SAICA DIFFERENCE MAKERS™

Ref: #*775096*
Ms Julindi Scheepers
Chief Financial Analyst
Council for Medical Schemes
Eco Glades 2 Office Park
420 Witch-Hazel Avenue
Eco Park
Centurion
0157

06 November 2023
Email: J.Scheepers@medicalschemes.co.za

Dear Julindi

IFRS 17 INSURANCE CONTRACTS IMPLEMENTATRION CONSIDERATIONS

This submission is intended to highlight IFRS 17 *Insurance Contracts* implementation considerations for the medical schemes industry, highlighting and addressing some of the practical issues identified through SAICA's Medical Schemes Project Group (MSPG) engagements.

We would like to highlight that the IFRS standards are principle based and thus the submission is not meant to be prescriptive but rather assist in guiding members when considering their contracts and that each medical scheme would still need to consider the specific facts and circumstances of each of their contracts when applying the standard.

Yours Sincerely

Shaun Osner
Chairman: SAICA MSPG

Esther Pieterse
Deputy Chair: SAICA MSPG

Kedibone Pilusa
SAICA PD Members in Business Technical

Chartered Accountants Worldwide

NPO-020-050 VAT No. 4570104366 | 17 Fricker Place, Illovo, Sandton, Johannesburg, 2196 | POSTAL ADDRESS Private Bag X32, Northlands, 2116 | TEL +27 8610 SAICA (72422) | EMAIL saica@saica.co.za | www.saica.co.za | www.accountancysa.org.za | Member of the International Federation of Accountants (IFAC), Pan African Federation of Accountants (PAFA), Global Accounting Alliance (GAA), Chartered Accountants Worldwide (CAW) and Investors in People. Proudly South African.

SAICA DIFFERENCE MAKERS™

IFRS 17 – INSURANCE CONTRACTS

Contents

Background........ 3

Impact on medical schemes........ 4

Overview of medical schemes........ 4

Assessment as to whether a medical scheme is a mutual entity........ 7

IFRS 17 considerations........ 8

Level of aggregation........ 10

Recognition........ 12

Premium allocation approach........ 12

Disclosure........ 24

Background

An International Accounting Standards Board (IASB) project commenced in 1997 to address accounting for insurance contracts. Phase 1 was completed in 2004 with the IASB issuing IFRS 4 *Insurance Contracts*. IFRS 4 was an interim standard which would be replaced by the new insurance standard on completion of the IASB insurance contract project.

IFRS 4 permitted entities to use a wide variety of accounting practices for insurance contracts, subject to limited improvements and specified disclosures. This practice allowed for differences in accounting treatment across jurisdictions, entities and products making it difficult for users of financial statements to understand and compare insurers' results. Even though opinions varied on what it should be, there was consensus on the need for a common global insurance accounting standard.

Under IFRS 4 certain accounting practices did not adequately reflect the true underlying financial position or performance arising from insurance contracts. To address these matters the IASB commenced an insurance contract project which was completed in May 2017 and issued IFRS 17 *Insurance Contracts* which is the outcome of Phase 2 and replaces IFRS 4. This Standard initially set the effective date for year ends commencing on 1 January 2021, but at the March 2020 IASB Board meeting the effective date was deferred to year ends commencing on 1 January 2023.

IFRS 17 sets out principles for recognition, measurement, presentation and disclosure of insurance contracts that fall within the scope of IFRS 17. The objective is to ensure that relevant information is provided that faithfully represents the insurance contracts issued, and that gives a basis for users of financial statements to assess the effect that insurance contracts have on the financial position, financial performance and cash flows of the entity.

The key principles of the standard are that an entity:

- Identifies its insurance contracts.
- Separates any specified embedded derivatives, distinct investment components and distinct performance obligations from the insurance contract.
- Divides the contracts into groups that it will recognise and measure.
- Recognise the profit from a group of insurance contracts over the period the entity provides insurance coverage, and as the entity is released from risk. If a group of contracts is, or becomes loss-making, the loss is recognised immediately.
- Presents separately insurance revenue, insurance service expenses and insurance finance income or expenses.

IFRS 17 shall be applied to:

a) Insurance contracts issued;
b) Reinsurance contracts held and/or issued; and
c) Investment contracts with discretionary participation features entity issues, provided the entity also issues insurance contracts.

Impact on medical schemes

Overview of medical schemes

South African medical schemes operate on a not-for-profit basis and are governed by the Medical Schemes Act 131 of 1998, as amended and the Regulations thereto (the Act) and regulated by the Council for Medical Schemes (CMS).

Section 1[1] of the Act defines the 'business of a medical scheme' as the business of undertaking liability in return for a contribution to make provision for obtaining any 'relevant health service'. Medical schemes can grant assistance to meet expenditure on a health service or can provide the relevant health service directly or by agreement with health care providers aimed at value services for health-related needs of members.

