes in the annual financial statements.

218. 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.

219. 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 but earlier adoption is welcome. 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;
 - Risk contributions 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; *
 - Non-healthcare expenditure per average beneficiary per month for the medical scheme as a whole and for each benefit option; *
 - Relevant healthcare expenditure as a percentage of risk contributions per benefit option (claims ratio);
 - Non-healthcare expenditure as a percentage of risk contribution income per 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 accumulated funds 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 enrolls 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 then 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 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 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 2021 annual financial statements, the Council for Medical Schemes (CMS) identified certain common problem areas regarding the application of IFRS. These problem areas are listed below to assist the schemes in the preparation of the 31 December 2022 financial statements.
2. Please note that reference should be made to IFRS 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.

Non-compliance matters

4. Section 37(5) of the Act requires that the Board of Trustees' report shall deal with every matter that is material for the appreciation by members. CMS considers all non-compliance matters to be of such a nature that it should be individually specified in the Board of Trustees' report.
5. All non-compliance matters included in the Board of Trustees' report must also be disclosed in a note to the annual financial statements.
6. Schemes are required to apply for exemption in terms of the Act if they do not comply with any provisions of the Act.
7. 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).
8. Corrective courses of action implemented would include exemptions obtained, suspension and termination of benefits in respect of outstanding contributions, and any other actions taken.
9. The following matter was specifically of concern during our 2021 analysis:
 - Section 33(2)(b) non-compliance was not disclosed: Benefit options need to be self-supporting in terms of financial performance at a net healthcare level.
10. Annexure B compliance monitoring: It was noted that many schemes incorrectly use investable assets as a denominator in the Annexure B percentage calculation instead of the assets calculated

in Regulation 30(2) and Regulation 30(3A). The denominator should be calculated as follows:

- Where the scheme's solvency exceeds 25%: The fair value of the liabilities plus the Regulation 29 funds; or
- Where the scheme's solvency is below 25%: The fair value of the liabilities plus the minimum required Regulation 29 funds (25% of the annualised contributions).

APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

These examples are intended mainly to illustrate some of the presentation and disclosure requirements of IFRS 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 rate risk and credit risk that IFRS 7 would have required, had the insurance contracts been within the scope of IFRS 7 (IFRS 4.39(d)). An illustrative sensitivity analysis required by IFRS 4.39 (c) (i) has also not been provided.

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, tax 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.

In terms of COVID-19 disclosures, each individual scheme should review the impact of its own facts and circumstances from a budget, sales, strategy, actuarial modelling and financial statements disclosure perspective.

1. ILLUSTRATIVE STATEMENT OF FINANCIAL POSITION

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			
Investment property			
Investments	Note 1		
Available-for-sale investments (IAS 39):			
Scheme			
Trust			
Financial assets at fair value through other comprehensive income (IFRS 9)			
Scheme			
Trust			
Financial assets at fair value through profit or loss (IAS 39/IFRS 9)			
Scheme			
Trust			
Loans and receivables (IAS 39) / Financial assets at amortised cost (IFRS 9)			
Current assets			
Investments	Note 1		
Available-for-sale investments (IAS 39)			
Scheme			
Trust			
Financial assets at fair value through other comprehensive income (IFRS 9)			
Scheme			
Trust			
Financial assets at fair value through profit (IAS 39/IFRS 9)			
Scheme			
Trust			
Loans and receivables (IAS 39) / Financial assets at amortised cost (IFRS 9)			
Cash and cash equivalents	Note 2		
Scheme			
Trust			
Total Assets			
FUNDS AND LIABILITIES			
Members' Funds			
Accumulated funds			
Property revaluation reserves			
Available-for-sale fair value reserve (IAS 39)			
Investments at fair value through other comprehensive income fair value reserve (IFRS 9)			
Non-current liabilities			
Retirement benefit obligations			
Finance lease liability			
Current liabilities			
Personal Medical Savings Account liability	Note 3		
Outstanding claims provision	Note 4		
Trade and other payables	Note 5		
Total funds and liabilities			

2. ILLUSTRATIVE STATEMENT OF COMPREHENSIVE INCOME

Name of Medical Scheme			
(Registration Number: 1234)			
STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 DECEMBER 20XX			
	Notes	20xx (CY)	20YY(PY)
Risk contribution income	Note 6		
Relevant healthcare expenditure	Note 7		
Net claims incurred	Note 7		
Risk claims incurred	Note 7		
Third party claims recoveries	Note 7		
Accredited managed healthcare services (no risk transfer)	Note 7		
Net (expense)/income on risk transfer arrangement	Note 7		
Risk transfer arrangement premiums paid			
Recoveries from risk transfer arrangements			
Profit/ (loss) share arising from risk transfer arrangements			
Gross healthcare result			
Net income/(expenses) on commercial reinsurance			
Commercial Reinsurance premiums paid			
Recoveries from commercial reinsurer			
Profit or loss share arising from commercial reinsurance			
Broker service fees	Note 7		
Administration fees and other operative expenses	Note 7		
Net impairment losses on healthcare receivables	Note 13.3.2		
Net healthcare result			
Other income			
Investment income	Note 8		
Income 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			
Interest paid on personal medical savings accounts	Note 8		
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 INCOME/ (EXPENSE) 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			
Available-for-sale investments – net change in fair value ⁵			
Available-for-sale investments – reclassification to profit or loss			
Reclassification adjustment on realised gains			
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 PERIOD, NET OF TAX			
TOTAL COMPREHENSIVE INCOME FOR THE YEAR			

⁵ 92 This disclosure would only be applicable to medical schemes that have deferred the implementation of IFRS

3 ILLUSTRATIVE STATEMENT OF CHANGES IN MEMBERS' FUNDS

Name of Medical
Scheme (Registration
Number: 1234)

STATEMENT OF CHANGES IN MEMBERS' FUNDS AND

RESERVES FOR THE YEAR ENDED 31 DECEMBER 20XX

	Link to Notes	Accumulated funds	Available for –sale- investment reserve ⁷ / Fair value through other comprehensive income investment reserve	Total members' funds
Balance as at 1 January 20YY				
Net income / (expense) for the year				
Other comprehensive Income				
Realised gains on disposal of available – for-sale investments (IAS 39)/ investments held through fair value through other comprehensive income (IFRS 9)				
Unrealised gains on revaluation of available- for- sale investments (IAS 39)/ investments held through fair value through other comprehensive income (IFRS 9)				
Total Comprehensive income				
Balance as at 31 December 20YY				
Balance as at 1 January 20XX				
Net income/ (expense) for the year				
Other comprehensive Income				
Realised gains on disposal of available- for-sale investments (IAS 39)/ investments held through fair value through other comprehensive income (IFRS 9)				
Unrealised gains on disposal of available- for-sale investments (IAS 39)/ investments held through fair value through other comprehensive income (IFRS 9)				
Total Comprehensive Income				
Balance as at 31 December 20XX				

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- contribution		
Cash receipts from members and provider – Other		
Cash paid to providers, employees and Members		
Cash paid to providers and employees- claims		
Cash paid to providers and employees- non healthcare 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)/Increase in borrowings		
Other (specify)		
Net cash from(used in) financing activities		
Net increase/(decrease) in cash and cash equivalents		
Cash and cash equivalents		
-as previously reported		
-Prior year adjustment		
Other (specify)		
Net cash flows upon consolidation		
Transfer of cash and cash equivalents due to Amalgamation		
Cash and cash equivalents at the end of the year (scheme and PMSA trust)		

