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International Accounting Standards Board
30 Cannon Street
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Email: CommentLetters@iasb.org

Dear Sir/Madam

SAICA MEDICAL SCHEMES PROJECT GROUP SUBMISSION ON EXPOSURE DRAFT ED/2013/7

In response to your request for comments on the IASB's Exposure Draft ED/2013/7 *A revision of ED/2010/8 Insurance Contracts*, attached is the comment letter prepared by the Medical Schemes Project Group (MSPG) of the South African Institute of Chartered Accountants (SAICA), in consultation with the Council for Medical Schemes (CMS). This submission was prepared, based on input of preparers and auditors of financial statements from the medical schemes industry in South Africa, in order to assess the impact that the proposals contained in the exposure draft will ultimately have on their financial reporting.

We thank you for the opportunity to provide comments on this document.

Please do not hesitate to contact us should you wish to discuss any of our comments.

Yours sincerely

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SPECIFIC COMMENTS

Question 1—Adjusting the contractual service margin

Do you agree that financial statements would provide relevant information that faithfully represents the entity's financial position and performance if differences between the current and previous estimates of the present value of future cash flows if:

(a) differences between the current and previous estimates of the present value of future cash flows related to future coverage and other future services are added to, or deducted from, the contractual service margin, subject to the condition that the contractual service margin should not be negative; and

(b) differences between the current and previous estimates of the present value of future cash flows that do not relate to future coverage and other future services are recognised immediately in profit or loss?

Why or why not? If not, what would you recommend and why?

The contract boundary and reporting period for medical schemes align and at the reporting date the cash flows relating to future coverage would be minimal; therefore we believe this will not have a major impact on medical schemes.

Question 2—Contracts that require the entity to hold underlying items and specify a link to returns on those underlying items

If a contract requires an entity to hold underlying items and specifies a link between the payments to the policyholder and the returns on those underlying items, do you agree that financial statements would provide relevant information that faithfully represents the entity's financial position and performance if the entity:

(a) measures the fulfilment cash flows that are expected to vary directly with returns on underlying items by reference to the carrying amount of the underlying items?

(b) measures the fulfilment cash flows that are not expected to vary directly with returns on underlying items, for example, fixed payments specified by the contract, options embedded in the insurance contract that are not separated and guarantees of minimum payments that are embedded in the contract and that are not separated, in accordance with the other requirements of the [draft] Standard (ie using the expected value of the full range of possible outcomes to measure insurance contracts and taking into account risk and the time value of money)?

(c) recognises changes in the fulfilment cash flows as follows:

(i) changes in the fulfilment cash flows that are expected to vary directly with returns on the underlying items would be recognised in profit or loss or other comprehensive income on the same basis as the recognition of changes in the value of those underlying items;

(ii) changes in the fulfilment cash flows that are expected to vary indirectly with the returns on the underlying items would be recognised in profit or loss; and

(iii) changes in the fulfilment cash flows that are not expected to vary with the returns on the underlying items, including those that are expected to vary with other factors (for example, with mortality rates) and those that are fixed (for example, fixed death benefits), would be recognised in profit or loss and in

other comprehensive income in accordance with the general requirements of the [draft] Standard?

Why or why not? If not, what would you recommend and why?

We believe that the financial statements would provide relevant information that faithfully represents the entity's financial position and performance if the entity measures the fulfilment cash flows that are expected to vary directly with returns on underlying items by reference to the carrying amount of the underlying items. Any changes in the fulfilment cash flows that are expected to vary directly with returns on the underlying items should also be recognised in profit or loss or other comprehensive income on the same basis as the recognition of changes in the value of those underlying items.

Background information to our response

The Medical Schemes Act 131 of 1998, as amended (the Act) allows medical schemes to provide for personal medical savings account facilities to assist members in managing cash flows for the payment of healthcare services for which they are themselves responsible. Members making use of these facilities enter into a single contract with the medical scheme and cannot access these offerings on a standalone basis.

In accordance with the Act, a maximum of 25% of the total gross contribution (premium) in respect of a member can be allocated to a personal medical savings account. The percentage applicable to a specific benefit option (i.e. registered set of benefits) is stipulated in the scheme's rules. Whilst these savings belong to the member, they may only be used for healthcare services in terms of the registered benefits and are only refundable as provided for in Regulation 10 of the Act. Personal medical savings account facilities may not be utilised to provide for benefits and co-payments relating to prescribed minimum benefits which needs to be funded from the scheme's risk pool. Prevailing legislation and regulatory guidance provides that personal medical savings accounts constitute trust money and must be kept and invested separately from scheme funds and may under no circumstances (even when the scheme is being liquidated) form part of the assets or funds of the medical scheme.

Due to the short-term nature of these monies, schemes are only allowed to invest the funds in bank deposits and call accounts or investments with similar liquidity and risk characteristics.