South African medical schemes are required to be registered under section 24(1) of the Act. Section 26[2] of the Act provides that on registration a medical scheme becomes a body corporate capable of suing and being sued and of doing or causing to be done all such things as may be necessary for or incidental to the exercise of its powers or the performance of its functions in terms of its rules. Section 26(2) of the Act states that no person shall have any claim on the assets or rights or be responsible for any liabilities or obligations of a medical scheme, except in so far as the claim has arisen or the responsibility has been incurred in connection with transactions relating to the business of the medical scheme. Section 26(11) provides that no medical scheme shall carry on any business other than the business of a medical scheme and no medical scheme shall enrol or admit any person as a member in respect of any business other than the business of a medical scheme.

There are two main administration models used by medical schemes, a self-administered model or an outsourced administration model to a CMS accredited medical scheme administrator. The extent of the outsourced administration is set out in the written administration agreement between a medical scheme and administrator.

Medical schemes derive income from member contributions and investment returns. The contributions received from members are pooled to fund members' claims and any surplus funds are transferred to medical scheme reserves.

---

[1] Section 1 of the Act defines the business of a medical scheme as the business of undertaking liability in return for a premium or contribution –

- to make provision for the obtaining of any relevant health service;
- to grant assistance in defraying expenditure incurred in connection with the rendering of any relevant 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.

[2] Section 26 1(a) of the Act

SAICA DIFFERENCE MAKERS™

Section 29(1) of the Act sets out the matters for which the rules of a medical scheme shall provide and states that the Registrar shall not register a medical scheme, and no medical scheme shall carry on the business of a medical scheme unless the matters set out under Section 29(1) are included in the rules. Section 29(1)(n) of the Act eliminates medical schemes' ability to underwrite individual policies and set contribution levels at a particular policyholder level that fully reflects the risks of that policy. In setting contribution levels, the Act only allows for contributions to be determined on the basis of income or the number of dependants, or both the income and the number of dependants.

Medical schemes determine member contributions annually with the primary objective being to ensure sufficient contribution income to pay all claims, and to return a modest surplus to meet regulatory requirements and to maintain a cushion against cost increases. Medical schemes provide members and their families the ability to access healthcare at every stage of their lives and provides members with sufficient choice to meet their medical and financial needs by offering different benefit plan options.

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

(a) Includes the prescribed benefits;
(b) Shall be self-supporting in terms of membership and financial performance;
(c) Is financially sound; and
(d) Will not jeopardise the financial soundness of any existing benefit option within the medical scheme.

In practice, the inability for a medical scheme to set a price at policyholder level prevents individual benefit options from being self-supporting and financially sound at the benefit option level, and in pricing cross-subsidisation from other benefit options is required to ensure the medical scheme as a whole is sustainable.

Section 30(1)(e) and Regulation10(1) of the Act deals with prescribed personal savings accounts (PMSAs) as part of the benefits of a medical scheme which may only be provided by registered medical schemes.

CMS issues an annual circular providing guidance on the key considerations that they will take into account when assessing the appropriateness of benefit changes, contribution rate increases, and overall cost industry increase assumptions for the respective benefit year. The assumptions included in the circular are presented at overall medical scheme level and not benefit plan level.

Medical schemes can be either unrestricted and open to any member of the public or restricted in terms of the rules of the scheme to certain employer groups or other institutions.

Other than in instances where employers make it compulsory for their employees to be members of a medical scheme, the general public or households can voluntarily become members of an open medical scheme, making contributions which are deemed as revenue to the medical schemes, and this is another key feature of how mutual societies operate. Although medical schemes own their assets and obligations,

SAICA DIFFERENCE MAKERS™

board of trustee composition should be at least 50% of members who have strategic direction and oversight over the scheme with, put simply, their objective being to benefit the members.

The Act prescribes how medical scheme funds can be utilised and for which purposes which is effectively for the benefit of members in line with the business of a medical scheme as defined.

Payments from medical schemes are restricted to covering the cost of benefits payable in terms of the scheme rules and costs of carrying on the business of a medical scheme and with a prohibition on other types of payments including dividends or bonuses to inter alia members. Section 26(4)[3] of the Act prescribes the transactions that can be paid from a medical scheme's bank account and Section 26(5) of the Act prohibits any payment directly or indirectly to any person as a dividend, rebate or bonus of any kind whatsoever.

The Act prescribes the minimum benefits, the Prescribed Minimum Benefits (PMBs), that medical schemes must make available to beneficiaries on all options, irrespective of whether that plan is a comprehensive plan (includes cover for hospital and out of hospital health event) or only a hospital plan.

The underlying principle of South African medical schemes is that of community rating and results in cross subsidisation across different income levels and age bands. An implicit principle accepted by members electing to join a medical scheme is the acceptance of risk by the medical scheme, the pooling of contributions for settlement of that individual member's benefits, other members' benefit and to support community rating in setting contributions for current and future members. Medical scheme reserves may be utilised to provide members with other economic benefits such as funding reductions in contributions or deferral of contribution increases.