STANDARDS AND INTERPRETATIONS ISSUED BUT NOT YET EFFECTIVE

The following IFRS and amendments to IFRS may affect financial statements for annual periods ending on 31 December 2022. The table was drawn up in October 2022 and may not include all pronouncements subsequent to that date, 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 2023	IFRS 17 <i>Insurance Contracts</i>	<p>IFRS 17 will impact the measurement of the contracts with members in the scheme's financial statements. The scheme will qualify for the premium allocation approach which requires the scheme to recognise a liability for remaining coverage (with reference to the premiums received) and a liability for incurred claims (calculated as the expected cash outflows and a risk adjustment). The scheme expects that the boundary of the contracts with members will be one year. The scheme will be required to assess for onerous contracts at the point members elect the benefit option for the following year based on relevant facts and circumstances.</p> <p>The standard should be applied retrospectively.</p> <p>Each scheme should add their own progress to adhere to the requirements of IAS 8. 31d</p>	Yes
IFRS 17, Insurance contracts Amendments	<p>Annual periods beginning on or after 1 January 2023</p> <p>(Published June 2020)</p>	In response to some of the concerns and challenges raised, the Board developed targeted amendments and a number of proposed clarifications intended to ease implementation of IFRS 17, simplify some requirements of the standard and ease transition. The amendments relate to eight areas of IFRS 17, and they are not intended to change the fundamental principles of the standard or unduly disrupt implementation already underway.	Yes, only if IFRS 17 is applied early

Annual periods beginning on or after 1 January 2022	Reference to the Conceptual Framework (Amendments to IFRS 3)	<p>The amendment updates a reference in IFRS 3 to the Conceptual Framework for Financial Reporting without changing the accounting requirements for business combinations.</p> <p>Reporting, in order to determine what constitutes an asset or a liability in a business combination.</p> <p>In addition, the Board added a new exception in IFRS 3 for liabilities and contingent liabilities. The exception specifies that, for some types of liabilities and contingent liabilities, an entity applying IFRS 3 should instead refer to IAS 37, 'Provisions, Contingent Liabilities and Contingent Assets', or IFRIC 21, 'Levies', rather than the 2018 Conceptual Framework.</p> <p>The Board has also clarified that the acquirer should not recognise contingent assets, as defined in IAS 37, at the acquisition date.</p>	Yes
Annual periods beginning on or after 1 January 2023	IAS 1 Presentation of Financial Statements	<p><i>Classification of Liabilities as Current or Non-current:</i> 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.</p> <p>There is limited guidance on how to determine whether a right has substance and the assessment may require management to exercise interpretive judgement.</p> <p>The existing requirement to ignore management's intentions or expectations for settling a liability when determining its classification is unchanged.</p> <p><i>Disclosure of Accounting Policies:</i> 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.</p>	Yes
Annual periods beginning on or after 1 January 2023	Definition of Accounting Estimates (Amendments to IAS 8)	<p>The amendments clarify how companies should distinguish changes in accounting policies from changes in accounting estimates, by replacing the definition of a change in accounting estimates with a new definition of accounting estimates. Under the new definition, accounting estimates are "monetary amounts in financial statements that are subject to measurement uncertainty". The requirements for recognising the effect of change in accounting prospectively remain unchanged.</p>	Yes

Annual periods beginning on or after 1 April 2021 (early adoption is permitted) (Published March 2021)	COVID-19 Related Rent Concessions (Amendments to IFRS 16)	The IASB has provided lessees (but not lessors) with relief in the form of an optional exemption from assessing whether a rent concession related to COVID-19 is a lease modification, provided that the concession meets certain conditions. On 31 March 2021, the IASB published an additional amendment to extend the date of the practical expedient from 30 June 2021 to 30 June 2022. Lessees can elect to account for such rent concessions in the same way as they would if they were not lease modifications. In many cases, this will result in accounting for the concession as variable lease payments in the period(s) in which the event or condition that triggers the reduced payment occurs. The March 2021 amendment will only be available if an entity chose to apply the May 2020 optional practical expedient.	Yes
Annual periods beginning on or after 1 January 2022	IAS 37 - Onerous Contracts: Cost of Fulfilling a Contract	Amendments to IAS 37, clarify that the 'costs of fulfilling a contract' when assessing whether a contract is onerous comprise both: <ul style="list-style-type: none"> the incremental costs – e.g. direct labour and materials; and an allocation of other direct costs – e.g. an allocation of the depreciation charge for an item of property, plant and equipment used in fulfilling the contract. 	Yes
Annual periods beginning on or after 1 January 2022	IFRS 9 Financial Instruments	Annual Improvements to IFRS Standards 2018-2020: The amendment clarifies that for the purpose of performing the "10 per cent test" for derecognition of financial liabilities – in determining those fees paid net of fees received, a borrower includes only fees paid or received between the borrower and the lender, including fees paid or received by either the borrower or lender on the other's behalf.	Yes
Annual periods beginning on or after 1 January 2022	Annual improvements cycle 2018 -2020	IFRS 16, 'Leases', amendment to the Illustrative Example 13 that accompanies IFRS 16 to remove the illustration of payments from the lessor relating to leasehold improvements. The amendment intends to remove any potential confusion about the treatment of lease incentives.	Yes

EXTRACTS FROM THE PRINCIPLE ACCOUNTING POLICIES WHICH RELATE SPECIFICALLY TO MEDICAL SCHEMES

1. INVESTMENTS ACCOUNTING POLICY

Financial assets under IAS 39 (only applicable to schemes that qualify and elected to defer IFRS 9)

Recognition and derecognition

The scheme initially recognises loans and receivables and debt securities issued on the date when they are originated. All other financial assets are initially recognised on the trade date when the entity becomes a party to the contractual provisions.

The scheme derecognises a financial asset when the contractual rights to the cash flows from the asset expires, 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 control over the transferred asset. Any interest in such derecognised financial asset that is created or retained by the scheme is recognized as a separate asset or liability.

Initial measurement

Financial assets are initially measured at fair value plus any directly attributable transaction costs except for financial asset through profit and loss where the directly attributable transaction costs are recognised in profit or loss as incurred.

Classification and subsequent measurement

The scheme classifies its financial assets in the following categories: at fair value through profit or loss, loans and receivables, and available for sale. The classification depends on the purpose for which the financial assets were acquired. Management determines the classification of its financial assets at initial recognition.

(a) Financial assets at fair value through profit or loss

Financial assets at fair value through profit or loss are financial assets held for trading. A financial asset is classified in this category if acquired principally for the purpose of selling in the short term. Assets in this category are classified as current assets if expected to be settled within 12 months, otherwise they are classified as non-current.

Financial assets at fair value are measured at fair value and changes therein, including any interest and dividend income are recognised in profit or loss.

Gains or losses arising from changes in the fair value of the 'financial assets at fair value through profit or loss' category are presented in the statement of comprehensive income within 'investment income' in the period in which they arise. Dividend income from financial assets at fair value through profit or loss is recognised in the statement of comprehensive income as part of investment income when the scheme's right to receive payments is established.

(b) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets, except for maturities greater than 12 months after the end of the reporting period. These are classified as non-current assets.

Subsequent to initial recognition, they are measured at amortised cost using the effective interest rate method.

(c) Available-for-sale financial assets

Available-for-sale financial assets are non-derivatives that are either designated in this category or not classified in any of the other categories. They are included in non-current assets unless the investment matures or management intends to dispose of it within 12 months of the end of the reporting period.

Subsequent to initial recognition, they are measured at fair value and changes therein, other than impairment losses, interest income and foreign currency differences on debt instruments are recognised in OCI and accumulated in the fair value reserve. When these assets are derecognised, the gain or loss accumulated in equity is reclassified to profit or loss.

Interest on available-for-sale securities calculated using the effective interest method is recognised as part of investment income. Dividends on available-for-sale equity instruments are recognised as part of investment income when the scheme's right to receive payments is established (IAS 39).

(d) Held to maturity financial assets

These assets are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, they are measured at amortised cost using the effective interest rate method.

Impairment

(a) Assets carried at amortised cost

The scheme assesses at the end of each reporting period whether there is objective evidence that a financial asset or group of financial assets is impaired. A financial asset or a group of financial assets is impaired and impairment losses are incurred only if there is objective evidence of impairment as a result of one or more events that occurred after the initial recognition of the asset (a 'loss event') and that loss event (or events) has an impact on the estimated future cash flows of the financial asset or group of financial assets that can be reliably estimated.