Any interest earned on these funds must be credited to the members' personal medical savings accounts.

Question 3—Presentation of insurance contract revenue and expenses

Do you agree that financial statements would provide relevant information that faithfully represents the entity's financial performance if, for all insurance contracts, an entity presents, in profit or loss, insurance contract revenue and expenses, rather than information about the changes in the components of the insurance contracts?

Why or why not? If not, what would you recommend and why?

We agree that the financial statements of medical schemes would provide relevant information if insurance contract revenue and expenses are presented and this presentation is in line with revenue recognition principles applied to non-insurance contracts with customers.

The majority of the users of medical scheme financial statements are the members and brokers of medical schemes, whose requirements are met with the proposed presentation under the exposure draft. We prefer the proposed presentation of insurance contract revenue as defined in the revised exposure draft to the summarised margin approach which was proposed under the previous exposure draft.

Under the requirements of IFRS 4 *Insurance Contracts*, most medical schemes in South Africa currently unbundle the medical savings and deposit accounts in terms of IAS 39 *Financial Instruments: Recognition and Measurement* (IAS 39). Under the proposals in the exposure draft, these would be treated as non-distinct investment components and any contributions related to these would not be recognised in profit or loss, similar to the current accounting treatment under IAS 39. We therefore agree that insurance contract revenue and incurred claims should exclude investment components that have not been separated (paragraph 58).

Question 4—Interest expense in profit or loss

Do you agree that financial statements would provide relevant information that faithfully represents the entity's financial performance if an entity is required to segregate the effects of the underwriting performance from the effects of the changes in the discount rates by:

(a) recognising, in profit or loss, the interest expense determined using the discount rates that applied at the date that the contract was initially recognised. For cash flows that are expected to vary directly with returns on underlying items, the entity shall update those discount rates when the entity expects any changes in those returns to affect the amount of those cash flows; and

(b) recognising, in other comprehensive income, the difference between:

(i) the carrying amount of the insurance contract measured using the discount rates that applied at the reporting date; and

(ii) the carrying amount of the insurance contract measured using the discount rates that applied at the date that the contract was initially recognised. For cash flows that are expected to vary directly with returns on underlying items, the entity shall update those discount rates when the entity expects any changes in those returns to affect the amount of those cash flows?

Why or why not? If not, what would you recommend and why?

An insurer is only required to discount if a contract has a financing component that is significant to the contract. Therefore, we believe that generally for the medical schemes industry, this requirement will not have a significant impact.

However, we do not believe that the segregation of the effects of the underwriting performance from the effects of the changes in the discount rates from initial recognition and when changes in returns are expected will provide useful information to the users of the financial statements.

We therefore recommend that where discounting is applied, the interest expense (calculated using a current interest rate) should be recognised in profit or loss.

Question 5—Effective date and transition

Do you agree that the proposed approach to transition appropriately balances comparability with verifiability?

Why or why not? If not, what do you suggest and why?

Medical scheme contracts are by their nature short-term contracts with a coverage period no more than 12 months and there is no long-term assumptions required to measure the contracts. We believe that the approximate three year period from the date of publication of the final insurance standard to the effective date of the new insurance standard will afford medical schemes the ability to collect the required information to apply the requirements of this draft standard.

Question 6—The likely effects of a Standard for insurance contracts

Considering the proposed Standard as a whole, do you think that the costs of complying with the proposed requirements are justified by the benefits that the information will provide? How are those costs and benefits affected by the proposals in Questions 1–5?

How do the costs and benefits compare with any alternative approach that you propose and with the proposals in the 2010 Exposure Draft?

Please describe the likely effect of the proposed Standard as a whole on:

(a) the transparency in the financial statements of the effects of insurance contracts and the comparability between financial statements of different entities that issue insurance contracts; and

(b) the compliance costs for preparers and the costs for users of financial statements to understand the information produced, both on initial application and on an ongoing basis.

We believe that the cost of complying with the proposals in the exposure draft is justified by the benefits that the information will provide. Overall, we do not believe that medical schemes in South Africa will be required to incur significant additional costs to comply with the proposals in the exposure draft.

The proposals will result in changes to both the measurement and presentation of medical scheme contracts when compared to the current reporting of medical scheme contracts and would require medical schemes to educate users which are primarily members in order to ensure members will be in a position to understand the performance of medical schemes.

In determining the pricing of medical scheme insurance contracts, cross-subsidisation is a key consideration. The cross-subsidisation occurs both within a portfolio of contracts and across the entire medical scheme and ensures the affordability and sustainability of the medical scheme contracts.

It is important to note that the losses incurred on the top-end options is driven to a large extent by anti-selection (i.e. only selecting comprehensive benefit options when the healthcare needs require extended cover) due to the much higher proportion of sicker members electing to join these plans. These plans' benefits are priced at an affordable level based on a number of considerations. Should the contributions on these options be increased in an attempt to address the losses, it would result in members buying down to the mid-options which would increase the losses on the top-end options resulting in these plans entering an actuarial death spiral. Due to the profile of these members (their claiming patterns generally do not change), combined with the lower registered contributions on the

mid-tier options, the mid-tier options would incur worse deficits than those incurred in the top-tier options, resulting in an actuarial death spiral for the medical scheme overall.