Medical schemes do not have shareholders and do not issue equity instruments. An independent Board of Trustees (the Trustees or the Board), of which the majority is elected from amongst members, manages the affairs of a medical scheme.

Section 35(6)(c) provides that a medical scheme shall not directly or indirectly borrow money. In practice medical schemes generally do not obtain approval for financing and therefore the only source of capital is obtained though member contributions.

Mechanisms for medical scheme reserves to be transferred from a medical scheme is through voluntary dissolution or an amalgamation. Members of the medical scheme are required to approve a voluntary dissolution or amalgamation by a majority vote at a general meeting.

[3] Section 26(4) of the Act states that no amount shall be debited to a medical scheme's bank account contemplated other than:

- payments by a medical scheme of any benefit, payable under the rules of a medical scheme;
- costs incurred by the medical scheme in the carrying on of the business as a medical scheme; or
- amounts invested by the board of trustees in accordance with the Act.

Section 63 of the Act sets out the requirements for amalgamations of medical schemes, which has been the general practice as opposed to winding up. Under an amalgamation, the reserves of the medical scheme are transferred to the medical scheme being amalgamated with.

Section 29(1)(h) requires that the medical scheme rules shall, subject to the provisions of the Act, set out the manner in which and the circumstances under which a medical scheme shall be terminated or dissolved. Section 64 of the Act states that "In the event of the rules of a medical scheme providing for the dissolution or termination of such medical scheme upon the expiry of a period or upon the occurrence of an event, or upon a resolution by the members that such medical scheme shall be terminated, then upon the expiry of such period, or the occurrence of such event, or the passing of such resolution, such medical scheme shall, subject to the provisions of this section, be liquidated in the manner provided for by the rules of such medical scheme, and the assets of that medical scheme shall, subject to the provisions of this Act, be distributed in the manner provided for by the rules of the medical scheme".

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

Assessment as to whether a medical scheme is a mutual entity.

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

Appendix A to IFRS 3 *Business Combinations* (IFRS 3) defines a mutual entity 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.

IFRS 17 does not define a "mutual entity" however it provides a key characteristic of a mutual entity in the basis of conclusion to the standard. BC265 explains that "a defining feature of an insurer that is a mutual entity is that the most residual interest of the entity is due to a policyholder and not a shareholder."

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

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

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

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

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

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

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

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

IFRS 17 considerations

Identification of insurance contracts

The contracts issued by medical schemes (the issuer) indemnify covered members (the policyholder) and their covered dependants against the risk of loss arising from the occurrence of a health event (insured event). The timing, frequency and severity of the health event covered is uncertain. These contracts fall under the scope of IFRS 17.

Whilst the timing, frequency, severity and type of health events are uncertain, the ultimate insurance risk covered by a medical scheme can be defined as a single risk – that of providing cover for a health event that the member may incur. The risk under the insurance contracts issued by medical schemes can be

expressed as the probability that an insured event ("health event") occurs, multiplied by the expected amount of the resulting claim.

Separating components from an insurance contract

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

The PMSA meets the definition of an investment component in IFRS 17 as it requires the medical scheme to repay a member in all circumstances, regardless if an insured event occurred. It needs to be assessed based on IFRS 17 whether the PMSA meets the definition of a distinct investment component and should be separated and accounted for as a financial instrument.

Firstly, to determine whether the investment component is distinct, it has to be considered under IFRS 17 whether the investment component and the insurance component are not highly interrelated:

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

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

- The second indication that the two components are highly interrelated is that the policyholder is unable to benefit from one component unless the other component is also present.

  If a member elects a benefit plan with a PMSA, he/she has no option but to take both the PMSA and risk component. Also, the lapse of one component will cause the lapse of the other.

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

The PMSA cannot be sold separately and the PMSA cannot survive without the medical scheme policy being active. Where the contract is cancelled, both the risk and PMSA component are cancelled. This means the condition where these can be sold separately is not met.

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

The PMSA is a non-distinct investment component with the balances included in either insurance contract assets or liabilities in the statement of financial position. While the cash flows relating to the PMSA are not recorded in the statement of comprehensive income, they are considered in assessing onerous contracts.

Level of aggregation

The level of aggregation has a significant impact on accounting for the insurance contract, the measurement of insurance contracts and the extent of offsetting or cross subsidisation to determine onerous contracts.

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

The only product line offered by medical schemes is that of insurance cover against the cost of a health event. Various benefit options may be offered by medical schemes, but ultimately the same risk covered is the health event, with similar types of benefits offered across the different options. The requirement of PMBs[4] ensures that similar benefits across benefit options are offered, however the extent of the benefit levels across the different options may vary. These benefit options are also managed together on a scheme level. It is possible that a medical scheme considers the results, financial position and cash flows at a lower level than at the overall scheme level. In such instances, the portfolio of insurance contracts could be at a lower level. Medical schemes should apply judgment in determining the portfolios of insurance contracts.