For loans and receivables category, the amount of the loss is measured as the difference between the asset's carrying amount and the present value of estimated future cash flows (excluding future credit losses that have not been incurred) discounted at the financial asset's original effective interest rate. The carrying amount of the asset is reduced and the amount of the loss is recognised in the statement of comprehensive income. Where the carrying amount of the asset is reduced through the use of an allowance account, it is written off against the allowance account. Subsequent recoveries of amounts previously written off are credited as other income or against operating expenses in profit or loss. If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised (such as an improvement in the debtor's credit rating), the reversal of the previously recognised impairment loss is recognised in the statement of comprehensive income.

(b) Assets classified as available-for-sale

The scheme assesses at the end of each reporting period whether there is objective evidence that a financial asset or a group of financial assets is impaired. For debt securities, if any such evidence exists the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in profit or loss.

If, in a subsequent period, the fair value of a debt instrument classified as available for sale increases and the increase can be objectively related to an event occurring after the impairment loss was recognised in profit or loss the impairment loss is reversed through profit or loss.

For members' funds' investments, a significant or prolonged decline in the fair value of the equity securities below its cost is also evidence that the assets are impaired. If any such evidence exists, the cumulative loss – measured as the difference between the acquisition cost and the current fair value, less any impairment loss on that financial asset previously recognised in profit or loss – is removed from equity and recognised in profit or loss.

Financial assets under IFRS 9 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, mandatorily 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 in 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 principle and interest on principle 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

- its contractual terms give rise to cash flows that are solely payments of principle and interest on principle amount outstanding on specified dates.

On initial recognition of an equity instrument that is not held for trading, the scheme may irrevocable 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 meet 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.

Financial assets that are held for trading or are managed and whose performance is evaluated on a fair value basis are measures at fair value through profit or loss.

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 recognised in profit or loss.

(b) Financial instruments under amortised cost

These assets are subsequently measured at amortised cost using the effective interest rate method. 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 other gains/(losses) together with foreign exchange gains and losses. Impairment losses are presented as separate line item in the statement of profit or loss and reduces the amortised cost of the financial asset.

(c) Debt instrument at fair value through other comprehensive income

These assets are subsequently measured at fair value. Movements in the carrying amount are taken through OCI, except for the recognition of 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 and recognised in profit or loss. Interest income from these financial assets is included in finance income using the effective interest method. Impairment expenses are presented as separate line item in the statement of comprehensive income.

(d) Equity instruments at fair value through other comprehensive income

These assets are subsequently measured at fair value. Dividends are recognised as 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 expires, 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 either all or substantially all of the risks and rewards of the transferred assets. In these cases, the transferred asset is not derecognised.

Impairment

(a) Trade receivables

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, the scheme applies the simplified approach permitted by IFRS 9, which requires expected lifetime losses to be recognised from initial recognition of the receivables.

Each entity to include specifics on how they have determined their simplified approach. The guidance in IFRS 9.5.5.15 should be used.

(b) Debt investments and carried at amortised cost

For debt investments and other instruments at amortised cost the scheme assesses on a forward looking basis the expected credit losses associated with its debt instruments carried and other instruments at amortised cost and FVOCI. The impairment methodology applied depends on whether there has been a significant increase in credit risk.

Each entity to include specifics on how they have determined their impairment methodology. The guidance in IFRS 9.5.5 should be used.

(c) Debt investments carried at FVOCI

Debt investments at fair value through other comprehensive income (FVOCI) include listed and unlisted debt securities. The loss allowance for debt investments at FVOCI is recognised in profit or loss.

Each entity to include specifics on how they have determined their 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 and must be enforceable in the normal course of business and in the event of default, insolvency or bankruptcy of the counterparty.

Offsetting financial instruments		
	20XX R'000	20YY R'000
INVESTMENTS		
Scheme		
Listed equity securities		
Unlisted 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
TRADE AND OTHER RECEIVABLES		
Insurance receivables		
Contributions receivable		
Recoveries from members and suppliers		
Total receivables arising from insurance contracts		
Financial assets		
Trade and other receivables		
Sundry receivables		
Total arising from financial receivables		
Total trade and other receivables		

2. CASH AND CASH EQUIVALENTS

ACCOUNTING POLICY

In the statement of cash flows, cash and cash equivalents includes 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 EQUIVALENTS⁶

	20XX R'000	20YY R'000
Scheme		
Bank accounts		
<i>Personal medical savings account trust monies invested</i>		
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 the 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. 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 (which are a deposit component of the insurance contracts), 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.

The deposit component of the insurance contracts has been unbundled, since the scheme can measure the deposit component separately. The deposit component is recognised in accordance with IAS 39/IFRS 9 and is initially measured at fair value and subsequently at amortised cost using the effective interest method. The insurance component is recognised in accordance with IFRS 4.

Unspent savings at year end are carried forward to meet future expenses for which the members are

⁶ All items disclosed as cash and cash equivalents should meet the definition of cash and cash equivalents in IAS 7 paragraph 6.

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.

Advances on savings contributions are funded from the scheme's funds and the scheme will assess the advances for impairment [please refer to IAS 39/IFRS 9 impairment accounting policy].

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.

NOTE DISCLOSURE

MEDICAL SAVINGS ACCOUNT MONIES MANAGED BY THE SCHEME ON BEHALF OF ITS MEMBERS

	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:		
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 <i>OR where a trust relationship exists</i> 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 enrolls in another benefit option or medical scheme without a personal medical savings account or does not enroll in another medical scheme.

Interest is paid in terms of the rules of the scheme on the personal medical savings accounts on a monthly basis, based on the effective interest method.

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).

Advances on personal medical savings accounts are funded by the scheme and are included in trade and other receivables. The scheme does not charge interest on advances on personal medical savings accounts.

A constitutional court judgment on 6 June 2017 found that Personal Medical Savings Account (PMSA) funds enter the scheme's bank account without being impressed by a trust or fiduciary relationship. 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 medical schemes may keep interest accruing from PMSAs in its bank account. The scheme rules shall determine whether PMSA assets are invested in separate bank or investment accounts and whether interest will be allocated to members with positive PMSA balances.

The effect of the judgment on the annual financial statements is summarised as follows:

- *The word “trust” in reference to PMSA assets and liabilities is no longer required;*
- *As there is no longer a legal requirement to separately invest PMSA assets, the separate disclosure on the face of the Statement of Financial Position is no longer required and these are now included as part of Cash and Cash Equivalents or Investments;*
- *The following changes have been made to the notes to the annual financial statements. Note X Cash and Cash Equivalents – Personal Medical Savings Account trust assets to the annual financial statements is no longer required and has been included under Note X Cash and Cash Equivalents;⁷*
- *Interest is allocated to members with positive PMSA balances in accordance with the rules of the scheme.*

Unclaimed monies are written back to scheme funds to the extent that it has prescribed in terms of the Prescription Act 69 of 1969.

OR

In accordance to the scheme’s rules the Personal Medical Savings Account (PMSA) monies belong to the members. This resulted in the creation of a trust relationship between the scheme and the member. Personal medical savings accounts accordingly 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.

Personal medical savings are invested separately from scheme funds, which are further clarified by section 4(5) of the Financial Institutions (Protection of Funds) Act 28 of 2001.

Unclaimed monies are paid over to the Guardian’s Fund after five years in accordance with the Administration of Estates Act 66 of 1965.

⁷ Where the rules of the scheme required PMSA assets to be invested separately, these assets should be identified in the Cash and cash equivalents note. Where the rules of the scheme do not require PMSA assets to be separately invested (i.e. no trust relationship had been created), these assets do not need to be separately disclosed

4. TRADE AND OTHER PAYABLES ACCOUNTING POLICY

ACCOUNTING POLICY

Trade payables are obligations to pay for goods or services that have been acquired in the ordinary course of business from suppliers. Accounts payable 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 recognized initially at fair value and subsequently measured at amortised cost using the effective interest method.