By recognising the loss (onerous contracts) at initial recognition (when members sign up for the next calendar year's benefits in November/ December) and only recognising the profit as it is earned during the following calendar year, the benefits and purpose of cross-subsidisation would not be reflected in the accounting for medical scheme contracts which in our view would not be reflective of the South African medical scheme operating environment.

Background information to our response

South African medical schemes are classified as not for profit under the Act and are similar to mutual funds as the members (policyholders) of the scheme own the scheme.

The Act enforces social solidarity, community rating and open enrolment and prohibits risk rating at individual member level. Individual contracts may not be priced based on the specific risks associated with the individual or any other individual criteria. A medical schemes' ability to impose underwriting conditions is limited to general waiting periods (a maximum of three months) and condition specific waiting period (maximum of twelve months).

The Act restricts South African medical schemes' ability to vary contributions only on the basis of income or the number of dependants, or both the income and the number of dependants. A medical scheme may load a member's contribution by applying a late joiner penalty in specific instances for members over the age of 35 years. All other forms of varying member contributions are strictly prohibited by the Act.

Medical schemes set prices that fully reflect the risk at a portfolio level which is typically the various benefit options offered as well as considering the risk at a consolidated scheme level (after taking into account investment income). These risks are managed in different portfolios of policyholders and cross-subsidise the level of contributions for sick members by using those of healthy members, which complies with the social solidarity community rating principles contained in the Act when setting contributions. This cross-subsidisation not only occurs within the portfolio, but also across the scheme as a whole.

Question 7—Clarity of drafting

Do you agree that the proposals are drafted clearly and reflect the decisions made by the IASB?

If not, please describe any proposal that is not clear. How would you clarify it?

We generally agree that the proposals are drafted clearly and reflect the decisions made by the IASB. However, we would like to comment on the following:

Fixed fee service contracts

Paragraph 7(e) indicates that fixed-fee service contracts that have as their primary purpose the provision of services and that meet certain conditions will be outside the scope of the insurance standard.

The FASB proposes in its Insurance Contracts Exposure Draft that capitation and other fixed-fee medical service arrangements could be examples of fixed-fee service contracts (paragraph 834-10-55-31 to 834-10-55-37).

We are concerned that South African medical schemes or certain benefit options within a medical scheme could be excluded from the scope of the insurance standard based on the current proposals in the IASB's exposure draft. This could result in medical schemes being required to measure certain of their benefit options in terms of the insurance standard and other benefit options in the same medical scheme under the revenue standard. The principles applied in managing the business of medical schemes are based on principles of insurance and we do not believe that requiring certain of these benefit options or medical scheme contracts to be accounted for under the revenue standard would reflect the manner in which medical schemes are managed.

In our view, the comparability across medical scheme or benefit option within medical schemes would be reduced should certain medical scheme or benefit option within medical schemes be accounted for in terms of the insurance standard and others in terms of the revenue standard.

We therefore recommend that entities that issue fixed-fee service contracts, which meet the definition of insurance contracts, should not be required to apply the insurance standard, but should be allowed to apply the revenue standard. We propose that entities should be provided with a scope exemption from applying the insurance standard (similar to IAS 28 *Investment in Associates and Joint Ventures* which allows exemptions from applying the equity method) as opposed to the scope exclusion currently proposed. The scope exemption will allow entities to elect to apply the insurance standard if their business model is similar to that of an insurer.

We recommend that entities on adoption of the new insurance standard explicitly indicate whether they regard fixed-fee service contracts as insurance contracts (i.e. if they meet definition of insurance contracts) or contracts within the scope of the revenue standard.

The boundary of an insurance contract (paragraph 23 (b)(i)) has been extended to provide for instances where the entity has the right or practical ability to reassess the risk of the portfolio of insurance contracts that contains the contract and as a result can set a price or level that fully reflects the risk of that portfolio. We propose that paragraph 7(e)(i) be extended to include the assessment at a portfolio level. This would align this definition to the definition of a contract boundary and ensure that all medical scheme contracts would be accounted for in terms of the insurance standard and ensure alignment between the accounting treatment and the manner in which medical schemes are managed (i.e. insurance principles).

Contract boundary

The legislation governing South African medical schemes prevents risk rating by medical schemes and provides for community rating. Furthermore, the coverage period for medical scheme contracts is one year or less and is generally re-priced on an annual basis. The current definition of a contract boundary proposed allows for medical scheme contracts to be accounted for in terms of the way they are managed, namely as short-term contracts and we are supportive of the revision to the contract boundary definition.