Careful consideration has to be given when making benefit and pricing changes for the top end options as any significant price increases or benefit changes could result in downgrades of healthier members, or members who can no longer afford the contribution levels to the middle to lower end benefit options. Similarly, consideration needs to be made when setting pricing levels for the middle to lower end options relative to the top end plan. Should the pricing differential between the middle and lower end plans increase significantly compared to the top end plans, members on these plans may also consider

[4] Section 29(1)(o) of the MSA – Matters for which rules shall provide - “The scope and level of minimum benefits that are to be available to beneficiaries as may be prescribed. Regulation 8(1) – “Subject to the provision of this regulation, any benefit option that is offered by a medical scheme must pay in full, without co-payment or the use of deductibles, the diagnosis, treatment and care costs of the prescribed minimum benefit conditions.

downgrading to these plans, or if the relative pricing decreases, then members on this middle to lower end plans may consider buying up to the higher plans.

Where members chose to buy down from the top end plan:

- The impact on the top end plan is a potential increase in losses as the healthier members no longer select this plan and chose lower-level options, reducing the benefit of their contribution to subsidising the cost of other members on the top end options.
- The impact on the lower options, is that less health members who can no longer afford the contributions on the top end options, downgrade to the lower options, with a lower contribution, but the same claiming pattern from the scheme, increasing the net cost to the scheme.

The level of dependency and cross-subsidisation between policyholders and across options is evident with the impact being carefully considered in determining pricing for the Medical Scheme as a whole.

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

IFRS 17.16 requires an entity to divide a portfolio into:

- 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 the remaining contracts at the portfolio, if any.

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

Section 29(1)(n)[5] of the Act limits a medical scheme's ability to set a price that reflects the risk and medical schemes cannot set a price that reflects the risk at policyholder level. The inability to set a price at the policyholder level results in the requirement of cross-subsidisation across different policyholders and different benefit options to ensure that a medical scheme remains affordable to members whilst remaining sustainable.

[5] Section 29(1)(n) – The terms and conditions applicable to the admission of a person as a member and his or her dependants, which terms and conditions shall provide for the determination of contributions on the basis of income or the number of dependants or both the income and the number of dependants, and 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, the frequency of rendering of relevant health services to an applicant or one or more of the applicant's dependant other than for the provisions as prescribed.

Based on the above, it should be considered whether the portfolio(s) consist of one or more groups of insurance contracts..

Recognition

Insurance contracts issued shall be recognised from the earliest of the following:
(a) The beginning of the coverage period;
(b) The date when the first payment from a policyholder becomes due; and
(c) For onerous contracts, when the contracts become onerous (IFRS 17.25).

Section 1 of the MSA sets the financial year end for all medical schemes as 31 December of each year. Medical scheme contracts are recognised on 1 January being the beginning of the coverage period. The member application forms include the billing and payment arrangements for contributions. Contributions are billed in advance or arrears and due within three days from the due date. For contributions received in December which are due in January, this would result in such contracts relating to the following financial year /coverage period, being required to be recognised in the current reporting period as a liability for remaining coverage.

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

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

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

Premium allocation approach

A key principle in determining the cash flows to be included in the insurance contracts issued is the contract boundary. Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which a medical scheme can compel a member to pay the contributions or in which the medical scheme has a substantive obligation to provide a member with services. The service under contracts issued by medical schemes is the

indemnification against the cost arising from a health event covered in terms of the rules of the medical scheme.

A substantive obligation to provide services ends when:

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

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

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

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

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

There are medical schemes that apply contribution increases on a date other than 1 January, typically March or July. For the majority of these medical schemes, even though contributions are increased during the financial year, benefits are increased from 1 January and contribution increases are set to reflect the risk over the 12-month period to December – the benefit year which aligns with the financial year.

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

The impact of this is that the contract boundary for contracts issued does not exceed 12 months and is generally aligned with a medical scheme's financial year.

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

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

(a) there is a reasonable expectation that the simplification would produce a measurement of the liability for remaining coverage for the group that would not differ materially from the one that would be produced applying the requirements in paragraphs 32–52. This is not met if at the inception of the group there is an expectation of significant variability in the fulfilment cash flows that would affect the measurement of the liability for remaining coverage during the period before a claim is incurred. Variability in the fulfilment cash flows increases with the extent of embedded derivatives and the length of the coverage period; or
(b) the coverage period of each contract in the group (including insurance contract services arising from all premiums within the contract boundary determined at that date applying paragraph 34) is one year or less.

The coverage period of each medical scheme contract is one year or less. The result of this is that medical schemes may simplify the measurement of the portfolio of insurance contracts by using the PAA.