NOTE DISCLOSURE

	20XX R'000	20YY R'000
Trade and other payables		
Insurance liabilities		
-Risk contributions receivable		
-Reported claims (contributions outstanding)		
Member + Service provider claims receivable		
Total liabilities arising from insurance contracts		
Financial Liabilities		
Sundry account Receivable		
Current portion of non-current borrowings		
Total arising from any financial trade receivables		
Total trade and other payables		
Reported claims not yet paid		
Balance at beginning of year		
Movements of year [specify]		
Balance at end of year		

5. OUTSTANDING RISK CLAIMS PROVISION

ACCOUNTING POLICY

Outstanding risk claims

Outstanding risk claims comprise provisions for the scheme's estimate of the ultimate cost of settling all claims incurred but not yet reported at the reporting date. Outstanding risk claims are determined as accurately as possible on the basis of a number of factors, which 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.

Estimated co-payments and payments from personal medical savings accounts are deducted in calculating the outstanding risk claims provision. The scheme does not discount its provision for outstanding risk claims, since the effect of the time value of money is not considered material.

Liabilities and related assets under the liability adequacy test

The liability for insurance contracts is tested for adequacy by discounting current estimates of all future contractual cash flows and comparing this amount to the carrying value of the liability net of any related assets (i.e. the value of the business acquired).

Where a shortfall is identified, an additional provision is made and the scheme recognises the deficiency in the profit/loss for the year.

NOTE DISCLOSURE

Please note that comparatives have not been presented in these illustrative financial statements but would be required to be shown in a full set of financial statements.

	Covered by risk transfer arrangements Commercial Other	Not covered by risk transfer arrangements	Total
20XX			
Provision for outstanding risk claims – incurred but not yet reported			
Provision arising from liability adequacy test			
Analysis of movements in outstanding risk claims			
Balance at the beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment of current year			
Balance at end of year			
Analysis of movements in provision arising from liability adequacy test			
Balance at the beginning of year			
Payments in respect of prior year			
Over/under provision in prior year			
Adjustment for current year			
Balance at year end			
Analysis of outstanding risk claims provision			
Estimated gross claims per registered rules			
Outstanding risk claims provision relating to risk transfer agreement			
Balance at year end			

Estimated recoveries from co-payments and personal medical savings accounts are Rxx (20yy: Ryy)

Analysis of outstanding risk claims provision			
Estimated gross claims per registered rules			
Outstanding risk claims provision relating to risk transfer agreement			
Less: estimated recoveries from co-payments personal medical savings account			
Balance at end of year			

Process used to determine the assumptions

This note disclosure should be on the basis of the actual processes used by the scheme to determine its assumptions. It is expected that this will differ among schemes. Schemes should consider obtaining input from their actuaries and consultants in compiling this note. Refer to paragraphs 36 to 39 and IG11 to IG71 of IFRS 4 for specific items that should be addressed in the disclosure.

Process used to determine the assumptions

The process used to determine the assumptions is intended to result in a neutral estimate of the most likely or expected outcome or to provide a given level of assurance. The sources of data used as inputs for the assumptions are internally obtained.

In determining the estimate there is more emphasis on current trends taking past experience into account. However, the ultimate liabilities may vary as a result of subsequent developments.

Assumptions

The assumptions that have the greatest effect on the measurement of the outstanding risk claims provision are the expected claims ratios for the most recent benefit years for the in-hospital, chronic and above-threshold categories of claims. These are used for assessing the outstanding risk claims provisions for the 20xx and 20yy benefit years. The expected claims ratio assumed for the benefit years 20xx and 20yy is XX% and XX% respectively for in-hospital, XX% and XX% respectively for chronic and XX% and XX% respectively for above- threshold benefits.

Changes in assumptions and sensitivities to changes in key variables

The table below outlines the sensitivity of insured liability estimates for reasonable possible movements in assumptions used in the estimation process. It should be noted that this is a deterministic⁹ approach with no correlations between the key variables.

Where variables are considered to be immaterial, no impact has been assessed for insignificant changes to these variables. Particular variables may not be considered material at present. However, should the materiality level of an individual variable change, assessment of and reasonable changes to that variable in the future may be required.

An analysis of sensitivity around various scenarios for the general medical insurance business provides an indication of the adequacy of the scheme's estimation process. The scheme believes that the liability for claims reported in the statement of financial position is adequate. However, it recognises that the process of estimation is based on certain variables and assumptions, which could differ when claims arise.

⁹ [Algorithm](#), [model](#), [procedure](#), process, etc., whose resulting [behaviour](#) is entirely determined by its initial state and inputs, and which is not [random](#) or [stochastic](#). [Processes](#) or [projects](#) having only one outcome are said to be deterministic their outcome is 'pre-determined.' A deterministic algorithm, for example, if given the same [input information](#) will always [produce](#) the same [output](#) information Source: *Business Dictionary.com*

Impact on members' funds reported caused by reasonable possible changes in key variables

	Change in variable	Change in liability	Change in liability
	%	20xx R'000	20yy R'000
Chronic claims ratio Above-threshold benefit claims ratio			
Inflation Manual claims as percentage of total claims			

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 liabilities will result in decreases in members' funds and vice versa. These reasonable possible changes in key variables do not result in any changes directly in reserves.

6. RISK CONTRIBUTION INCOME

ACCOUNTING POLICY

Contributions on member insurance contracts are accounted for monthly when their collection in terms of the insurance contract is reasonably certain. Risk contributions represent the gross contributions per the registered rules after the unbundling of savings contributions. The earned portion of risk contributions received is recognised as revenue. Risk contributions are earned from the date of attachment of risk, over the indemnity period on a straight-line basis. Risk contributions are shown before the deduction of broker service fees and other acquisition costs.

NOTE DISCLOSURE

RISK CONTRIBUTION INCOME

20xx

20yy

Gross contributions per registered rules Less:

Personal medical savings account contributions received*

Risk contribution income per statement of comprehensive income

*The Savings contributions are received by the scheme in terms of Regulation 10(1) and the scheme's registered rules and held in trust on behalf of its members. Refer to note x to the financial statements for more detail on how these monies were utilised.

7. RELEVANT HEALTHCARE EXPENDITURE ACCOUNTING POLICY

Road Accident Fund recoveries

Recoveries from the Road Accident Fund are recognised on a receipt basis and are netted off against claims expenditure.

Risk claims incurred

Risk claims incurred comprise the total estimated cost of all claims arising from healthcare events that have occurred in the year and for which the scheme is responsible in terms of its registered rules, whether or not reported by the end of the year. Risk claims incurred represent claims incurred net of discounts received, recoveries from members for co-payments and personal medical savings accounts. Net risk claims incurred represent risk claims incurred after taking into account recoveries from third parties.

Relevant healthcare expenditure

Relevant healthcare expenditure consists of net claims incurred and net income or expense from risk transfer arrangements.

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 contracts issued by the scheme and that meet the classification requirements of insurance contracts 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 are recognised as an expense over the indemnity period on a straight-line basis. Where applicable, a portion of risk transfer premiums/fees is treated as pre-payments.

Risk transfer claims and benefits reimbursed are presented in the statement of comprehensive income and statement of financial position on a gross basis.

Assets relating to risk transfer arrangements include balances due under risk transfer arrangements for outstanding risk claims provisions and claims reported not yet paid. Amounts recoverable under risk transfer arrangements are estimated in a manner consistent with the risk claims provisions, claims reported not yet paid, and settled claims associated with the risk transfer arrangement taking into account the terms of the contract. The amounts recoverable under such contracts are recognised in the same year as the related claim.