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

In applying the PAA, the medical scheme:
a) may choose to recognise any insurance acquisition cash flows as expenses when it incurs those costs.
b) shall measure the liability for incurred claims for the group of insurance contracts at the fulfilment cash flows relating to incurred claims. The future cash flows are not required to be adjusted for the time value of money and the effect of financial risk as these cash flows are expected to be paid in one year or less from the date the claims are incurred.

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

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

Liability for remaining coverage

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

The premiums, if any, received at initial recognition;
minus any insurance acquisition cash flows at that date, unless the entity chooses to recognise the payments as an expense;
plus or minus any amount arising from the derecognition at that date of:
• any asset for insurance acquisition cash flows; and
• any other asset or liability previously recognised for cash flows related to the contracts.

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

The premiums received in the period;
minus insurance acquisition cash flows; unless the entity chooses to recognise the payments as an expense;
plus any amounts relating to the amortisation of insurance acquisition cash flows recognised as an expense in the reporting period; unless the entity chooses to recognise insurance acquisition cash flows as an expense;
plus any adjustment to a financing component;
minus the amount recognised as insurance revenue for services provided in that period; and
minus any investment component paid or transferred to the liability for incurred claims.

As the coverage period and the financial year for a medical scheme is the same, there would be no liability for remaining coverage at the year end reporting date, assuming that the actual cash collected for contributions equals the contributions recognised.

Liability for incurred claims

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

The liability for incurred claims is measured at the fulfilment cash flows related to past service, allocated to the group at year end, and only for cash flows within the contract boundary.

The estimate of future cash flows shall:

a) incorporate, in an unbiased way, all reasonable and supportable information available without undue cost or effort about the amount, timing and uncertainty of those future cash flows. To do this, the probability weighted mean of the full range of possible outcomes shall be estimated;
b) reflect the perspective of the medical scheme, provided that the estimates of any relevant market variables are consistent with observable market prices for those variables;
c) be current – the estimates shall reflect conditions existing at the measurement date, including assumptions at that date about the future;

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

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

a) for the increase in the liability because of claims and expenses incurred in the period, excluding any investment components; and
b) for any subsequent changes in fulfilment cash flows relating to incurred claims and incurred expenses.

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

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

Where the medical scheme benefit year, financial year and contract boundary align, at the reporting date all contracts entered into during the reporting period would have expired with the only area of uncertainty being related to the IBNR, which would require the risk adjustment.

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

(a) risks with low frequency and high severity will result in higher risk adjustments for non-financial risk than risks with high frequency and low severity;
(b) risks with a wider probability distribution will result in higher risk adjustments for non-financial risk than risks with a narrower distribution;
(c) the less that is known about the current estimate and its trend, the higher will be the risk adjustment for non-financial risk; and
(d) to the extent that emerging experience reduces uncertainty about the amount and timing of cash flows, risk adjustments for non-financial risk will decrease and vice versa.

The medical scheme shall apply judgement when determining an appropriate estimation technique for the risk adjustment for non-financial risk and consider whether the technique provides concise and

informative disclosure so that users of financial statements can benchmark the performance against the performance of other medical schemes.

Paragraph 119 requires an entity that uses a technique other than the confidence level technique for determining the risk adjustment for non-financial risk to disclose the technique used and the confidence level corresponding to the results of that technique. A key input in setting the risk adjustment expected to be used by medical schemes is the historical claims experience and IBNR run-off.

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

Mutual entity measurement considerations

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

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

The scheme should recognise a liability in terms of IFRS 17.B71 in its statement of financial position to provide coverage to future members. This is on the basis that the scheme is in a surplus position. If the scheme is in a deficit position, then there is no residual to draw on to raise a liability.

This liability is in essence incurred because by "signing" the contract with the member, the scheme is obliged to:

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

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

a) in the statement of financial position, the liability attributable to policyholders in their capacity as policyholders from the liability attributable to policyholders with the most residual interest in the entity; and
b) in the statement(s) of financial performance, the income or expenses attributable to policyholders in their capacity as policyholders before determination of the amounts attributable to policyholders with the most residual interest in the entity (IFRS 17.BC 269)".

On measurement of this liability, the fulfilment cash flows of this liability are measured at the current value.

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

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

Onerous contract assessment

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

- the carrying amount of the liability for remaining coverage determined applying the premium allocation approach; and
- the fulfilment cash flows that relate to the remaining coverage of the group, applying the general measurement model. If the entity does not adjust the liability for incurred claims for the effect of the time value of money or financial risk, it shall not include in the fulfilment cash flows these adjustments".

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

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

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

Measurement: Cash flows

The cash flows to fulfil an insurance contract include:

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

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

- investment returns – these are recognised, measured and presented separately
- cash flows (payments or receipts) that arise under reinsurance contracts held (excluding risk transfer arrangements directly attributable to covered members)
- cash flows that may arise from future insurance contracts, i.e. cash flows outside the boundary of existing contracts
- cash flows that cannot be directly attributed to the portfolio on insurance contracts that contain the contracts, such as some product development and training costs - such costs are recognised in profit or loss when incurred
- cash flows that arise from abnormal amounts of wasted labour or other resources that are used to fulfil the contract - such costs are recognised in profit or loss when incurred
- cash flows arising from components separated from the insurance contract and accounted for using other applicable Standards.

Table 3 and Table 4 provide a high-level assessment of a typical medical scheme's current financial statements indicating items that fall under the scope of IFRS 17. The detailed assessment and the impact for each item has been included in Annexure A – Detailed assessment of IFRS 17 on Financial Statement Line Items. This analysis is provided as an indication of items under the scope of IFRS 17. Medical schemes would have to assess which expenses are included or excluded depending on the nature of the expenses taking into account scheme specific considerations.

Table 3: Assessment of Medical Scheme Statement of Comprehensive Income in terms of IFRS 17

Financial statement item	Under Scope of IFRS 17
Risk Contribution Income	Yes
PMSA Contribution Income	Yes
Risk Claims Incurred	Yes
PMSA Claims Incurred	Yes
Third Party claim recoveries	Yes
Member Co-payments	Yes
Discount Received	Yes
Risk Transfer Arrangement – Capitation Fees	Yes
Accredited Managed Healthcare Services	Yes
Broker Service Fees	Yes
Expenses for Administration	Yes
Other Operating Expenses	It depends
Investment Income	No
Net (losses)/gains on Financial Assets	No
Sundry Income	No
Expenses for Asset Management Services Rendered	No
Finance Costs – PMSA Interest	Yes
Lease Costs	It depends
Finance Costs – Other	No

Table 4 Assessment of Medical Scheme Statement of Financial Position in terms of IFRS 17

SAICA DIFFERENCE MAKERS™

Financial Statement Item	Under Scope of IFRS 17
Property and equipment – Right of Use Asset	No
Long Term Employee Benefit Plan Asset	No
Financial Assets at Fair Value through Profit or Loss	No
Derivative Financial Instruments	No
Trade and Other Receivables – Insurance Receivables	Yes
Trade and Other Receivables – Loans and Other Receivables	No
Cash and cash equivalents	No
Lease liability	No
Outstanding Claims Provision	Yes
PMSA liabilities	Yes
Trade and Other Payables – Insurance Payables	Yes
Trade and Other Payables – Financial Liabilities	No

Risk transfer arrangements

Medical schemes enter into contractual arrangements with third parties who undertake to indemnify the medical scheme against all or part of the loss that a medical scheme may incur as a result of carrying on the business of a medical scheme. Risk transfer arrangements (RTA) do not reduce the medical scheme's primary obligations to its members and their dependants. The arrangements only decrease the loss a medical scheme may incur as a result of carrying on the business of a medical scheme. These arrangements met the definition of a reinsurance contract under IFRS 4. The third parties are not reinsurers as defined in Section 1[6] of the Act and these arrangements are not defined as a reinsurance contract in terms of the Act as the counterparty does not meet the definition of a reinsurer. These arrangements do not fall under the requirements of Section 20(3)[7] of the Act.

The fees payable to the RTA providers by a medical scheme are generally based on a fixed fee per member per month multiplied by the number of enrolled members under the respective arrangement. The RTA providers fulfil their obligations to the medical scheme through provision of the contracted services and not by making cash payments to the medical scheme. RTA providers generally contract at agreed rates with their providers and/or networks thereby quantifying the cost for the respective service transferred under the RTA.

Under the current accounting policy, RTA fees (including "Managed care: healthcare services") are recognised as an expense over the indemnity period on a straight-line basis. 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 these contracts are recognised in the same year as the related claims. The claims incurred liability covered by the RTA and the equivalent RTA receivable are presented in the statement of financial position on a gross basis. Assets relating to RTAs include balances receivable under RTAs for outstanding claims and claims reported not yet paid. Amounts recoverable under RTAs are generally estimated in a manner consistent with the outstanding claims provision, claims reported not yet paid and settled claims associated with the RTA. These are calculated recoveries to provide a view as to the estimate of the amount that a medical scheme would incur to settle claims under these arrangements, based on the medical scheme's underlying assumptions and not actual cash recoveries from the RTA provider.

In assessing the pricing of these arrangements, the RTA provider reflects the assessment of the risk associated with the medical scheme as whole in setting the price to be charged and consequently the pricing reflects an assessment of the risk associated with the medical scheme as an individual customer.