Amounts recoverable under risk transfer arrangements are assessed for impairment at each reporting date. Such assets are deemed impaired if there is objective evidence, as a result of an event that occurred after its initial recognition, that the scheme may not recover all amounts due and that the event has a reliably measurable impact on the amounts that the scheme will receive under the risk transfer arrangement.

NOTE DISCLOSURE		
	20XX R'000	20YY R'000
Claims incurred excluding claims incurred in respect of risk transfer arrangements		
Current year claims per registered rules		
Services provided to member in own facilities		
Movement in outstanding risk claims provision		
Over/under provision in prior year		
Adjustment for current year		
Claims paid from personal medical savings accounts*		
Accredited managed healthcare services		
Claims incurred in respect of risk transfer arrangements		
Current-year claims incurred in respect of risk transfer arrangements		
Movement in outstanding risk claims provision		
Over/under provision in prior year		
Adjustment for current year		
Movement in provision arising from liability adequacy test		
Over/under provision in prior year		
Adjustment for current year		
Third party claims recoveries		
Net claims incurred per the statement of comprehensive income		

*Claims are paid on behalf of the members from their personal savings accounts in the terms of Regulation 10(3) and the scheme's registered benefits. Refer to note x to of the financial statements for a breakdown of the movement in these balances.

Net income/ (expense) on risk transfer arrangements

Premiums/fees paid

Claims incurred in respect of related risk transfer arrangements Recoveries received

Net income/ (expense)

[Disclosure is required for all risk transfer arrangements and reinsurance arrangements entered into by the scheme with the total reconciling to the statement of comprehensive income.]

	20XX R'000	20YY R'000
ACCREDITED MANAGED HEALTHCARE SERVICES		
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) - required for year-end beginning 1 January 2021		
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) - required for year-end beginning 1 January 2021		
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		
Broker service fee		
Broker fees		
Other distribution costs paid to brokers		

APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

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	Accom- modation 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].

8. INVESTMENT INCOME

	20XX R'000	20YY R'000
Interest and dividend income		
Financial assets at fair value through profit or loss:		
-Dividend income		
-Interest income		
Available-for-sale financial assets (IAS 39)		
-Dividend income		
-Interest income		
Loans and receivables (IAS 39) / Financial instruments at amortised cost (IFRS 9)		
-Interest income		
Financial asset at fair value through OCI (IFRS 9)		
-Dividend income		
-Interest income		
Equity instruments		
-Dividend income		
Cash and cash equivalents		
-Interest income		
Net gains or losses		
Members' personal savings account trust investments		
<i>Cash and cash equivalents interest income</i>		
8.1 Net realised gains or losses available –for-sale financial assets (IAS 39)		
Realised gains on financial assets available-for-sale:		
-Equity securities		
-Money market		
Realised losses on financial assets available-for-sale:		
-Equity securities		
-Money market		
8.2 Net gains or losses on financial assets at fair value through profit or loss		
Net fair value gains on financial assets at fair value through profit or loss (IAS 39 and IFRS 9), including derivatives:		
-Equity Securities		
-Money Market		
Net fair value gains on financial assets at fair value through other comprehensive income (IFRS 9)		
-Equity Securities		
-Money Market		
Other Income		
Interest on balances due by administrator		
Unallocated amounts written back as prescribed		
Outdated cheques written back		
Interest Paid		
Financial liabilities not at fair value through profit or loss:		
Interest on personal medical savings accounts monies		

9. INCOME/ (EXPENSE) ON OWN FACILITY

ACCOUNTING POLICY

Own facility

The revenue generated on own facilities is measured at the fair value of the consideration received or receivable and represents amounts receivable for services provided in the normal course of business to third parties, net of discounts. 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 per benefit Option		
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.

10. 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:

- Risk contributions;
- Risk claims incurred;
- Net income/(expense) on risk transfer arrangement fees;
- Managed care: management services;
- Administration fees;
- Broker fees; and
- 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	ACB 70/100 Option	ACB Major Events Option	Total Scheme
	R'000	R'000	R'000	R'000
20XX				
[insert line per statement of comprehensive income]				
Income/(Expense) for the year				
Number of members				
Number of beneficiaries				
Average age				
Pensioner ratio				
20YY				
[Insert line per statement of comprehensive income]				
Income/(Expense)for the year				
Number of members				
Number of beneficiaries				
Average age				
Pensioner Ratio				

11. CRITICAL ACCOUNTING JUDGEMENTS AND AREAS OF KEY SOURCES OF ESTIMATION UNCERTAINTY

ACCOUNTING POLICY

This illustrative note only addresses areas of critical accounting judgment and areas of 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.

The calculation of the provision for outstanding risk claims is based on various factors *[insert key factors applicable to scheme]*.

OR

There are some sources of estimation uncertainty that have to be considered in the estimate of the liability arising from claims made under insurance contracts. Initial estimates are made by insurance staff in relation to the best calculations on reported claims and derived as the claims process develops. All estimates are revised and adjusted at year end by management. On intimated claims a calculation using an XXX claims reserving method on historical data is performed.

12. INSURANCE RISK MANAGEMENT

Please note that the disclosure provided below should be tailored for the scheme and boilerplate disclosure should not be used.

ACCOUNTING POLICY

Insurance contracts

Contracts under which the scheme accepts significant insurance risk from another party (the member) by agreeing to compensate the member or other beneficiary if a specified uncertain future event (the insured event) adversely affects the member or other beneficiary are classified as insurance contracts. The contracts issued compensate the scheme's members for healthcare expenses incurred.

NOTE DISCLOSURE

Risk-management objectives, policies, processes and methods for mitigating insurance risk

The primary insurance activity carried out by the scheme assumes the risk of loss from members and their dependants that are directly subject to the risk. 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 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 and 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 risk contribution income and claims 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.

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

Age Grouping in years		In- Hospital		Chronic		Day-to-day	Total
		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 consumed by members 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.

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.

Risk in terms of risk transfer arrangements

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%	-	-	-

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. As a result of the requirements in IFRS 4.39(d) (i), medical schemes may wish to disclose information about the estimated timing of the net cash outflows from recognised insurance liabilities as an alternative to the maturity analysis required by IFRS 7.39(a).]

APPENDIX II – ILLUSTRATIVE DISCLOSURE IN THE FINANCIAL STATEMENTS

13. FAIR VALUES AND FINANCIAL RISK MANAGEMENT

	Financial assets at fair value through profit or loss		Loans and receivables (IAS 39) / Financial instruments at amortised cost (IFRS 9)	Available-for-sale financial assets (IAS 39)	Financial assets at fair value through Other Comprehensive Income (IFRS 9)	Financial liabilities at fair value through profit or loss					Fair value of financial instruments			Total
	Designated upon initial recognition	Classified				Designated upon initial recognition	Classified as held for trading				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	R'000	R'000
Investments														
- Bonds and debentures														
- Equity investments														
- Unlisted investments														
Cash and cash equivalents														
<i>Personal medical savings account trust investment*</i>														
Trade and other receivables*														
Personal medical savings account liability*														
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.

** Insurance receivables and payables included amounts due from/ (to):

- Contribution debtors;
- Recoveries from members for co-payments;
- Member balances excluding balances arising from MSA; and- Reported claims not yet paid.

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.