[6] **"reinsurer"** means and insurer -

(a) registered as a long-term insurer in terms of section 9 of the Long-term Insurance act, 1998 (Act No.53 of 1998), unless that insurer is prohibited from engaging in the practice of reinsurance in terms of section 10 of that Act; or

(b) registered as a short-term insurer in terms of section 9 of the Short-term Insurance act, 1998 (Act No.53 of 1998), unless that insurer is prohibited from engaging in the practice of reinsurance in terms of section 10 of that Act;

[7] Section 20(3) Where a medical scheme intends entering into any reinsurance contract, or effecting any amendment of such reinsurance contract, the board of trustees shall furnish to the Registrar –

(a) a copy of any such reinsurance contract or amendment of such reinsurance contract; and

(b) an evaluation of the need for the proposed reinsurance contract undertaken by a person with the necessary expertise to conduct such an evaluation, and who has no direct or indirect financial interest in the relevant reinsurance contract.

Under IFRS 17 it is important to consider whether insurance risk is transferred to the RTA provider. If insurance risk is transferred the risk transfer arrangement is in the scope of IFRS 17.

Disclosure

The objective of the IFRS 17 disclosure requirements is to disclose information in the notes that, together with the information provided in the statement of financial position, statement of financial performance and statement of cash flows, gives a basis for users to assess the effect that contracts within the scope of IFRS 17 have on the financial position, financial performance and cash flows.

To achieve that objective, disclosure of qualitative and quantitative information about:

(a) the amounts recognised in its financial statements for contracts within the scope of IFRS 17;
(b) the significant judgements, and changes in those judgements, made when applying IFRS 17; and
(c) the nature and extent of the risks from contracts within the scope of IFRS 17.

Of the disclosures required by paragraphs 98–109A, only the following paragraphs apply to contracts under the premium allocation approach.

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

	(b) any loss component (see paragraphs 47–52 and 57–58). (c) the liabilities for incurred claims. For insurance contracts to which the premium allocation approach described in paragraphs 53–59 or 69–70 has been applied, an entity shall disclose separate reconciliations for: (i) the estimates of the present value of the future cash flows; and (ii) the risk adjustment for non-financial risk.
Paragraph 102	The objective of the reconciliations in paragraphs 100–101 is to provide different types of information about the insurance service result.
Paragraph 103	An entity shall separately disclose in the reconciliations required in paragraph 100 each of the following amounts related to insurance services, if applicable: (a) insurance revenue. (b) insurance service expenses, showing separately: (i) incurred claims (excluding investment components) and other incurred insurance service expenses; (ii) amortization of insurance acquisition cash flows; (iii) changes that relate to past service, i.e. changes in fulfilment cash flows relating to the liability for incurred claims; and (iv) changes that relate to future service, i.e. losses on onerous groups of contracts and reversals of such losses. (c) investment components excluded from insurance revenue and insurance service expenses.
Paragraph 105	To complete the reconciliations in paragraphs 100–101, an entity shall also disclose separately each of the following amounts not related to insurance services provided in the period, if applicable: (a) cash flows in the period, including: (i) premiums received for insurance contracts issued (or paid for reinsurance contracts held); (ii) insurance acquisition cash flows; and (iii) incurred claims paid and other insurance service expenses paid for insurance contracts issued (or recovered under reinsurance contracts held), excluding insurance acquisition cash flows.

	(b) the effect of changes in the risk of non-performance by the issuer of reinsurance contracts held; (c) insurance finance income or expenses; and (d) any additional line items that may be necessary to understand the change in the net carrying amount of the insurance contracts.
Paragraph 105A	An entity shall disclose a reconciliation from the opening to the closing balance of assets for insurance acquisition cash flows recognised applying paragraph 28B. An entity shall aggregate information for the reconciliation at a level that is consistent with that for the reconciliation of insurance contracts, applying paragraph 98.
Paragraph 105B	An entity shall separately disclose in the reconciliation required by paragraph 105A any impairment losses and reversals of impairment losses recognised applying paragraph 28E–28F.
Paragraph 109A	An entity shall disclose quantitatively, in appropriate time bands, when it expects to derecognise an asset for insurance acquisition cash flows applying paragraph 28C.

With medical schemes using the Premium Allocation Approach, it shall disclose:

(a) whether it makes an adjustment for the time value of money and the effect of financial risk;
- No adjustment is made for the time value of money and the effect of financial risk.

(b) the method it has chosen to recognise insurance acquisition cash flows.
- Insurance acquisition costs are expensed as incurred.

The reconciliation required in paragraphs 100 and 103 has been included below:

		Current Year				Prior Year			
		Liability for Remaining Coverage		Liability for Incurred Claims	Total	Liability for Remaining Coverage		Liability for Incurred Claims	Total
	R'000	Excluding loss Component	Loss Component			Excluding loss Component	Loss Component		
IFRS17 (99)(b)	**Insurance contract liabilities/(Insurance contract assets) as at 1 January**				-				-
IFRS17 (103)(a)	**Insurance revenue**				-				-
IFRS17 (103)(b)	**Insurance service expenses**				-				-
IFRS17 (103)(b)(i)	Incurred claims and other incurred insurance service expenses				-				-
IFRS17 (103)(b)(ii)	Amortisation of insurance acquisition cash flows (will not be applicable)				-				-
IFRS17 (103)(b)(iii)	Changes that relate to past service, i.e. changes in fulfilment cash flows relating to the liability for incurred claims				-				-
IFRS17 (103)(b)(iv)	Changes that relate to future service, i.e. losses on onerous groups of contracts and reversals of such losses.				-				-

	Changes in liability towards future members								
	Insurance service expenses	-	-	-	-	-	-	-	-
	Insurance service result	-	-	-	-	-	-	-	-
IFRS17 (105)(c)	Finance expenses from insurance contracts issued				-				-
	Total amounts recognised in comprehensive income	-	-	-	-	-	-	-	-
IFRS17 (105)(a)	**Cash flows**								
IFRS17 (105)(a)(i)	Contributions received				-				-
IFRS17 (105)(a)(ii)	Insurance acquisitions cash flows				-				-
IFRS17 (105)(a)(iii)	Incurred claims paid and other insurance service expenses paid (excluding insurance acquisition cash flows)				-				-
IFRS17 (105)(c)	Insurance finance income or expenses				-				-
	Total cash flows	-	-	-	-	-	-	-	-
IFRS17 (99)(b)	**Insurance contract liabilities/(Insurance contract assets) as at 31 December**	-	-	-	-	-	-	-	-

Statement of financial position presentation

IAS 1 requires the statement of financial position to present current and non-current assets, and current and non-current liabilities as separate classifications, except when a presentation based on liquidity provides information that is reliable and more relevant. In such cases an entity shall present all assets and liabilities in order of liquidity. The standard acknowledges that for some entities, such as financial institutions, presentation of assets and liabilities using the order of liquidity provides information that is reliable and more relevant than a current/non-current presentation because the entity does not supply goods or services within a clearly identifiable operating cycle.

Even though the coverage period for a Medical Scheme's benefits is twelve months or less, in instances where members terminate membership prior to the end of a benefit year, surpluses generated are recognised as a liability towards future members. The timing of the settlement of this liability is uncertain. Fluctuations in claim trends and the solvency requirement over time results in uncertainty around the asset utilisation cycle. There is subjectivity around the realisation of assets thus making the current and non-current classification not very reliable as currently included in the primary financial statements. The order of liquidity provides more information about the liquidity of the assets and liabilities on the primary financial statements, with more detail in the notes that support that disclosure. Medical scheme would be required to disclose in the notes amounts expected to be recovered or settled within twelve months, and longer than twelve months.

Whether or not the items are presented based on the order of liquidity, is an area of management judgment.

SAICA DIFFERENCE MAKERS™

An illustration of the presentation of medical scheme's statement of financial position has been included below.

Table 5: Statement of Financial Position presentation

Presentation based on order of liquidity
ASSETS
Property and equipment
Derivative financial instruments
Financial assets at fair value through profit or loss
Insurance contract assets
Reinsurance contract assets
Trade and other receivables
Cash and cash equivalents
TOTAL ASSETS
FUNDS AND LIABILITIES
Members' funds
Accumulated funds (if still applicable)
Property revaluation reserves
Financial assets at fair value through other comprehensive income
LIABILITIES
Retirement benefit obligations
Leases
Insurance contract liabilities (one amount or split out the insurance liability to future members and present separately)
Reinsurance contract liabilities
Derivative financial instruments
Trade and other payables
TOTALS FUNDS AND LIABILITIES

Statement of Comprehensive Income

Table 6: Statement of Comprehensive Income presentation

Presentation with IFRS 17
Insurance revenue
Insurance service expense (*These items disclosed on the SOCI face or in a note)*
Claims incurred
Third party claim recoveries
Accredited management healthcare services
Broker service fees
Directly attributable expenses
Amounts attributable to future members
Net income/ (expense) from risk reinsurance agreements
Risk transfer premiums paid
Recoveries from reinsurance agreements
Insurance service result
Other operating expenses
Other income
Investment income
Income from use of own facilities by external parties
Grants
Sundry income
Gain on derecognition of financial assets at amortised cost
Other expenditure
Expenses for asset management services rendered (if not directly attributable)
Sundry expenses
Cost incurred in provision of own facilities to external parties
Loss on derecognition of financial assets at amortised cost
Net finance income/ expense from insurance contracts
Finance costs
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 other comprehensive income – net change in fair value
Items that will be reclassified to profit or loss
Debt instruments at fair value through OCI – net change in value
Debt instruments at fair value through OCI – reclassified to profit or loss
OTHER COMPREHENSIVE INCOME FOR THE YEAR
TOTAL OTHER COMPREHENSIVE INCOME FOR THE YEAR