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 and loss		Available– for- sale financial assets (IAS 39)	Total R'000
	Bonds	Equity investments	Equity Investments	
	R'000	R'000	R'000	
Opening Balance				
Gains and losses for the period				
Gain or loss included in [insert name of line in SOCI]				
-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 included in net income/(expense) 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 - available-for-sale (IAS 39)]*, reasonably possible changes at the reporting date to one of the significant unobservable inputs, holding other inputs constant, would have the following effects:

Equity securities – Available-for-sale

(IAS 39)

OCI, net of tax

20xx

	Increase R'000	Decrease R'000
<i>[insert significant observable input here] (xx% movement)</i>		
<i>[insert significant observable input here] (xx% movement)</i>		

Equity securities – Designated as at fair value through profit or loss

Profit of loss

20xx

	Increase R'000	Decrease R'000
<i>[insert significant observable input here] (xx% movement)</i>		
<i>[insert significant observable input here] (xx% movement)</i>		

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 invest					
Cash and cash equivalents	x			x	x*
Personal medical savings account trust investment *	x				x
Trade and other receivables*	x				
Personal medical savings account Liability		x		x	
Trade and other payables*		x			
IBNR		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 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. *[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*
- *Concentrations of risk (e.g. geographical, counterparty, sectors)*
- *Information about the credit quality of financial assets that are neither past due nor impaired*
- *The amount that best represents the Scheme's maximum exposure to credit risk at the end of the reporting period]*

Example:

Loans and receivables/ 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.

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.

Please refer to IFRS 4 par 39B to 39J for disclosure requirements if IFRS 9 is deferred, further information relating to this is included in appendix III: Deferral of IFRS 9 Financial Instruments.

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 for the management of 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 maturities¹⁰ of financial liabilities at reporting date. The amounts are gross and undiscounted, and include estimated interest payments and exclude the impact of netting agreements:

	Months R'000	Months R'000	Months R'000	Years R'000	Years R'000	Years R'000	Total R'000
Financial							
- Personal Medical savings accounts liability							
- Trade and other Payables							
Insurance Liabilities							
- Outstanding risk Claims							

(Disclose members' personal medical savings accounts in earliest period repayable as it has a demand feature)

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 member funds 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.

¹⁰ 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.

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 equity by Rxx after tax (20yy: Rxx).¹¹

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.

If equity prices had been x% higher/lower:

- Net income/expense for the year ended 31 December 20xx would have been unaffected as the equity investments are classified as available-for-sale and no investments were disposed of or impaired; and
- Other reserves would increase/decrease by RXXX (20yy: increase/decrease by RXXX) for the Scheme as a result of the changes in fair value of available-for-sale shares.

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.

Capital management

[explain how the Scheme manages its risk]

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.

¹¹ This would be relevant only if debt instruments have been classified as available for sale

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%

14. 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 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 funds 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 that has 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 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 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 the voting rights of this fund. 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 a grants the scheme the right to appoint, remove and set the remuneration of management responsible for directing the relevant activities of the fund. 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.

15. 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 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 comprehensive income

Risk contribution income received Savings contributions received
Claims paid from personal medical savings account on behalf of the member Ex gratia payments

Healthcare provider fees paid Risk claims incurred **Statement of financial position**

Contribution debtor – risk portion Claims reported not yet paid liability
Personal medical savings account liability 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.
Contribution debtor	This constitutes outstanding contributions payable. The amounts are due immediately. No provisions for doubtful debts have been raised on these amounts.
Claims reported not yet paid	These are claims that have been reported, but not yet paid due to the fact that the scheme does a payment run twice a month. All claims are settled within 30 days of being received.

Personal medical savings accounts	The amounts owing to the related parties relate to medical aid savings Balances which are held and managed on their behalf. In line with the terms applied to third parties and in terms of the rules of the scheme, the balances earn interest at the effective interest rate, which accrues to the member. The amounts are all current and would need to be payable on demand should an appropriate claim be issued, or the member exit 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 – Employer8		
Statement of 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 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 comprehensive income		
Accredited managed healthcare service fees		

Statement of financial position		
Accredited managed healthcare service fees		
QRS- Investment manager		
Statement of comprehensive income		
Investment fees		
Statement of financial position		
Investment fees due		
TUV – Broker*		
Statement of 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.*

16. 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 becoming due.

Cause of non-compliance

There are instances where the Scheme received contributions after three days of it becoming due. It should be noted that there are no contracts in place that is 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):

<i>Benefit option</i>	<i>Nr of members</i>	<i>Net healthcare deficit</i>	<i>Net result</i>
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 improving 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 on 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 small 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 investing activities of the asset manager.

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 members 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 an 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.

APPENDIX III – EXAMPLE: DEFERRAL OF IFRS 9 FINANCIAL INSTRUMENTS

The effective date of IFRS 9 Financial Instruments (IFRS 9) is for annual periods beginning on or after 1 January 2018. IFRS 9 will change the classification of financial assets to either amortised cost, fair value through profit or loss (FVTPL) or fair value through other comprehensive income (FVTOCI).

In addition, IFRS 9 replaces the "incurred loss" model in IAS 39 Financial Instruments: Recognition and Measurement (IAS 39) with an "expected credit loss model", which means that a loss event will no longer need to occur before an impairment allowance is recognised.

The effective date of IFRS 17 Insurance Contracts is for annual periods beginning on or after 1 January 2022 (due course). The differing effective dates of IFRS 9 and IFRS 17 could have a significant impact on insurers (including medical schemes). Entities whose predominant activity (refer paragraph 77 of this SAICA Medical Schemes Accounting Guide), is the issuing insurance contracts within the scope of IFRS 4 Insurance Contracts (IFRS 4) were afforded the option to defer the implementation of IFRS 9 (Deferral Approach) i.e. granted temporary exemption from recognising financial instruments in accordance with IFRS 9 (thus permitted to continue to apply IAS 39) until the recognition of insurance contracts has been finally settled, although this option may not be used after 1 January 2022 (due course).

The scheme meets the requirements at date preceding 1 April 2016 as its insurance liabilities are x% of total liabilities and have elected to adopt the Deferral Approach.

IFRS 9 Impact of adoption of IFRS 9 on the scheme

In terms of each investment portfolio, the Scheme will need to assess if the investment will be measured subsequently at amortised cost or fair value on the basis of the entity's business model for managing the financial assets and the contractual cash flow characteristics of the financial assets.

I. Financial assets measured at amortised cost

A debt instrument is measured at amortised cost if it is held within a business model whose objective is to hold financial assets in order to collect contractual cash flows and its contractual terms give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding. The Fund includes in this category short-term non-financing receivables including cash collateral posted on derivative contracts, accrued income and other receivables.

II. A financial asset is measured at fair value through profit or loss if:

- (a) Its contractual terms do not give rise to cash flows on specified dates that are solely payments of principal and interest (SPPI) on the principal amount outstanding; or
- (b) It is not held within a business model whose objective is either to collect contractual cash flows, or to both collect contractual cash flows and sell; or
- (c) At initial recognition, it is irrevocably designated as measured at FVPL when doing so eliminates or significantly reduces a measurement or recognition inconsistency that would otherwise arise from measuring assets or liabilities or recognising the gains and losses on them on different bases.

With regards to the impairment of the financial assets:

I. Impairment of debt instruments held at amortised cost and fair value through other comprehensive income.

In relation to the impairment of financial assets, IFRS 9 requires an expected credit loss model as opposed to an incurred credit loss model under IAS 39. The expected credit loss model requires the scheme to account for expected credit losses and changes in those expected credit losses at each reporting date to reflect changes in credit risk since initial recognition of the financial assets. In other words, it is no longer necessary for a credit event to have occurred before credit losses are recognised.

The following table shows measurement categories in accordance with IAS 39 reflected in the scheme's financial statements in comparison with the measurement's categories under IFRS 9 if the scheme adopted IFRS 9 for the year under review.

Financial asset categories	IAS 39 Classification	IAS 39 Measurement R'000	IFRS 9 Classification	IFRS 9 Measurement R'000

The following table shows the fair value and change in fair value of financial assets (IFRS 4.39B(b)):

Financial asset classes	Financial instruments with contractual terms that give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding	Other <ul style="list-style-type: none"> with contractual terms that do not give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding that meets the definition of held for trading in IFRS 9; or that is managed and whose performance is evaluated on a fair value basis
Item		
Opening balance		
Additions		
Disposal		
Closing		

*IFRS 4.39E states an insurer shall disclose the fair value at the end of the reporting period and the amount of change during that period. The opening balance, additions and disposals are included here for completeness.

Credit risk exposure for assets that pass the SPPI criteria (i.e. Amortised cost and fair value through other comprehensive income instruments)

Exposure to credit risk	Credit ratings

Include disclosure required by IFRS4.39G (see paragraph 46-48).

APPENDIX IV – OVERVIEW OF IFRS 17 FOR MEDICAL SCHEMES

The below represents a high level overview of the IFRS 17 requirements and the potential impact on Medical Schemes. The overview does not aim to provide an exhaustive list of all impacts. Therefore, the overview should be used as a guide. We encourage a Medical scheme to perform appropriate procedures to identify impacts specific to its facts and circumstances.

For the purpose of this appendix, only the premium allocation approach (measurement basis in IFRS 17) has been discussed.

IFRS 17 requirement		Potential impact on Medical Schemes
Identify a portfolio of contracts		
IFRS 17.14	<p>An entity shall identify portfolios of insurance contracts.</p> <p>A portfolio comprises contracts subject to similar risk and that are managed together.</p> <p>Contracts within a product line would be expected to be in the same portfolio if they are managed together.</p>	<p>The question is whether the Medical Scheme as a whole or each benefit plan provided by the Medical Scheme, represents a portfolio.</p> <p>Identification of a portfolio is based on specific facts and circumstances. Therefore, each Medical Scheme should identify its portfolio(s) applicable to its business.</p>
Level of aggregation		
IFRS 17.16	<p>An entity shall divide a portfolio of insurance contracts issued into a minimum of:</p> <ul style="list-style-type: none"> • A group of contracts that are onerous at initial recognition • A group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently • A group of remaining contract in the portfolio. 	<p>Medical Schemes reassess risks at a portfolio level. Therefore, the contracts in the portfolio will be classified as follows:</p> <ul style="list-style-type: none"> • Onerous • Profitable (no significant possibility of becoming onerous) • Residual.
IFRS 17.20	<p>If, applying paragraphs 14–19, 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. The entity shall not apply this paragraph by analogy to other items.</p>	<p>MSA prevents schemes to set different prices for its members, therefore the schemes should assess if they can apply this exemption.</p>
IFRS 17.22	<p>An entity shall not include contracts issued more than one year apart in the same group.</p>	
Initial recognition		

IFRS 17.25	<p>A group of insurance contracts that is issued will be recognised from the earliest of the following:</p> <ul style="list-style-type: none"> • The beginning of the coverage period of the group of contracts; • The date when the first payment from the policyholder becomes due; or • When the group becomes onerous. 	<p>Member contracts are generally recognised on 1 January each year. Contracts for members who join during the course of the year, will be added to a group provided the contract is issued no more than one year from contracts already recognised in the group.</p> <p>Onerous groups of contracts should be recognised when facts and circumstances indicate that they are onerous.</p> <p>This could be in the previous financial year when members indicate which benefit plan they would like to elect for the following calendar year.</p>
IFRS 17.18	<p>For contracts issued to which an entity applies the premium allocation approach, the entity shall assume no contracts in the portfolio are onerous at initial recognition, unless facts and circumstances indicate otherwise. An entity shall assess whether contracts 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.</p>	

Contract boundary		
IFRS 17.34	<p>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 the entity:</p> <ul style="list-style-type: none"> • Can compel the policyholder to pay the premiums; or • Has a substantive obligation to provide the policyholder with insurance contract services. <p>This substantive obligation ends when both of the following criteria are satisfied:</p> <ul style="list-style-type: none"> • The entity has a practical ability to reassess the risk of the portfolio of insurance contracts and as a result can set the price or level of benefits that fully reflects the risks of that portfolio; and • The pricing of the premiums up to the date when the risks are reassessed does not take into account the risks that relate to periods after the reassessment date. 	<p>Medical Schemes generally reassess the risk of the portfolio of member contracts on an annual basis and set contributions for each calendar year.</p> <p>Generally, the contract boundary of a group of member contracts will be 12 months or shorter, depending on when the Scheme has the practical ability to reassess the risk of the portfolio.</p> <p>If the scheme rules allow for the insurer to assess risk and fully adjust either the benefits or premiums during the existing member contract, the boundary may be impacted.</p>
Measurement model		
IFRS 17.53	<p>An entity <u>may</u> simplify the measurement of a group of insurance contracts using the premium allocation approach (PAA) if at inception of the group:</p> <ul style="list-style-type: none"> • The entity reasonably expects that such simplifications would produce a measurement for the liability for remaining coverage (LRC) for the group that would not differ materially from the amount calculated using the general measurement model (GMM) or • The coverage period of each contract in the group is one year or less. 	<p>Based on the assessment of coverage period, Medical Schemes meet the eligibility criteria to apply the PAA.</p> <p>For the purpose of this appendix, only the PAA will be discussed.</p>

Onerous contracts		
IFRS 17.57	<p>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:</p> <ul style="list-style-type: none"> the carrying amount of the LRC determined applying the PAA; and the fulfilment cash flows that relate to the remaining coverage of the group, applying the GMM. <p>If the entity does not adjust the LIC for the effect of the time value of money or financial risk, it shall not include in the fulfilment cash flows these adjustments.</p>	<p>A Medical Scheme should assess whether there are any onerous groups of contracts based on facts and circumstances.</p> <p>Accounting for onerous groups of contracts:</p> <ol style="list-style-type: none"> 1. Calculate the LRC applying the PAA 2. Calculate the LRC applying the GMM 3. Compare LRC calculated under GMM to LRC under the PAA 4. Recognise a loss for the excess of the carrying value of the LRC (GMM) over the carrying value of the LRC (PAA) and increase the LFRC. <p>The Medical Scheme should continue to apply the PAA – recognition of an onerous loss does not result in a change in measurement approach.</p> <p>Medical Schemes should consider facts and circumstances throughout the coverage period, to determine if any group of contracts became onerous and recognise additional losses or increases losses relating to existing onerous groups of contracts.</p>
IFRS 17.58	<p>To the extent that the fulfilment cash flows exceed the carrying amount of the LRC (determined applying the PAA), the entity shall recognise a loss in profit or loss and increase the liability for remaining coverage.</p>	
Savings account		
IFRS 17.A	<p>An investment component is the amount that an insurance contract requires the entity to repay to a policyholder in all circumstances, regardless of whether an insured event occurs.</p>	<p>Medical Schemes may offer savings account options for members.</p>
IFRS 17.B31	<p>Paragraph 11(b) requires an entity to separate a distinct investment component if both the following conditions are met:</p> <ul style="list-style-type: none"> The investment component and the insurance component are not highly interrelated. A contract with equivalent terms is sold, or could be sold, separately in the same market or the same jurisdiction, either by entities that issue insurance contracts or by other parties. 	<p>The savings account should be accounted for as part of the membership contract (in terms of IFRS 17) as it is a non-distinct investment component (based on paragraphs B31 and B32).</p> <p>Medical schemes may be providing an investment return service as a result of the existence of the savings components.</p>

IFRS 17.B32	<p>An investment component and an insurance component are highly interrelated if:</p> <ul style="list-style-type: none"> • The entity is unable to measure one component without considering the other, or • The policyholder is unable to benefit from one component unless the other is also present. Thus, if the lapse or maturity of the one component in the contract causes the lapse or maturity of the other. <p>Insurance contracts without direct participation features may provide an investment-return service if, and only if:</p> <ul style="list-style-type: none"> • an investment component exists, or the policyholder has a right to withdraw an amount; • the entity expects the investment component or amount the policyholder has a right to withdraw to include an investment return (an investment return could be below zero, for example, in a negative interest rate environment); and • the entity expects to perform investment activity to generate that investment return. 	
Measurement: LRC		
IFRS 17.A	<p>The LRC is defined as an entity's obligation to investigate and pay claims under existing insurance contracts for insured events that relates to the unexpired portion of the coverage period.</p> <p><i>Initial recognition</i></p> <p>An entity shall measure the LRC as follows:</p> <ul style="list-style-type: none"> • The premiums received in cash at initial recognition; minus • Insurance acquisition cash flows (unless the entity choose 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 applying IFRS 17.28C and any other asset or liability previously recognised for cash flows related to 	<p>The LRC is calculated based on contributions received in cash and acquisition cash flows paid.</p> <p>Therefore, no contribution receivables should be recognised as separate assets.</p>
IFRS 17.55		

	<p>groups of contracts as specified in IFRS 17.B66A.</p> <p><i>Subsequent measurement (end of each reporting period)</i></p> <p>An entity shall recognise the LRC as the sum of:</p> <ul style="list-style-type: none"> • The previous carrying amount • Premiums received in the period • Amount of amortisation of insurance acquisition cash flows (unless the entity choose to recognise insurance acquisition cash flows as an expense) • Any adjustments to a financing component <p>Minus the sum of:</p> <ul style="list-style-type: none"> • Insurance acquisition cash flows (unless the entity choose to recognise the payments as an expense) • Insurance revenue recognised in the period • Any investment component paid or transferred to the liability for incurred claims. 	
Measurement: Insurance acquisition cash flows		
IFRS 17.59	<p>In applying the PAA, an entity <u>may</u> choose to recognise any insurance acquisition cash flows as expenses when it incurs those costs, provided that the coverage period of each contract in the group at initial recognition is no more than one year.</p>	<p>An example of insurance acquisition cash flows is broker fees.</p> <p>The coverage period of member contracts is generally one year and therefore Medical Schemes may choose to expense the acquisition cash flows as they are incurred.</p> <p>Alternatively, the Medical Schemes may capitalise the costs against the LRC when it incurs the costs.</p> <p>The choice of treatment of the acquisition costs for contracts with a contract boundary of less than a year, represents an accounting policy choice.</p>
Measurement: Discounting of the LRC		
IFRS 17.56	<p>If insurance contracts in the group have a significant financing component, an entity shall adjust the carrying amount of the LRC to reflect the time value of money</p>	<p>A Medical Scheme is not required to adjust the cash flows for time value of money or financial risk in the measurement of the LRC as monthly</p>

	<p>and the effect of financial risk using the discount rates specified in paragraph 36, as determined on initial recognition.</p> <p>The entity is not required to adjust the carrying amount of the LRC to reflect the time value of money and the effect of financial risk if, at initial recognition, the entity expects that the time between providing each part of the services and the related premium due date is no more than a year.</p>	<p>contributions are received for monthly insurance contract service provided by the Medical Scheme.</p>
Measurement: Liability for incurred claims (LIC)		
IFRS 17.A	<p>The LIC is defined as an entity's obligation to</p> <p>(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 (IBNR), and other incurred insurance expenses; and</p> <p>(b) pay amounts that are not included in (a) that relate to insurance contract services that have already been provided or any investment components or other amounts that are not related to the provision of insurance contract services and that are not in the LRC.</p>	<p>Medical Schemes are required to use the GMM to calculate the LIC.</p>
IFRS 17.59	<p>In applying the PAA, an entity shall measure the LIC for the group of insurance contracts at the fulfilment cash flows relating to incurred claims, applying the GMM.</p>	
IFRS 17.33 - 37	<p>The LIC is calculated as the fulfilment cash flows comprising:</p> <ul style="list-style-type: none"> • Estimates of future cash flows (paragraph 33 – 35) • An adjustment to reflect the time value of money and the financial risks related to the future cash flows, to the extent that the financial risks are not included in the estimates of the future cash flows (paragraph 36) • Risk adjustment for non-financial risk (<i>the compensation that the entity requires for bearing the uncertainty about the amount and timing of the cash flows that arise from non-performance risk</i>). 	

LIC: Future cash flows		
IFRS 17.B65	<p>Cash flows within the boundary of an insurance contract are those that relate directly to the fulfilment of the contract.</p> <p>Examples of cash flows within the boundary:</p> <ul style="list-style-type: none"> • Claims handling costs • Policy administration and maintenance costs • Transaction based taxes arising directly from the insurance contracts or can be attributed to them on a reasonable and consistent basis. • Potential cash inflows from recoveries (such as salvage and subrogation) on future claims 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 • Allocation of fixed and variable overheads that are directly attributable to fulfilling the insurance contracts • Other costs that are specifically chargeable to the policyholder under the terms of the contract. 	Medical schemes should evaluate which cash flows should be included in the measurement of the LIC.
LIC: Discounting		
IFRS 17.59	The entity is not required to adjust future cash flows for the time value of money and the effect of financial risk if those cash flows are expected to be paid or received in one year or less from the date the claims are incurred.	Medical Schemes are not required to discount the LIC as claims are typically paid within a year from the date the claims were incurred.
Insurance revenue		
IFRS 17.B126	<p>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.</p> <p>The entity shall allocate the expected premium receipts to each period of insurance contract services:</p> <ul style="list-style-type: none"> • on the basis of the passage of time; • but if the expected pattern of release of risk during the coverage 	<p>Risk contributions will continue to be recognised as insurance revenue.</p> <p>The Medical Scheme should determine whether revenue will be recognised based on the passage of time or if the expected pattern of release of risk differs significantly from the passage of time, on the basis of the expected timing of incurred insurance service expenses.</p> <p>An example of when the coverage period differs significantly from the passage of time could be where there are higher</p>

	period differs significantly from the passage of time, then on the basis of the expected timing of incurred insurance service expenses.	claims during the winter season for flu and therefore it would be more appropriate to recognise a higher revenue during the winter months.
PAA for reinsurance contracts held		
IFRS 17 Appendix A	A reinsurance contract is 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).	Review if risk transfer arrangements meet the definition of a reinsurance contract in IFRS 17.
IFRS 17.69	<p>An entity may use the PAA to simplify the measurement of a group of reinsurance contracts held, if at the inception of the group:</p> <ul style="list-style-type: none"> the entity reasonably expects the resulting measurement would not differ materially from the result of applying the GMM; or the coverage period of each contract in the group of reinsurance contracts held is one year or less. 	Medical Schemes will have to assess whether the eligibility criteria are met for risk transfer arrangements in order to apply the PAA to these arrangements.
Recoveries from the Road Accident Fund (RAF)		
IFRS 17.B65 (k)	Fulfilment cash flows include potential cash flows from recoveries (in the form of salvages and subrogation) on future claims covered by existing insurance contracts and to the extent they do not qualify for recognition as a separate asset, potential cash inflows from recoveries on past claims.	This paragraph applies to the measurement of LIC and has to be considered for estimated recoveries from the RAF.
Derecognition of insurance contracts		
IFRS 17.74	An entity shall derecognise an insurance contract when, and only when it is extinguished, i.e. when the obligation specified in the insurance contract expires or is discharged or cancelled; or if the insurance contract is substantially modified.	Medical Schemes should apply the paragraph based on the rules of the Medical Scheme.

Effective date and transition approach		
IFRS 17.C1	IFRS 17 is effective for annual periods beginning on or after 1 January 2023.	Medical Schemes are expected to have the information available to apply IFRS 17 retrospectively.
IFRS 17.C3	An entity shall apply IFRS 17 retrospectively.	
IFRS 17.C4	To apply IFRS 17 retrospectively, an entity shall at the transition date: identify, recognise and measure each group of insurance contracts as if IFRS 17 had always applied and derecognise any existing balances that would not exist had IFRS 17 always applied and recognise any resulting net difference in equity.	
IFRS 17.C5	<p>If, it is impracticable for an entity to apply IFRS 17 retrospectively for a group of insurance contracts, an entity shall apply the following approaches:</p> <ul style="list-style-type: none"> the modified retrospective approach; or the fair value approach. 	

Note: For entities that deferred IFRS 9, the guidance in IFRS 9.7.2 should be applied on the transition to IFRS 17.